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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

2022-00733

Department

200 - Department of Revenue

Agency

201 - Taxation Division

CCR number

1 CCR 201-2

Rule title

INCOME TAX

Rulemaking Hearing

Date

12/15/2022

Time

10:00 AM

Location

Virtual Hearing See Comments

Subjects and issues involved

This rule repeals and replaces the existing rule and provides guidance regarding the required addition for any part of an individuals, estates, or trusts federal net operating loss deduction that is not allocated to Colorado.

Statutory authority

The statutory bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-104(3)(l), 39-22-104(4)(z), and 39-22-504, C.R.S.

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DEPARTMENT OF REVENUE

Taxation Division

INCOME TAX

1 CCR 201-2

Rule 39-22-504–1. Colorado Net Operating Losses for Individuals, Estates, and Trusts.

Basis and Purpose. The bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-104(3)(l), 39-22-104(4)(z), and 39-22-504, C.R.S. The purpose of this rule is to provide guidance regarding the portion of any net operating losses deducted in the calculation of federal taxable income for an individual, estate, or trust that is allocated to Colorado and any required addition for any portion of a net operating loss that is not allocated to Colorado.

(1) **General Rule.** Except as provided in sections 39-22-104(3)(l), 39-22-104(4)(z), and 39-22-504, C.R.S., and this rule, a net operating loss deduction is allowed for Colorado income tax purposes in the same manner that it is allowed under the Internal Revenue Code. An individual, estate, or trust that has claimed a net operating loss deduction pursuant to section 172 of the Internal Revenue Code is neither required nor allowed to make any further modification to federal taxable income related to the net operating loss deduction in the calculation of Colorado income tax, except as provided by law and this rule.

(2) **Addition Required for Loss Not Allocated to Colorado.** In the calculation of Colorado income tax pursuant to section 39-22-104, C.R.S., an addition to federal taxable income is required in the amount determined pursuant to section 39-22-504, C.R.S., and this rule. The amount of the addition is equal to the amount of any federal net operating loss deducted pursuant to section 172 of the Internal Revenue Code in the calculation of federal taxable income, minus the portion of such deducted loss that is allocated to Colorado in the taxable year that the net operating loss was sustained.

(a) *Full-year Colorado Residents.* In the case of an individual, estate, or trust that is a Colorado resident pursuant to section 39-22-103, C.R.S., for the entirety of the taxable year in which the net operating loss was sustained, the entire loss is allocated to Colorado.

(b) *Colorado Nonresidents.* In the case of an individual, estate, or trust that is not a Colorado resident pursuant to section 39-22-103, C.R.S., for any part of the taxable year in which the net operating loss was sustained, the loss is allocated to Colorado to the extent that it is derived from sources within Colorado as determined pursuant to section 39-22-109 or 39-22-403, C.R.S., as applicable.

(c) *Part-year Colorado Residents.* In the case of an individual, estate, or trust that is a Colorado resident pursuant to section 39-22-103, C.R.S., for only part of the taxable year in which the net operating loss was sustained, the loss shall be allocated to Colorado pursuant to this paragraph (2)(c).

(i) The net operating loss shall first be allocated to Colorado pursuant to paragraph (2)(b) of this rule.

(ii) Any part of the net operating loss that is not allocated to Colorado pursuant to paragraph (2)(c)(i) of this rule, shall be allocated to Colorado by multiplying that part of the net operating loss by a fraction, the numerator of which is number of days during the tax year that the taxpayer was a Colorado resident and the denominator of which is the total number of days in the tax year.

~~**Rule 39-22-504. Colorado Net Operating Losses.**~~

~~(1) **Colorado Net Operating Losses of Individuals, Estates and Trusts.**~~

~~(a) *Computation of Loss.* The Colorado net operating losses of individuals, estates and trusts shall be computed under the federal statutes and rules for computing net operating losses of individuals, estates and trusts. The Colorado net operating loss of resident individuals, estates and trusts shall be the same as the federal net operating loss except to the extent the modifications required and allowed by section 39-22-104, C.R.S., affect the computation of the Colorado loss.~~

~~(b) *Carrybacks and Carryovers of the Colorado Net Operating Losses of Individuals, Estates and Trusts.*~~

~~(i) Individual, estate and trust Colorado net operating losses incurred in taxable years beginning prior to January 1, 1984, could be carried back three years and forward fifteen. Such losses had to be carried back before they could be carried forward.~~

~~Example: A 1983 individual Colorado net operating loss had to be applied in the following sequence: 1980, 1981, 1982, 1984, 1985, (and so on through 1998).~~

~~(ii) Individual, estate and trust Colorado net operating losses incurred in taxable years beginning on or after January 1, 1984, but before January 1, 1987, could not be carried back to a prior tax year. They could be carried forward and claimed as a modification in determining Colorado taxable income for up to fifteen years.~~

~~(iii) Individual, estate and trust Colorado net operating losses incurred in taxable years beginning on or after January 1, 1987, but before January 1, 1990 can be carried back three years to taxable years beginning prior to January 1, 1987, but only if the taxpayer elects to carry back a federal net operating loss, if any, incurred in the same tax year.~~

~~Example: Taxpayer incurred 1988 federal and Colorado net operating losses of $40,300. He elects to forgo his federal net operating loss carryback and to carry his federal loss forward. As he has the potential of receiving the full benefit of this federal net operating loss carryforward for Colorado income tax purposes, he may not carry his 1988 Colorado loss back to any earlier years.~~

~~(iv) Individual, estate or trust Colorado net operating losses incurred in tax years beginning on or after January 1, 1987, may not be carried to any other tax year beginning on or after January 1, 1987. Federal net operating losses incurred in tax years beginning on or after January 1, 1987 and carried to tax years beginning on or after January 1, 1987, will be allowed for Colorado income tax purposes in lieu of any such Colorado net operating losses being allowed.~~

~~Example: A nonresident taxpayer incurred a 1990 federal net operating loss of $150,000 which he carried back and applied as follows: 1987 — $80,000; 1988 - $60,000; 1989 — $10,000. $120,000 of the loss was from Colorado sources. The~~

~~amount of the federal loss he can claim for Colorado purposes in 1988 is limited to the loss applied to 1988 for federal purposes ($80,000) or that part of his federal loss sourced to Colorado ($120,000).~~

~~Assume the taxpayer uses $46,000 of the loss to zero out his 1987 Colorado income. The amount of the loss he can use for 1988 for Colorado income tax purposes is the smaller of the federal loss applied ($60,000) or the remaining Colorado-source loss ($74,000).~~

~~Assume the taxpayer uses $31,000 of the loss to zero out his 1988 Colorado income. The amount of the loss he can use for 1989 for Colorado income tax purposes is the smaller of the federal loss applied ($10,000) or the remaining Colorado-source loss ($43,000).~~

~~The taxpayer would source the entire $10,000 federal net operating loss applied to 1989 to Colorado. The balance of the Colorado-source loss ($33,000) would cease to exist.~~

COLORADO DEPARTMENT OF REVENUE
OFFICE OF TAX POLICY

STATEMENT OF BASIS AND PURPOSE

Colorado Net Operating Losses for Individuals, Estates, and Trusts
Rule 39-22-504-1
1 CCR 201-2

Basis

The statutory bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-104(3)(l), 39-22-104(4)(z), and 39-22-504, C.R.S.

Purpose

This new rule replaces Rule 39-22-504. The purpose of this rule is to provide guidance regarding the portion of any net operating losses deducted in the calculation of federal taxable income for an individual, estate, or trust that is allocated to Colorado and any required addition for any portion of a net operating loss that is not allocated to Colorado. For this purpose, the rule prescribes the allocation of net operating losses to Colorado as follows:

- for Colorado residents, the entire net operating loss is allocated to Colorado;
- for nonresidents, the net operating loss is allocated to Colorado to the extent that it is derived from sources within Colorado; and
- for part-year residents, the net operating loss is first allocated to Colorado to the extent that it is derived from sources within Colorado and any remaining portion of the net operating loss is allocated to Colorado pro rata based upon the number of days during the tax year that the taxpayer was a Colorado resident.

Notice of Proposed Rulemaking

Tracking number

2022-00731

Department

200 - Department of Revenue

Agency

201 - Taxation Division

CCR number

1 CCR 201-2

Rule title

INCOME TAX

Rulemaking Hearing

Date

12/15/2022

Time

10:00 AM

Location

Virtual Hearing See Comments

Subjects and issues involved

This rule repeals and replaces the existing rule and provides guidance regarding the definition of foreign source income, the foreign source income exclusion, and the requirement to report any changes to that amount.

Statutory authority

The statutory bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-103(11), 39-22-303, 39-22-303.6, 39-22-304, and 39-22-305, C.R.S.

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DEPARTMENT OF REVENUE

Taxation Division

INCOME TAX

1 CCR 201-2

Rule 39-22-303(10). Foreign Source Income.

Basis and Purpose. The bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-103(11), 39-22-303, 39-22-303.6, 39-22-304, and 39-22-305, C.R.S. The purpose of this rule is to provide guidance regarding the definition of foreign source income in section 39-22-303(10), C.R.S., the calculation of the amount of foreign source income considered in the apportionment and allocation of a C corporation's net income, and the requirement to report any changes to that amount.

(1) **General Rule.** In apportioning and allocating income, a C corporation's foreign source income shall be considered only to the extent provided in section 39-22-303(10), C.R.S., and this rule. In the case of a combined return filed pursuant to section 39-22-303(11), C.R.S., a consolidated return filed pursuant to section 39-22-305, C.R.S., or a combined-consolidated return filed pursuant to sections 39-22-303(11) and -305, C.R.S., the foreign source income exclusion shall be calculated with respect to only the C corporations that are included in such combined, consolidated, or combined-consolidated return and based upon the foreign tax credit or deduction determined with respect to only the group of C corporations included in that combined, consolidated, or combined-consolidated Colorado return. In the case of a separate return filed by a single C corporation, the foreign source income exclusion shall be calculated with respect to only that C corporation and based upon the foreign tax credit or deduction determined with respect to only that C corporation.

(2) **Foreign Source Income.** For the purpose of this rule, unless context otherwise requires, "foreign source income" means taxable income from sources without the United States, as used in section 862 of the Internal Revenue Code, and includes any taxable income from sources without the United States considered in the calculation of the limit on the federal foreign tax credit pursuant to section 904(a) of the Internal Revenue Code. In accordance with section 862(b) of the Internal Revenue Code, there shall be deducted from gross income from sources without the United States any expenses, losses, and other deductions properly apportioned or allocated thereto, including any deduction allowed pursuant to section 250 of the Internal Revenue Code, and a ratable part of any other expenses, losses, or deductions that cannot be allocated to some item or class of gross income. "Gross income from sources without the United States" includes, but is not limited to:

(a) the types of income enumerated in section 862(a) of the Internal Revenue Code;

(b) income allocated to sources without the United States pursuant to section 863 of the Internal Revenue Code;

(c) amounts included in a C corporation's federal taxable income pursuant to section 951 or 951A of the Internal Revenue Code;

(d) the amount treated as a dividend received by the C corporation pursuant to section 78 of the Internal Revenue Code; and

(e) any item of income treated as arising from sources outside of the United States under treaty obligation of the United States as described in section 245(a)(10), 904(d)(6), or 904(h)(10) of the Internal Revenue Code.

(3) **Federal Deduction for Foreign Tax.** If, for federal income tax purposes, a C corporation has elected to claim foreign taxes paid or accrued as a deduction, the portion of the C corporation's foreign source income to be subtracted in apportioning and allocating the C corporation's income shall be determined pursuant to section 39-22-303(10), C.R.S., and this paragraph (3). The amount of the deduction allowed pursuant to section 164(a)(3) of the Internal Revenue Code for foreign income taxes paid or accrued shall be subtracted from:

(a) the C corporation's net income determined pursuant to section 39-22-304(1), C.R.S., to the extent that such foreign taxes:

(i) were added to the C corporation's federal taxable income pursuant to section 39-22-304(2)(a); and

(ii) do not exceed the foreign source income otherwise included in the C corporation's federal taxable income upon which such foreign taxes were paid or accrued; and

(b) the total receipts of the C corporation in the calculation of the denominator described in section 39-22-303.6(4)(a), C.R.S., to the extent that such foreign taxes do not exceed the foreign source income, otherwise included in the denominator, upon which such foreign taxes were paid or accrued.

(4) **Federal Credit for Foreign Tax.**

(a) If, for federal income tax purposes, a C corporation has elected to claim foreign taxes as a credit, the portion of the C corporation's foreign source income to be excluded in apportioning and allocating the C corporation's income shall be determined pursuant to section 39-22-303(10), C.R.S., and this paragraph (4).

(b) *Separate Calculation of Exclusion with Respect to Certain Categories of Income*. In accordance with section 39-22-103(11), C.R.S., the amount that shall be excluded pursuant to section 39-22-303(10)(b), C.R.S., and paragraph (4) of this rule shall be calculated separately with respect to each category of income for which separate calculation of the foreign tax credit is required pursuant to section 245(a)(10), 865(h), 901(j), 904(d), 904(d)(6), or 904(h)(10) of the Internal Revenue Code. The sum of such separately calculated amounts shall be excluded from federal taxable income and total receipts as prescribed by section 39-22-303(10), C.R.S., and this paragraph (4).

(c) *Coordination with Sections 39-22-303(8)(b) and 39-22-304(3)(q), C.R.S.*

(i) For the purpose of this paragraph (4)(c), a "section 303(8)(b) included entity" means a business entity that is included in a combined or combined-consolidated return pursuant to section 39-22-303(8)(b), C.R.S.

(ii) In the case of a combined or combined-consolidated return that includes a section 303(8)(b) included entity, the application of section 39-22-303(10), C.R.S., and this rule to that return shall be made as follows:

(A) for the purpose of section 39-22-303(10)(b), C.R.S., and this paragraph (4), the federal taxable income of the section 303(8)(b) included entity

shall be determined in accordance with sections 39-22-304(1)(b) and 39-22-303(10)(c), C.R.S.;

(B) for the purpose of section 39-22-303(10)(b), C.R.S., and paragraph (4)(e)(i)(A) of this rule, the foreign taxes paid or accrued by the section 303(8)(b) included entity shall be determined under the applicable provision of the Internal Revenue Code as if that C corporation was a domestic corporation, as defined in section 7701(a)(3) and (4) of the Internal Revenue Code;

(C) any amount that is subtracted from federal taxable income on the combined or combined-consolidated return pursuant to section 39-22-304(3)(q), C.R.S., shall be disregarded in the determination of both foreign source income, for the purpose of section 39-22-303(10), C.R.S, and paragraphs (2) and (4) of this rule, and federal taxable income, for the purpose of section 39-22-303(10)(b), C.R.S., and paragraph (4) of this rule; and

(D) any foreign tax deemed paid pursuant to section 960 of the Internal Revenue Code by a U.S. shareholder of a section 303(8)(b) included entity, on any amount included in federal taxable income pursuant to section 951(a) or 951A(a) of the Internal Revenue Code and subtracted pursuant to 39-22-304(3)(q), C.R.S., shall be disregarded for the purpose of section 39-22-303(10)(b), C.R.S., and paragraph (4)(e)(i)(B) of this rule.

(d) The portion of the C corporation's foreign source income, determined pursuant to this paragraph (4), shall be excluded, subject to the limit prescribed in paragraph (4)(g) of this rule, from:

(i) the C corporation's net income determined pursuant to section 39-22-304(1), C.R.S., to the extent such foreign source income is otherwise included in the C corporation's net income; and

(ii) the total receipts of the C corporation in the calculation of the denominator described in section 39-22-303.6(4)(a), C.R.S., to the extent such foreign source income is otherwise includible in total receipts. See section 39-22-303.6(4)(b), C.R.S., regarding the exclusion of foreign source income from the numerator described in section 39-22-303.6(4)(a), C.R.S.

(e) The portion of a C corporation's foreign source income that shall be excluded pursuant to paragraph (4)(d) of this rule shall be determined by first deducting from foreign source income any amount subtracted from federal taxable income pursuant to section 39-22-304(3)(j), C.R.S., and multiplying the remaining foreign source income by a fraction calculated pursuant to this paragraph (4)(e).

(i) The numerator of the fraction shall be the total of any income taxes, subject to the limitation imposed by section 904(a) of the Internal Revenue Code and any other sections of the Internal Revenue Code imposing limitations on the amount of the federal foreign tax credit allowed, that are:

(A) paid or accrued to foreign countries and United States possessions during the tax year by the C corporation pursuant to section 901 of the Internal Revenue Code;

(B) deemed paid pursuant to section 960 of the Internal Revenue Code for the tax year; and

(C) carried over or carried back to such tax year pursuant to section 904(c) of the Internal Revenue Code.

(ii) The denominator of the fraction shall be determined by multiplying:

(A) the C corporation's effective federal corporate income tax rate, as computed pursuant to section 39-22-303(10)(b)(III), C.R.S., and paragraph (4)(f) of this rule, by:

(B) the C corporation's foreign source income without first deducting from such foreign source income any amount subtracted from federal taxable income pursuant to section 39-22-304(3)(j), C.R.S.

(f) *Effective Federal Corporate Income Tax Rate.* For purposes of paragraph (4)(e)(ii)(A) of this rule, a C corporation's effective federal corporate income tax rate is a fraction.

(i) The numerator of the fraction is the C corporation's federal corporate income tax calculated in accordance with section 11(a) and (b) of the Internal Revenue Code, without regard to any credits against tax allowed or claimed by the C corporation.

(ii) The denominator of the fraction is the C corporation's federal taxable income as determined pursuant to section 63 of the Internal Revenue Code.

(g) The amount that shall be excluded from net income pursuant to paragraph (4)(d)(i) of this rule and from total receipts pursuant to paragraph (4)(d)(ii) of this rule shall be limited to the foreign source income otherwise included in net income or total receipts, respectively.

(h) The amount excluded pursuant to section 39-22-303(10)(b)(III), C.R.S., and paragraph (4) of this rule is the sum of the exclusion amounts calculated separately for each income category described in paragraph (4)(b) of this rule. The calculation of the exclusion amount for each income category pursuant to section 39-22-303(10)(b)(III), C.R.S., and paragraphs (4)(e) and (4)(f) of this rule is represented by the formula in paragraph (4)(h)(i) of this rule with the terms therein defined in paragraph (4)(h)(ii):

(i) Separate Income Category Exclusion = (FSI net § 78) X (FT / (Fed. Rate X FSI))

(ii) As used in the formula presented in paragraph (4)(h)(i):

(A) "Separate Income Category Exclusion" means the amount of foreign source income in the separate income category to be excluded and determined pursuant to paragraph (4)(e) of this rule;

(B) "FSI net § 78" means foreign source income, as defined in section 39-22-303(10), C.R.S., and paragraph (2) of this rule, in the separate income category, minus the amount treated as a dividend received by the C corporation with respect to such separate category income pursuant to section 78 of the Internal Revenue Code and subtracted from federal taxable income pursuant to section 39-22-304(3)(j), C.R.S., as described in paragraph (4)(e) of this rule;

(C) "FT" means the amount of foreign income taxes with respect to the separate income category determined pursuant to paragraph (4)(e)(i) of this rule and the applicable provisions of the Internal Revenue Code;

(D) "Fed. Rate" means the effective federal corporate income tax rate determined pursuant to paragraphs (4)(e)(ii)(A) and (4)(f) of this rule; and

(E) "FSI" means foreign source income in the separate income category, as defined in section 39-22-303(10), C.R.S., and paragraph (2) of this rule, as described in paragraph (4)(e)(ii)(B) of this rule.

(i) In any case in which the amount of foreign source income excluded on the C corporation's Colorado return was not properly calculated, as the result of an error in the original calculation, adjustments made in the accounting of the C corporation's foreign source income, or for any other reason, the C corporation shall file an amended return reflecting the corrected calculation of the amount excluded.

(j) *Redetermination Under Section 905(c) of the Internal Revenue Code.*

(i) If a redetermination of federal tax is made or required pursuant to section 905(c) of the Internal Revenue Code for a C corporation that excluded any foreign source income pursuant to section 39-22-303(10)(b), C.R.S., and paragraph (4) of this rule in the calculation of its Colorado income tax, that C corporation shall file an amended Colorado return to report any change to the amount of the foreign source income exclusion resulting from any adjustment to the amount of the federal foreign tax credit.

(ii) Pursuant to section 39-21-107(2), C.R.S., and section 6501(c)(5) of the Internal Revenue Code, any additional Colorado income tax due as the direct result of a redetermination of federal tax pursuant to section 905(c) of the Internal Revenue Code and a corresponding adjustment to the C corporation's foreign source income exclusion may be assessed and collected at any time, without regard to the provisions of section 6501(a) of the Internal Revenue Code (relating to limitations on assessment and collection). A C corporation may claim a credit or refund in the time provided by section 39-21-108(1), C.R.S., and section 6511(d)(3) of the Internal Revenue Code for any overpayment of Colorado income tax resulting directly from a redetermination of federal tax pursuant to section 905(c) of the Internal Revenue Code and a corresponding adjustment to the C corporation's foreign source income exclusion. This paragraph (4)(j)(ii) shall not apply to any increase or decrease in Colorado income tax that does not result directly from a redetermination of federal tax pursuant to section 905(c) of the Internal Revenue Code and a corresponding adjustment to the C corporation's foreign source income exclusion.

~~**Rule 39-22-303(10). Foreign Source Income.**~~

~~"Foreign source income" is taxable income from sources outside the United States as defined in section 862 of the internal revenue code. "Foreign source income" includes, but is not limited to, interest, dividends (including Sec. 78 "gross-up,") compensation for personal services, rents and royalties, and net income from the sale of property. "Foreign source income" is gross income, less expenses, losses, and other deductions properly apportioned or allocated thereto and a ratable part of any other expenses, losses, or deductions that cannot be allocated to some item or class of gross income.~~

~~IRC Sec. 78 dividend shall be subtracted from federal taxable income in accordance with 39-22-304(3)(j), C.R.S.~~

~~(1) If a taxpayer elects to claim foreign income taxes as a deduction for federal income tax purposes, such deductions shall also be allowed for Colorado income tax purposes.~~

~~Colorado modifications to federal taxable income shall include any foreign source income and related foreign income taxes included in a combined report but not included in the federal return.~~

~~(2)~~

~~(a) If a federal election is made to claim foreign taxes as a credit, a percentage of foreign source income shall be excluded from Colorado income subject to apportionment and from the numerator and denominator of the receipts factor.~~

~~For purposes of this rule, foreign tax includes tax paid or accrued, deemed paid, or carried over or carried back to the tax year, per the federal income tax return. Not included are taxes carried over from, or carried back to, a tax year beginning before Jan. 1, 1986.~~

~~The foreign source income exclusion shall be the lesser of:~~

~~(i) Foreign source income (Excluding Sec. 78 Dividend), or~~

~~(ii) The product of Foreign Taxes Paid ("FT") and the Foreign Source Income (Excluding Sec. 78 Dividend) ("FSI net §78") divided by the product of the effective federal corporation tax rate ("Fed Rate") and the Foreign Source Income (Including Sec.78 Dividend) ("FSI"). This is expressed as the following formula:~~

~~(FT X "FSI net §78") / (Fed Rate X FSI)~~

~~The effective federal corporation tax rate means the combined taxpayer's federal corporate income tax (calculated in accordance with section 11(a) and (b) of the internal revenue code for such tax year) divided by the combined taxpayer's federal taxable income. As a formula:~~

~~Effective federal corporate tax rate = federal corporate income tax / federal corporate taxable income~~

~~Modifications computed per this rule shall be claimed as "other" additions or subtractions in the modification section of the Colorado corporate income tax return.~~

~~(b) For tax years commencing prior to January 1, 2000, the denominator of the formula in subsection (a)(ii) will use 46% in place of the effective federal corporation tax rate.~~

~~(3) When determining foreign source income for a foreign corporation, such income shall not include any income of the foreign corporation that is derived from the conduct of a trade or business within the United States.~~

~~(4) The excess, if any, of a taxpayer's foreign source income over the foreign source income exclusion shall not be included in the numerator of the Colorado receipts factor (see §39-22-303.6(4)(b), C.R.S.).~~

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Foreign Source Income
Rule 39-22-303(10)
1 CCR 201-2

Basis

The statutory bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-103(11), 39-22-303, 39-22-303.6, 39-22-304, and 39-22-305, C.R.S.

Purpose

The purpose of the amendment to this rule, regarding foreign source income, is to:

- provide guidance regarding the definition of foreign source income, the calculation of the amount of foreign source income considered in the apportionment and allocation of a C corporation's net income, and the requirement to report any changes to that amount;

- clarify that the provisions in both statute and rule regarding the exclusion of foreign source income apply collectively to all C corporations included in the same combined, consolidated, or combined-consolidated Colorado return;

- specify that foreign source income potentially eligible for exclusion includes the types of income enumerated in IRC section 862(a), income allocated to sources without the United States pursuant to IRC section 863, Subpart F income, global intangible low-tax income (GILTI), any section 78 gross-up, and any item of income treated as arising from sources outside of the United States under treaty obligation of the United States as described certain sections of the Internal Revenue Code;

- explain the application of the foreign source income exclusion to C corporations that have elected to claim foreign taxes paid or accrued as a federal deduction;

- advise that the foreign source income exclusion for a C corporation that has elected to claim foreign taxes as a credit must be calculated separately with respect to each category for which separate calculation of the foreign tax credit is required;

- coordinate the foreign source income exclusion with provisions in House Bill 21-1311 regarding C corporations that are incorporated in a foreign jurisdiction for the purpose of tax avoidance;

- coordinate the foreign source income exclusion with the subtraction authorized by section 39-22-304(3)(j), C.R.S., for section 78 dividends;

- specify that foreign taxes considered in the calculation of the foreign source income exclusion are subject to the limits imposed on the federal foreign tax credit by IRC section 904 and any other section of the Internal Revenue Code;

- clarify that the effective federal corporate income tax rate, for the purpose of calculating the foreign source income exclusion, is determined without regard to any credits allowed or claimed with respect to the taxpayer's federal income tax;

- clarify that the amount of foreign source income that may be excluded from net income and total receipts is limited to the amount of foreign source income otherwise included in net income or total receipts, respectively;

- provide a formula concisely illustrating the calculation of the foreign source income exclusion for a C corporation that has elected to claim foreign taxes as a credit;

- advise that any taxpayer claiming a foreign source income exclusion based on a foreign tax credit is required to file an amended Colorado return to report any change to the amount of the foreign source income exclusion and to advise that any additional Colorado income tax due as the result of a redetermination of federal tax pursuant to section 905(c) of the Internal Revenue Code may be assessed and collected at any time; and

- improve the clarity and readability of the existing rule.

Notice of Proposed Rulemaking

Tracking number

2022-00732

Department

200 - Department of Revenue

Agency

201 - Taxation Division

CCR number

1 CCR 201-2

Rule title

INCOME TAX

Rulemaking Hearing

Date

12/15/2022

Time

10:00 AM

Location

Virtual Hearing See Comments

Subjects and issues involved

This new rule provides clarification regarding the subtraction from federal taxable income for amounts treated as dividends pursuant section 78 of the Internal Revenue Code.

Statutory authority

The statutory bases for this rule are sections 39-21-112(1), 39-22-103(5.3), and 39-22-304(3)(j), C.R.S.

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DEPARTMENT OF REVENUE

Taxation Division

INCOME TAX

1 CCR 201-2

Rule 39-22-304(3)(j). Corporate Subtraction for Section 78 Dividend.

Basis and Purpose. The bases for this rule are sections 39-21-112(1), 39-22-103(5.3), and 39-22-304(3)(j), C.R.S. The purpose of this rule is to clarify the application of section 39-22-304(3)(j), C.R.S., regarding the subtraction from federal taxable income of amounts treated as dividends pursuant to section 78 of the Internal Revenue Code.

(1) **General Rule.** The subtraction allowed pursuant to section 39-22-304(3)(j), C.R.S., is limited to the amount treated as a dividend and included in a C corporation's federal taxable income pursuant to section 78 of the Internal Revenue Code. The subtraction is not allowed for any part of an amount treated as a dividend pursuant to section 78 of the Internal Revenue Code that is deducted in the calculation of federal taxable income.

(2) **Coordination with Section 250.** No subtraction is allowed for any amount treated as a dividend pursuant to section 78 of the Internal Revenue Code that is:

(i) attributable to global intangible low-taxed income pursuant to section 951A and 960(d) of the Internal Revenue Code; and

(ii) deducted, pursuant to section 250(a)(1)(B)(ii) of the Internal Revenue Code, in the calculation of federal taxable income.

(3) **Subtraction Allowed Only to C Corporations.** The subtraction authorized by section 39-22-304(3)(j), C.R.S., is allowed only to C corporations subject to Colorado income tax imposed by Part 3 of Article 22 of Title 39, C.R.S. The subtraction is not allowed to any individual, estate, or trust subject to Colorado income tax imposed by Part 1 of Article 22 of Title 39, C.R.S.

COLORADO DEPARTMENT OF REVENUE
STATEMENT OF BASIS AND PURPOSE

Corporate Subtraction for Section 78 Dividend
Rule 39-22-304(3)(j)
1 CCR 201-2

Basis

The statutory bases for this rule are sections 39-21-112(1), 39-22-103(5.3), and 39-22-304(3)(j), C.R.S.

Purpose

The purpose of this rule, regarding the subtraction from federal taxable income for amounts treated as dividends pursuant to section 78 of the Internal Revenue Code, is to:

- advise taxpayers that the subtraction is limited to amounts included in federal taxable income;
- clarify that no subtraction is allowed for amounts already deducted, pursuant to section 250 of the Internal Revenue Code or otherwise, in the calculation of federal taxable income; and
- clarify that the subtraction is allowed only to C corporations and not to individuals, estates, or trusts.

Notice of Proposed Rulemaking

Tracking number

2022-00734

Department

200 - Department of Revenue

Agency

201 - Taxation Division

CCR number

1 CCR 201-2

Rule title

INCOME TAX

Rulemaking Hearing

Date

12/15/2022

Time

10:00 AM

Location

Virtual Hearing See Comments

Subjects and issues involved

This rule repeals and replaces the existing rule and provides guidance regarding the Colorado net operating loss deduction allowed to C corporations.

Statutory authority

The statutory bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-304(2)(c), 39-22-304(3)(g), and 39-22-504, C.R.S.

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DEPARTMENT OF REVENUE

Taxation Division

INCOME TAX

1 CCR 201-2

Rule 39-22-504–2. Colorado Net Operating Losses for C Corporations.

Basis and Purpose. The bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-304(2)(c), 39-22-304(3)(g), and 39-22-504, C.R.S. The purpose of this rule is to provide guidance regarding the Colorado net operating loss deduction allowed to C corporations.

(1) **Allocation of Federal Net Operating Loss to Colorado.** The Colorado net operating loss of a C corporation is allowed in the same manner as a federal net operating loss, except that the Colorado net operating loss is computed as only that portion of the federal net operating loss that is allocated to Colorado pursuant to article 22 of title 39, C.R.S., and this rule. In accordance with paragraph (1)(a) of this rule, and subject to the limitation described in paragraph (1)(d) of this rule, the portion of the federal net operating loss that is allocated to Colorado shall be determined by modifying the federal net operating loss as prescribed in paragraph (1)(b) of this rule and apportioning and allocating the resulting modified federal net operating loss, if any, as prescribed in paragraph (1)(c) of this rule. The requirements of paragraph (1)(a) of this rule relating to combined, consolidated, combined-consolidated, and separate filing and the modification, allocation, and apportionment provisions of paragraphs (1)(b) and (1)(c) of this rule shall apply in accordance with the law in effect for the tax year in which the loss was sustained, as provided in paragraph (1)(e) of this rule.

(a) *Combined, Consolidated, Combined-Consolidated, and Separate Filing.* In the case of a combined return filed pursuant to section 39-22-303(11), C.R.S., a consolidated return filed pursuant to section 39-22-305, C.R.S., or a combined-consolidated return filed pursuant to sections 39-22-303(11) and -305, C.R.S., the Colorado net operating loss shall be calculated with respect to only the C corporations that are included in such combined, consolidated, or combined-consolidated return and based upon the federal net operating loss determined with respect to only the group of C corporations included in that combined, consolidated, or combined-consolidated Colorado return. In the case of a separate return filed by a single C corporation, the Colorado net operating loss shall be calculated with respect to only that C corporation and based upon the federal net operating loss determined with respect to only that C corporation.

(b) *Modification of Federal Net Operating Loss.* For the purpose of Colorado income tax, the federal net operating loss of a C corporation computed pursuant to section 172 of the Internal Revenue Code, represented as a negative amount, shall be modified by any addition, subtraction, or other modification required or allowed in the calculation of the net income of the C corporation for the loss year, including, but not limited to:

(i) any addition required by section 39-22-304(2), C.R.S.;

(ii) any subtraction allowed by section 39-22-304(3), C.R.S.; and

(iii) any exclusion of foreign source income pursuant to section 39-22-303(10), C.R.S.

(c) *Allocation and Apportionment of Modified Federal Net Operating Loss.* For the purpose of Colorado income tax, the modified federal net operating loss of a C corporation computed pursuant to paragraph (1)(b) of this rule shall be allocated and apportioned pursuant to this paragraph (1)(c).

(i) Unless the C corporation has made an election pursuant to section 39-22-303.6(8), C.R.S., to treat all income as apportionable income, any nonapportionable income, as defined by section 39-22-303.6(1)(c), C.R.S., included in a C corporation's federal taxable income shall be subtracted from the modified federal net operating loss computed pursuant to paragraph (1)(b) of this rule.

(A) *Example 1.* A taxpayer has $110,000 of apportionable income, $90,000 of nonapportionable income, $250,000 of federal deductions, and no Colorado modifications. This results in a modified federal net operating loss of $50,000. To determine the modified federal net operating loss after deduction of nonapportionable income under this paragraph (1)(c)(i), the $90,000 of nonapportionable income is subtracted from negative $50,000. The result is negative $140,000.

(B) *Example 2.* A taxpayer has $95,000 of apportionable income, a $30,000 loss that is nonapportionable income, $150,000 of federal deductions, and no Colorado modifications. This results in a modified federal net operating loss of $85,000. To determine the modified federal net operating loss after deduction of nonapportionable income under this paragraph (1)(c)(i), the negative $30,000 of nonapportionable loss is subtracted from negative $85,000. The result is negative $55,000.

(ii) The amount computed pursuant to paragraph (1)(c)(i) of this rule, shall be allocated to Colorado by multiplying it by the fraction determined pursuant to section 39-22-303.6(4)(a), C.R.S., and any applicable special apportionment rules promulgated by the Department, for the C corporation for the loss year.

(iii) Any nonapportionable income, as defined by section 39-22-303.6(1)(c), C.R.S., included in a C corporation's gross income and allocated to Colorado pursuant to section 39-22-303.6(7), C.R.S., shall be added to the amount computed pursuant to paragraph (1)(c)(ii) of this rule.

(iv) For the purpose of paragraphs (1)(c)(i) and (1)(c)(iii) of this rule, nonapportionable income shall be the net of the nonapportionable income and any federal expenses, losses, and other deductions and any Colorado modifications allowed pursuant to paragraph (1)(b) of this rule that are properly apportioned or allocated to such nonapportionable income.

(d) If the Colorado net operating loss calculated pursuant to paragraph (1) of this rule exceeds the amount of the federal net operating loss, the Colorado net operating loss is limited to the amount of the federal net operating loss computed in accordance with paragraph (1)(a) of this rule.

(i) If a group of C corporations filing a combined, consolidated, or combined-consolidated Colorado return does not collectively have a federal net operating loss for a tax year, as determined with respect to only the group of C corporations included in that combined, consolidated, or combined-consolidated Colorado return, that group does not have a Colorado net operating loss for that tax year.

(ii) If a C corporation filing a separate Colorado return does not have a federal net operating loss for a tax year, as determined with respect to only that C corporation, that C corporation does not have a Colorado net operating loss for that year.

(e) *Determining Colorado Net Operating Loss Under Laws Applicable to the Loss Year.* Paragraph (1) of this rule shall be applied in determining the amount of the Colorado net operating loss by reference to the applicable provisions of part 3 of article 22 of title 39, C.R.S., in effect for the tax year in which the loss arose. For tax years commencing prior to January 1, 2019, that includes, but is not limited to:

(i) section 39-22-304, C.R.S., for the modification of the federal net operating loss pursuant to paragraph (1)(b) of this rule; and

(ii) section 39-22-303, section 39-22-303.5, or Article IV in section 24-60-1301, C.R.S., as applicable, for the allocation and apportionment of modified federal net operating loss pursuant to paragraph (1)(c) of this rule.

(2) **Carryforward of Colorado Net Operating Losses.** Colorado net operating losses may be carried forward as prescribed in section 39-22-504(3), C.R.S. The entire amount of any Colorado net operating loss shall be first carried forward to the tax year immediately following the tax year in which the loss was sustained. In the event a C corporation has available for deduction Colorado net operating losses originating in multiple tax years, the C corporation must first deduct the loss arising from the earliest tax year. If all or any part of an available net operating loss may not be deducted because of the limitations prescribed in paragraph (3) of this rule, the part that may not be deducted may be carried forward to the next tax year, but in no event may a loss be carried forward beyond the time periods prescribed in section 39-22-504(3), C.R.S.

(3) **Limitations on Colorado Net Operating Loss Deduction.**

(a) The Colorado net operating loss deduction a C corporation may claim for any given tax year is limited to the C corporation's Colorado taxable income before net operating loss deduction determined pursuant to article 22 of title 39, C.R.S., and paragraph (3)(c) of this rule for that tax year. The Colorado net operating loss deduction is also subject to the limitations described in paragraph (3)(b) of this rule.

(b) Except as provided in section 39-22-504(1)(b), C.R.S., and this paragraph (3), the Colorado net operating loss deduction allowed for any taxable year shall be subject to the same limitations that apply with respect to the federal net operating loss deduction allowed pursuant to section 172 of the Internal Revenue Code.

(i) Limitations applicable to the Colorado net operating loss deduction include, but are not limited to, the limitations prescribed by:

(A) section 172(a)(2) of the Internal Revenue Code, subject to the requirements of section 39-22-504(1)(b), C.R.S., and paragraph (3)(b)(ii) of this rule;

(B) sections 381, 382, and 384 of the Internal Revenue Code;

(C) section 860E of the Internal Revenue Code; and

(D) 26 CFR § 1.1502-21.

(ii) *Eighty Percent Limitation Pursuant to Section 39-22-504(1)(b), C.R.S.* The 80 percent limitation prescribed by section 172(a)(2) of the Internal Revenue Code and section 39-22-504(1)(b), C.R.S., shall apply to Colorado net operating loss deductions, subject to the following requirements:

(A) The 80 percent limitation shall apply to Colorado net operating loss deductions claimed for losses arising in taxable years beginning after December 31, 2017, regardless of the tax year for which the deduction is claimed.

(B) The 80 percent limitation shall apply with respect to a C corporation's Colorado taxable income before net operating loss deduction determined pursuant to paragraph (3)(c) of this rule. Pursuant to section 39-22-504(1)(b), C.R.S., and notwithstanding section 172(a)(2)(B)(ii)(I) of the Internal Revenue Code, federal taxable income shall be determined for the purpose of paragraph (3)(c) with regard to any deduction allowed under section 250 of the Internal Revenue Code.

(C) The 80 percent limitation shall apply with respect to Colorado taxable income after the deduction of any Colorado net operating loss deduction allowed pursuant to section 39-22-504, C.R.S., for a loss arising in a taxable year beginning prior to January 1, 2018.

(iii) *Limitation Established by Section 382 of the Internal Revenue Code.* For its application to the Colorado net operating loss deduction, the net operating loss limitation prescribed by section 382 of the Internal Revenue Code shall be apportioned to Colorado using the Colorado apportionment fraction for the old loss corporation for the last full tax year prior to the change in ownership. If the old loss corporation's Colorado apportionment fraction for the last full tax year prior to the change in ownership does not fairly represent the extent of the old loss corporation's business activity in Colorado, the old loss corporation may petition for, or the executive director may require, an alternative method for apportioning the limitation prescribed by section 382.

(iv) *Limitation Established by Section 860E of the Internal Revenue Code.* Pursuant to section 860E of the Internal Revenue Code, the excess inclusion of any holder of a residual interest in a REMIC may not be offset by a Colorado net operating loss. For the purpose of paragraph (3)(c) of this rule, a C corporation's federal taxable income shall be reduced, prior to modification, allocation, and apportionment, by any excess inclusion included therein pursuant to section 860E of the Internal Revenue Code.

(v) *SRLY Limitation Established by 26 CFR § 1.1502-21(c).* For the application of the SRLY limitation prescribed by 26 CFR § 1.1502-21(c) to Colorado net operating losses, the provisions of this paragraph (3)(b)(v) apply. The SRLY limitation applies to a Colorado net operating loss only if it is a portion of a federal net operating loss to which the SRLY limitation applies. For the purpose of this paragraph (3)(b)(v), whether a taxable year is a separate return year or separate return limitation year, as defined in 26 CFR § 1.1502-1(e) and (f), or a consolidated return year, as defined in 26 CFR § 1.1502-1(d), is determined with respect to the filing of the corporation's federal income tax return, not its Colorado income tax return.

(A) The aggregate of the Colorado net operating loss carryforwards of a member (SRLY member) arising (or treated as arising) in SRLYs (SRLY NOLs) that are included in the Colorado net operating loss deductions for

all consolidated return years of the group may not exceed the aggregate Colorado taxable income for all consolidated return years of the group determined by reference to only the member's items of income, gain, deduction, and loss (cumulative register) and pursuant to 26 CFR § 1.1502-21(c) and this rule.

(B) For the purpose of paragraph (3)(b)(v)(A) of this rule, the aggregate Colorado taxable income for all consolidated return years of the group determined by reference to only the member's items of income, gain, deduction, and loss (cumulative register) is the sum of the consolidated taxable income for each consolidated return year, determined pursuant to 26 CFR § 1.1502-21(c)(1)(i) by reference to only the member's items of income, gain, deduction, and loss, and modified, allocated, and apportioned pursuant to paragraph (3)(b)(v)(C) of this rule.

(C) The consolidated taxable income for each consolidated return year, determined pursuant to 26 CFR § 1.1502-21(c)(1)(i) by reference to only the member's items of income, gain, deduction, and loss shall be, for Colorado income tax purposes:

(I) modified by any additions and subtractions required by Colorado law, including, but not limited to, section 39-22-304, C.R.S., determined by reference to only the member; and

(II) allocated and apportioned pursuant to section 39-22-303.6, C.R.S., by reference to only the member’s receipts, income, and loss.

(D) If a limitation on the amount of Colorado taxable income that may be offset under section 172(a) of the Internal Revenue Code and section 39-22-504(1)(b), C.R.S., applies in a taxable year to a member whose carryforwards are subject to a SRLY limitation (SRLY member), the amount of net operating loss subject to a SRLY limitation that is available for use by the affiliated group in that year is limited to the percentage of the balance in the cumulative register (determined pursuant to paragraphs (3)(b)(v)(A), (B), and (C) or this rule) that would be available for offset under section 172(a) of the Internal Revenue Code and section 39-22-504(1)(b), C.R.S., if the SRLY member filed a separate return and reported as Colorado taxable income in that year the amount contained in the cumulative register. For example, assume that an affiliated group has a SRLY member that is a corporation other than a nonlife insurance company, and that the SRLY member has a SRLY NOL that arose in a taxable year beginning after December 31, 2017 (post-2017 NOL). The affiliated group's Colorado taxable income for a consolidated return year is $200, but the cumulative register has a positive balance of only $120 (and no other net operating loss carryforwards are available for the year). Because the SRLY limitation would be $96 ($120 × 80 percent), only $96 of SRLY loss may be used, rather than $160 ($200 × 80 percent). In addition, to the extent that this paragraph (3)(b)(v)(D) applies, the cumulative register is decreased by the full amount of income required under section 172(a) of the Internal Revenue Code to support the amount of SRLY NOL absorption.

(E) If a corporation becomes a member of a federal consolidated group as defined in 26 CFR § 1.1502-1(h) (the SRLY event) within six months of the change date of an ownership change giving rise to an IRC section

382(a) limitation with respect to the carryover of a federal net operating loss (the section 382 event) so as to constitute an overlap as defined in 26 CFR § 1.1502(g)(2)(ii) and thereby precluding the application of the SRLY limitation to that federal net operating loss carryover, then the SRLY limitation will also not apply to the Colorado net operating loss that is a portion of that federal net operating loss carryover.

(vi) Treasury Regulations 26 CFR §§ 1.1502-1, 1.1502-11, and 1.1502-21, are hereby incorporated by reference. The regulations hereby incorporated are the versions of those regulations in effect as of April 1, 2021 and does not include any later amendments or editions of these regulations. Copies of these regulations are available online at:

(A) https://www.govinfo.gov/content/pkg/CFR-2021-title26-vol14/pdf/CFR-2021-title26-vol14-sec1-1502-1.pdf

(B) https://www.govinfo.gov/content/pkg/CFR-2021-title26-vol14/pdf/CFR-2021-title26-vol14-sec1-1502-11.pdf and

(C) https://www.govinfo.gov/content/pkg/CFR-2021-title26-vol14/pdf/CFR-2021-title26-vol14-sec1-1502-21.pdf.

(c) *Colorado Taxable Income Before Net Operating Loss Deduction for Determining Colorado Net Operating Loss Deduction and Limits Thereon.* For the purpose of determining the allowable Colorado net operating loss deduction pursuant to section 39-22-504, C.R.S., and paragraphs (3)(a), (3)(b)(ii), and (3)(b)(v) of this rule, a C corporation's Colorado taxable income before net operating loss deduction is its federal taxable income modified, apportioned, and allocated pursuant to article 22 of title 39, C.R.S., computed without regard to the Colorado net operating loss deduction allowed pursuant to sections 39-22-304(3)(g) and 504, C.R.S.

~~**Rule 39-22-504(2). C Corporation Net Operating Loss.**~~

~~(1) The Colorado net operating loss of a C corporation is computed the same as a federal net operating loss except that the Colorado loss is computed using the modified federal income allocated and apportioned to Colorado~~

~~(2) Limitations on the amount of net operating loss that may be carried over where such loss was obtained by the acquisition of one C corporation by another as contained in Section 382 of the Internal Revenue Code shall also apply for Colorado income tax purposes.~~

~~(3)~~

~~(a) For the tax years beginning prior to January 1, 1984, the Colorado C corporation net operating loss could be carried back and forward to the same years to which a federal net operating loss could be carried.~~

~~(b) For tax years beginning on or after January 1, 1984, but prior to August 6, 1997, Colorado C corporation net operating losses may be carried forward for fifteen years. They may not be carried back to an earlier year.~~

~~(c) For tax years beginning on or after August 6, 1997, Colorado C corporation net operating losses may be carried forward for twenty years. They may not be carried back to an earlier year.~~

~~(4)~~

~~(a) For tax years beginning on or after January 1, 2011, but prior to January 1, 2014, the amount of Colorado C corporation net operating losses used cannot exceed $250,000 in any tax year.~~

~~(b) If the $250,000 limitation prevents a corporation from using any part of a net operating loss carryforward in a tax year, then all net operating losses carried forward to such tax year may be carried forward one additional year for each tax year the restriction applies.~~

~~(c) Any portion of a net operating loss carryforward that cannot be used solely due to the $250,000 limitation shall be increased by 3.25% for that tax year.~~

~~(d) For any short tax year, the 3.25% rate will be prorated to by the number of months in the tax year divided by 12.~~

~~(e) Example: A corporation carries a $600,000 net operating loss from 2009 and a $100,000 loss from 2010 to tax year 2011. In 2011, the corporation could have used $300,000 of the carryforward loss to offset income, but is limited to a $250,000 net operating loss. The 2009 and 2010 losses may be carried forward an additional year to 2030 and 2031 respectively. The 2009 net operating loss carryforward to 2012 will be $351,625 ($350,000 unused loss plus 3.25% of the $50,000 that otherwise would have been used in 2011). The 2010 net operating loss carryforward to 2012 will be $100,000 and is not increased because the limitation did not prevent any of this loss from being used in 2011.~~

~~In 2012, the corporation has a $50,000 loss. The $250,000 limitation does not limit the use of any loss in 2012, so the net operating loss carryforwards are not increased by the 3.25% and the 2009 and 2010 losses can still be carried forward to 2030 and 2031 respectively. The 2012 loss can be carried forward until 2031 as well.~~

~~In 2013, the corporation can use $400,000 in net operating loss to offset its taxable income, which results in $150,000 of 2009 net operating loss not used as a result of the $250,000 limitation. The remaining 2009 loss may be carried forward to 2031 and the 2010 and 2011 losses may be carried forward to 2032. The 2009 net operating loss carryforward to 2014 will be $104,928 ($101,625 unused loss plus 3.25% of the $101,625 that otherwise would have been used in 2013). The 2010 net operating loss carryforward to 2014 will be $101,572 ($100,000 unused loss plus 3.25% of the $48,375 that otherwise would have been used in 2013). The 2012 loss is not increased because the limitation did not prevent any of this loss from being used in 2013.~~

~~In 2014, the $250,000 limitation will no longer apply, so the carryforward period will not be adjusted and there will be no 3.25% increase to any unused net operating loss.~~

COLORADO DEPARTMENT OF REVENUE
OFFICE OF TAX POLICY

STATEMENT OF BASIS AND PURPOSE

Colorado Net Operating Losses for C Corporations
Rule 39-22-504-2
1 CCR 201-2

Basis

The statutory bases for this rule are sections 39-21-112(1), 39-22-103(5.3), 39-22-304(2)(c), 39-22-304(3)(g), and 39-22-504, C.R.S.

Purpose

This new rule replaces Rule 39-22-504(2). The purpose of this rule is to provide guidance regarding the Colorado net operating loss deduction allowed to C corporations.

The rule prescribes the method for determining the portion of the federal net operating loss that is allocated to Colorado under section 39-22-504(1) and Article 22 of Title 39, C.R.S. This method requires:

- the calculation of the Colorado net operating loss based upon the federal net operating loss determined with respect to only the C corporations included in the Colorado return. In the case of a combined, consolidated, or combined-consolidated return, the Colorado net operating loss is determined with respect to only the C corporations that are included in such combined, consolidated, or combined-consolidated return. In the case of a separate return filed by a single C corporation, the Colorado net operating loss is determined with respect to only that C corporation;

- the modification of the federal net operating loss by any additions and subtractions allowed;

- the allocation and apportionment of the modified federal net operating loss in accordance with section 39-22-303.6, C.R.S.;

- the limitation of the Colorado net operating loss to the amount of the federal net operating loss; and

- for losses arising in tax years commencing prior to January 1, 2019, the modification, allocation, and apportionment of the federal net operating loss in accordance with Colorado statutes in effect and applicable to the taxpayer for the tax year.

The rule also clarifies, with respect to the carryforward of Colorado net operating losses:

- that a Colorado net operating loss arising in a tax year is carried forward to the immediately following tax year;

- the requirement to deduct first the Colorado net operating loss arising from the earliest year, in the event that losses arising from multiple tax years are available for deduction; and

- that any Colorado net operating loss not deducted as the result of applicable limitations is carried forward to the next tax year.

Finally, the rule explains the various limitations applicable to the deduction of Colorado net operating losses. Specifically:

- the Colorado net operating loss deduction is limited to the taxpayer's Colorado taxable income before the net operating loss deduction for the tax year;

- except as otherwise provided in Colorado law and rule, any limitation that applies to the federal net operating loss deduction also applies to the Colorado net operating loss deduction;

- any Colorado net operating loss deduction for losses arising in tax years beginning after December 31, 2017 is limited to 80% the taxpayer's Colorado taxable income before the deduction, regardless of the tax year for which the deduction is claimed;

- for its application to the Colorado net operating loss deduction, the net operating loss limitation prescribed by section 382 of the Internal Revenue Code is apportioned to Colorado using the Colorado apportionment fraction for the loss corporation for the last full tax year prior to the change in ownership;

- pursuant to section 860E of the Internal Revenue Code, any excess inclusion may not be offset by a Colorado net operating loss and must excluded from federal taxable income, prior to modification, allocation, and apportionment, in determining the amount of net operating loss deduction that may be claimed for a given tax year;

- the SRLY limitation established in 26 CFR § 1.1502-21(c) applies to Colorado net operating loss deductions as prescribed in proposed Rule 39-22-504-2; and

- for its application to the Colorado net operating loss deduction, any limitation on the federal net operating loss deduction imposed in relation to federal taxable income shall be determined with respect to the Colorado net income as modified, allocated, and apportioned.

Notice of Proposed Rulemaking

Tracking number

2022-00714

Department

200 - Department of Revenue

Agency

203 - Liquor and Tobacco Enforcement Division

CCR number

1 CCR 203-2

Rule title

COLORADO LIQUOR RULES

Rulemaking Hearing

Date

12/15/2022

Time

11:00 AM

Location

1881 Pierce Street, Conference Room #110, Lakewood, CO 80214; Meeting ID meet.google.com/ewc-pvvb-myk, Phone +1 386-603-3236, PIN 882 456 156#

Subjects and issues involved

The Executive Director of the Colorado Department of Revenue, on behalf of the Liquor Enforcement Division (Division), serving as the State Licensing Authority pursuant to section 44-3-201, C.R.S., will consider the promulgation of additions and amendments to the Colorado Liquor Rules, 1 C.C.R. 203-2, as authorized by Article 3 of Title 44, C.R.S. For specific information and language concerning the proposed changes and new rules, please refer to the contents of this Notice and the proposed rules that are set forth following this notice and are available on the Divisions website: https://sbg.colorado.gov/liquor.

Statutory authority

The Executive Director promulgates the additions and amendments to these rules pursuant to the authority granted in section 44-3-202, C.R.S., and section 24-4-103, C.R.S., of the Administrative Procedure Act, and the specific rulemaking authority set forth in the basis and purpose for each rule incorporated herein and identified below.

Contact information

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NOTICE OF RULEMAKING HEARING

Department of Revenue
Liquor Enforcement Division

The Executive Director of the Colorado Department of Revenue, on behalf of the Liquor Enforcement Division ("Division"), serving as the State Licensing Authority pursuant to section 44-3-201, C.R.S., will consider the promulgation of additions and amendments to the Colorado Liquor Rules, 1 C.C.R. 203-2, as authorized by Article 3 of Title 44, C.R.S. For specific information and language concerning the proposed changes and new rules, please refer to the contents of this Notice and the proposed rules that are set forth following this notice and are available on the Division's website: https://sbg.colorado.gov/liquor.

STATUTORY AUTHORITY FOR RULEMAKING

The Executive Director promulgates the additions and amendments to these rules pursuant to the authority granted in section 44-3-202, C.R.S., and section 24-4-103, C.R.S., of the Administrative Procedure Act, and the specific rulemaking authority set forth in the basis and purpose for each rule incorporated herein and identified below.

SUBJECT OF RULEMAKING

The proposed rules and relevant information are posted on Division's website, https://sbg.colorado.gov/liquor. In addition, the proposed rules attached to this Notice are fully incorporated herein.

The Executive Director will consider the promulgation of the following list of new rules and/or existing rules with proposed changes. For specific information and language concerning the proposed changes, please refer to the proposed rules that are set forth with this Notice, posted on Division's website, and posted 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 47-302. Changing, Altering, or Modifying Licensed Premises.
Regulation 47-312. Change of Location.

RULEMAKING RECORD AND PUBLIC PARTICIPATION

1. Official Rulemaking Record. The official record for purposes of the rulemaking hearing to be held on December 15, 2022, will include any written comments or oral testimony submitted or presented.

2. Written Comments. The Executive Director encourages interested parties to submit written comments on the proposed rules, including alternate proposals, by December 9, 2022, so that the Executive Director 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 December 16, 2022. Written comments may be emailed to: dor_led_rulemaking@state.co.us. In addition, you may submit written comments to:

   Liquor and Tobacco Enforcement Division
   Attn: Liquor Rules
   P.O. Box 17087
   Denver, CO 80217-0087

3. Oral Comments. At his discretion, the Executive Director may afford interested parties an opportunity to make brief oral presentations at the rulemaking hearing. If allowed, oral presentations likely will 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.

HEARING SCHEDULE

Date: December 15, 2022
Time: 11:00a.m. – 12:00p.m.
Location: 1707 Cole Blvd, Suite 300, Red Rocks Conference Room
Lakewood, CO 80401

The hearing will be held in the "Red Rocks" conference room as well as virtually through Google Meet. Access details are below:

Meeting ID
meet.google.com/ewc-pvvb-myk

Phone Numbers
(US)+1 386-603-3236
PIN: 882 456 156#

Access links/Meeting IDs for the rulemaking hearing will also be posted on the Division's website and the Secretary of State's website.

The hearing may be continued at such place and time as the Executive Director may announce.

The Executive Director shall deliberate upon the rulemaking record, including oral testimony and written submissions presented, 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 Executive Director 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 dor_led@state.co.us no later than December 9, 2022.

Dated this ____ day of _____, 2022.

THE COLORADO DEPARTMENT OF REVENUE,
LIQUOR ENFORCEMENT DIVISION

Mark Ferrandino
Digitally signed by Mark Ferrandino
Date: 2022.11.09 13:09:51 -07'00'

Mark Ferrandino
Executive Director/Chief Executive Officer
Colorado Department of Revenue

Notice of Rulemaking Hearing
Department of Revenue
Liquor Enforcement Division

DEPARTMENT OF REVENUE

Liquor Enforcement Division

COLORADO LIQUOR RULES

1 CCR 203-2

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

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

Basis and Purpose. The statutory authority for this regulation includes, but is not limited to, 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 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 on file with the state and local licensing authorities without application to, and the approval of, the 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:

1. Any increase or decrease in the total size or capacity of the licensed premises.

2. The sealing off, creation of or relocation of a common entryway, doorway, passage or other such means of public ingress and/or egress, when such common entryway, doorway or passage alters or changes the sale or distribution of alcohol beverages within the licensed premises.

3. Any substantial or material enlargement of a bar, 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.

5. Any material change in the interior of the premises that would affect the basic character of the premises or the physical structure 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.

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 detailed in the latest approved plans and specifications on file with the state and local licensing authorities.

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:

   a. The licensee has been granted an easement for the public thoroughfare for the purpose of transporting alcohol beverages.

   b. The public thoroughfare is authorized solely for pedestrian and non-motorized traffic.

   c. The inclusion of the public thoroughfare is solely for the purpose of transporting alcohol beverages between licensed areas, and no sale or consumption will occur on or within the public thoroughfare.

   d. Any other conditions as established by the local licensing authority.

8. The addition of a noncontiguous location to the licensed premises of a winery licensed pursuant to sections 44-3-402 or 44-3-403, C.R.S.

9. Modification of the licensed premises to include a communal outdoor dining area, subject to the requirements of section 44-3-912, C.R.S., and Regulation 47-1103.

B. In making its decision with respect to any proposed changes, alterations or modifications, the licensing authority must consider whether the premises, as changed, altered or modified, will meet all of the pertinent requirements of the Colorado Liquor or Beer Codes and related regulations. Factors to be taken into account by the licensing authority shall include, but not be limited to, the following:

1. The reasonable requirements of the neighborhood and the desires of the adult inhabitants.

2. The possession, by the licensee, of the changed premises by ownership, lease, rental or other arrangement.

3. Compliance with the applicable zoning laws of the municipality, city and county or county.

4. Compliance with the distance prohibition in regard to any public or parochial school or the principal campus of any college, university, or seminary.

5. The legislative declaration that the Colorado Liquor and Beer Codes are an exercise of the police powers of the state for the protection of the economic and social welfare and the health, peace, and morals of the people of this state.

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, including the addition of a noncontiguous location to the licensed premises of a winery licensed pursuant to sections 44-3-402 or 44-3-403, C.R.S. Except, any change, alteration, or modification of a sales room, shall be reported in accordance with subsection (A).

E. The state licensing authority shall not 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, except for applications to modify the premises through the addition of a noncontiguous location to the licensed premises of a winery licensed pursuant to sections 44-3-402 or 44-3-403, C.R.S.

~~F. Due to public health concerns raised by the presence COVID-19 in Colorado, a licensee may apply to temporarily modify its licensed premises to facilitate social distancing by employees and customers and to facilitate compliance with the requirements of applicable public health orders (*See* Regulation 47-1102).~~

~~1. If permitted by the relevant local licensing authority, the temporary premises modification may include expansion of the licensed premises into outside areas that the licensee possesses in accordance with subsection (B)(2) of this regulation, provided that:~~

~~a. Any outside area proposed to be included in the licensed premises, as temporarily modified, is contiguous or adjacent to the licensed premises and appropriately monitored by the licensee;~~

~~b. The licensed premises, as temporarily modified, will comprise a definite contiguous area;~~

~~c. The licensee will designate the boundaries of the licensed premises, as temporarily modified, using barriers approved by the local licensing authority and state licensing authority and post warning signs in areas visible to the public, including all points of ingress and egress, regarding laws against public consumption of alcohol beverages;~~

~~d. The licensed premises, as temporarily modified, will not encroach upon or overlap with the licensed premises of any other licensee;~~

~~e. The licensed premises, as temporarily modified, complies with local building and zoning laws; and~~

~~f. The licensed premises, as temporarily modified, complies with all other restrictions and requirements imposed by the Colorado Liquor Code and Rules.~~

~~2. A temporary modification of a licensed premises pursuant to this paragraph (F) may be approved by the state and local licensing authorities after the filing of a temporary modification of premises application on a form approved by the State Licensing Authority, including plans and specifications of the licensed premises, as temporarily modified, and a one-time payment of the modification of licensed premises fee set forth in Regulation 47-506.~~

~~3. Any temporary modification approved pursuant to this paragraph (F) shall expire on May 31, 2022, unless the relevant local licensing authority imposes an earlier expiration date. A licensee~~

~~is not required to pay an additional modification of licensed premises fee or obtain approval to remove a temporary modification to the licensed premises upon expiration of this paragraph (F).~~

~~4. Nothing in this regulation requires a local licensing authority to allow temporary premises modifications in response to COVID-19. A local licensing authority that allows temporary premises modifications may establish an earlier expiration date for any temporary modifications issued in the relevant jurisdiction and may establish additional requirements for temporary modifications that are at least as restrictive as the requirements in this paragraph (F).~~

~~5. This subsection (F) is effective until May 31, 2022 and is repealed effective June 1, 2022.~~

Regulation 47-312. Change of Location.

Basis and Purpose. The statutory authority for this regulation includes, but is not limited to, subsections 44-3-103, 44-3-202(1)(b), 44-3-202(2)(a)(I)(A), 44-3-202(2)(a)(I)(D), 44-3-202(2)(a)(I)(R), 44-3-301(9), 443-309, and 44-3-410, C.R.S. The purpose of this regulation is to establish procedures for a licensee requesting to change the location of the licensed premises, and provide factors the licensing authority must consider when evaluating a change for approval or rejection.

A. When a licensee desires to change the location of its licensed premises from the location named in an existing license, it shall make application to the applicable licensing authorities for permission to change location of its licensed premises, except that an application for change of location shall not be required for the demolition and reconstruction of the building in which the original licensed premises was located.

B. Applications to change location shall be made upon forms prepared by the state licensing authority and shall be complete in every detail. Each such application shall state the reason for such change, and in case of a retail license, shall be supported by evidence that the proposed change will not conflict with the desires of the adult inhabitants and the reasonable requirements of the neighborhood in the vicinity of the new location.

1. An application to change the location of a retail license shall contain a report of the local licensing authority of the town, city, county, or city and county in which the license is to be exercised. Such report shall describe the findings of the local licensing authority concerning the reasonable requirements of the neighborhood and the desires of the adult inhabitants with respect to the new location, except that pursuant to section 44-3-312(2)(a), C.R.S., the needs of the neighborhood shall ~~need~~ not be considered for a change of location for a club license.

2. When a licensee is required by lease, lease renewal, condemnation, or reconstruction to move its licensed premises to a new address that is located within the same shopping center, campus, fairground, or similar retail center, the local or state licensing authority may, at its discretion, waive the neighborhood needs and desires assessment requirements should it determine that the new location remains within the same neighborhood as the old location.

C. For retail licenses, no change of location shall be permitted until the state licensing authority has, after approval of the local licensing authority, considered the application and such additional information as it may require, and approved of such change. The licensee shall, within sixty (60) days of approval, change the location of its licensed premises to the place specified therein. Once at the new location, the licensee shall no longer conduct the manufacture or sale of alcohol beverages at the former location. A local licensing authority may, at its discretion, extend the time to change the location of the licensed premises, for good cause shown. However, no extension that is beyond twelve (12) months from the original date of approval shall be granted.

D. For those licensees not subject to approval by the local licensing authority, no change of location shall be permitted until the state licensing authority has considered the application and such additional information as it may require, and approved of such change. The licensee shall, within sixty (60) days of approval, change the location of its licensed premises to the place specified therein. Once at the new location, the licensee shall no longer conduct the manufacture or sale of alcohol beverages at the

former location. The state licensing authority may, at its discretion, extend the time to change the location, for good cause shown. However, no extension that is beyond twelve months from the original date of approval shall be granted.

E. Once the licensee has changed the location of its licensed premises, the permit to change location shall be conspicuously displayed at the new location, immediately adjacent to the license to which it pertains until the license is renewed.

F. For retail licenses no change of location shall be allowed except to another location within the same city, town, county, or city and county in which the license was originally issued. Except, a retail liquor store licensed on or before January 1, 2016, may apply to move its permanent location to another place within or outside the municipality or county in which the license was originally granted. Once approved, the retail liquor store licensee shall change the location of its premises within three (3) years after such approval.

1. A change of location for a fermented malt beverage retailer or retail liquor store will be approved only if the new location satisfies the distance requirements in section 44-3301(9)(a)(I)(B)-(C), C.R.S.

2. It is unlawful for a licensee to sell any alcohol beverage at a new location until permission is granted by the state licensing and local licensing authorities.

G. Upon application for change of location, public notice shall be required by the local licensing authority in accordance with Section 44-3-311, C.R.S.

H. A licensee located within 500 feet from any public or parochial school or principal campus of any college, university or seminary may apply for a change of location within the same prohibited area in accordance with the requirements of section 44-3-301(9), C.R.S., but may not apply for a change of location within any other prohibited area as defined within section 44-3-313, C.R.S.

I. A licensee that is in lawful possession of its alcohol beverage inventory at the time it receives approval from the local and state licensing authorities to change the location of its licensed premises, may continue to possess its alcohol beverage inventory for sale at the new location.

DEPARTMENT OF REVENUE

Liquor Enforcement Division

COLORADO LIQUOR RULES

1 CCR 203-2

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

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

Basis and Purpose. The statutory authority for this regulation includes, but is not limited to, 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 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 on file with the state and local licensing authorities without application to, and the approval of, the 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:

1. Any increase or decrease in the total size or capacity of the licensed premises.

2. The sealing off, creation of or relocation of a common entryway, doorway, passage or other such means of public ingress and/or egress, when such common entryway, doorway or passage alters or changes the sale or distribution of alcohol beverages within the licensed premises.

3. Any substantial or material enlargement of a bar, 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.

5. Any material change in the interior of the premises that would affect the basic character of the premises or the physical structure 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.

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 detailed in the latest approved plans and specifications on file with the state and local licensing authorities.

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:

   a. The licensee has been granted an easement for the public thoroughfare for the purpose of transporting alcohol beverages.

   b. The public thoroughfare is authorized solely for pedestrian and non-motorized traffic.

   c. The inclusion of the public thoroughfare is solely for the purpose of transporting alcohol beverages between licensed areas, and no sale or consumption will occur on or within the public thoroughfare.

   d. Any other conditions as established by the local licensing authority.

8. The addition of a noncontiguous location to the licensed premises of a winery licensed pursuant to sections 44-3-402 or 44-3-403, C.R.S.

9. Modification of the licensed premises to include a communal outdoor dining area, subject to the requirements of section 44-3-912, C.R.S., and Regulation 47-1103.

B. In making its decision with respect to any proposed changes, alterations or modifications, the licensing authority must consider whether the premises, as changed, altered or modified, will meet all of the pertinent requirements of the Colorado Liquor or Beer Codes and related regulations. Factors to be taken into account by the licensing authority shall include, but not be limited to, the following:

1. The reasonable requirements of the neighborhood and the desires of the adult inhabitants.

2. The possession, by the licensee, of the changed premises by ownership, lease, rental or other arrangement.

3. Compliance with the applicable zoning laws of the municipality, city and county or county.

4. Compliance with the distance prohibition in regard to any public or parochial school or the principal campus of any college, university, or seminary.

5. The legislative declaration that the Colorado Liquor and Beer Codes are an exercise of the police powers of the state for the protection of the economic and social welfare and the health, peace, and morals of the people of this state.

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, including the addition of a noncontiguous location to the licensed premises of a winery licensed pursuant to sections 44-3-402 or 44-3-403, C.R.S. Except, any change, alteration, or modification of a sales room, shall be reported in accordance with subsection (A).

E. The state licensing authority shall not 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, except for applications to modify the premises through the addition of a noncontiguous location to the licensed premises of a winery licensed pursuant to sections 44-3-402 or 44-3-403, C.R.S.

~~F. Due to public health concerns raised by the presence COVID-19 in Colorado, a licensee may apply to temporarily modify its licensed premises to facilitate social distancing by employees and customers and to facilitate compliance with the requirements of applicable public health orders (*See* Regulation 47-1102).~~

~~1. If permitted by the relevant local licensing authority, the temporary premises modification may include expansion of the licensed premises into outside areas that the licensee possesses in accordance with subsection (B)(2) of this regulation, provided that:~~

~~a. Any outside area proposed to be included in the licensed premises, as temporarily modified, is contiguous or adjacent to the licensed premises and appropriately monitored by the licensee;~~

~~b. The licensed premises, as temporarily modified, will comprise a definite contiguous area;~~

~~c. The licensee will designate the boundaries of the licensed premises, as temporarily modified, using barriers approved by the local licensing authority and state licensing authority and post warning signs in areas visible to the public, including all points of ingress and egress, regarding laws against public consumption of alcohol beverages;~~

~~d. The licensed premises, as temporarily modified, will not encroach upon or overlap with the licensed premises of any other licensee;~~

~~e. The licensed premises, as temporarily modified, complies with local building and zoning laws; and~~

~~f. The licensed premises, as temporarily modified, complies with all other restrictions and requirements imposed by the Colorado Liquor Code and Rules.~~

~~2. A temporary modification of a licensed premises pursuant to this paragraph (F) may be approved by the state and local licensing authorities after the filing of a temporary modification of premises application on a form approved by the State Licensing Authority, including plans and specifications of the licensed premises, as temporarily modified, and a one-time payment of the modification of licensed premises fee set forth in Regulation 47-506.~~

~~3. Any temporary modification approved pursuant to this paragraph (F) shall expire on May 31, 2022, unless the relevant local licensing authority imposes an earlier expiration date. A licensee is not required to pay an additional modification of licensed premises fee or obtain approval to remove a temporary modification to the licensed premises upon expiration of this paragraph (F).~~

~~4. Nothing in this regulation requires a local licensing authority to allow temporary premises modifications in response to COVID-19. A local licensing authority that allows temporary premises modifications may establish an earlier expiration date for any temporary modifications issued in the relevant jurisdiction and may establish additional requirements for temporary modifications that are at least as restrictive as the requirements in this paragraph (F).~~

~~5. This subsection (F) is effective until May 31, 2022 and is repealed effective June 1, 2022.~~

Regulation 47-312. Change of Location.

Basis and Purpose. The statutory authority for this regulation includes, but is not limited to, subsections 44-3-103, 44-3-202(1)(b), 44-3-202(2)(a)(I)(A), 44-3-202(2)(a)(I)(D), 44-3-202(2)(a)(I)(R), 44-3-301(9), 443-309, and 44-3-410, C.R.S. The purpose of this regulation is to establish procedures for a licensee requesting to change the location of the licensed premises, and provide factors the licensing authority must consider when evaluating a change for approval or rejection.

A. When a licensee desires to change the location of its licensed premises from the location named in an existing license, it shall make application to the applicable licensing authorities for permission to change location of its licensed premises, except that an application for change of location shall not be required for the demolition and reconstruction of the building in which the original licensed premises was located.

B. Applications to change location shall be made upon forms prepared by the state licensing authority and shall be complete in every detail. Each such application shall state the reason for such change, and in case of a retail license, shall be supported by evidence that the proposed change will not conflict with the desires of the adult inhabitants and the reasonable requirements of the neighborhood in the vicinity of the new location.

1. An application to change the location of a retail license shall contain a report of the local licensing authority of the town, city, county, or city and county in which the license is to be exercised. Such report shall describe the findings of the local licensing authority concerning the reasonable requirements of the neighborhood and the desires of the adult inhabitants with respect to the new location, except that pursuant to section 44-3-312(2)(a), C.R.S., the needs of the neighborhood shall ~~need~~ not be considered for a change of location for a club license.

2. When a licensee is required by lease, lease renewal, condemnation, or reconstruction to move its licensed premises to a new address that is located within the same shopping center, campus, fairground, or similar retail center, the local or state licensing authority may, at its discretion, waive the neighborhood needs and desires assessment requirements should it determine that the new location remains within the same neighborhood as the old location.

C. For retail licenses, no change of location shall be permitted until the state licensing authority has, after approval of the local licensing authority, considered the application and such additional information as it may require, and approved of such change. The licensee shall, within sixty (60) days of approval, change the location of its licensed premises to the place specified therein. Once at the new location, the licensee shall no longer conduct the manufacture or sale of alcohol beverages at the former location. A local licensing authority may, at its discretion, extend the time to change the location of the

licensed premises, for good cause shown. However, no extension that is beyond twelve (12) months from the original date of approval shall be granted.

D. For those licensees not subject to approval by the local licensing authority, no change of location shall be permitted until the state licensing authority has considered the application and such additional information as it may require, and approved of such change. The licensee shall, within sixty (60) days of approval, change the location of its licensed premises to the place specified therein. Once at the new location, the licensee shall no longer conduct the manufacture or sale of alcohol beverages at the former location. The state licensing authority may, at its discretion, extend the time to change the location, for good cause shown. However, no extension that is beyond twelve months from the original date of approval shall be granted.

E. Once the licensee has changed the location of its licensed premises, the permit to change location shall be conspicuously displayed at the new location, immediately adjacent to the license to which it pertains until the license is renewed.

F. For retail licenses no change of location shall be allowed except to another location within the same city, town, county, or city and county in which the license was originally issued. Except, a retail liquor store licensed on or before January 1, 2016, may apply to move its permanent location to another place within or outside the municipality or county in which the license was originally granted. Once approved, the retail liquor store licensee shall change the location of its premises within three (3) years after such approval.

1. A change of location for a fermented malt beverage retailer or retail liquor store will be approved only if the new location satisfies the distance requirements in section 44-3301(9)(a)(I)(B)-(C), C.R.S.

2. It is unlawful for a licensee to sell any alcohol beverage at a new location until permission is granted by the state licensing and local licensing authorities.

G. Upon application for change of location, public notice shall be required by the local licensing authority in accordance with Section 44-3-311, C.R.S.

H. A licensee located within 500 feet from any public or parochial school or principal campus of any college, university or seminary may apply for a change of location within the same prohibited area in accordance with the requirements of section 44-3-301(9), C.R.S., but may not apply for a change of location within any other prohibited area as defined within section 44-3-313, C.R.S.

I. A licensee that is in lawful possession of its alcohol beverage inventory at the time it receives approval from the local and state licensing authorities to change the location of its licensed premises, may continue to possess its alcohol beverage inventory for sale at the new location.

Notice of Proposed Rulemaking

Tracking number

2022-00736

Department

200 - Department of Revenue

Agency

207 - Division of Gaming - Rules promulgated by Gaming Commission

CCR number

1 CCR 207-1

Rule title

GAMING REGULATIONS

Rulemaking Hearing

Date

12/15/2022

Time

09:15 AM

Location

1707 Cole Blvd, Redrocks Conference Room, Lakewood, CO 80401, and virtually

Subjects and issues involved

Pursuant to the passing of HB 22-1402, and to meet the effective date set therein, the Gaming Commission adopted emergency Rule changes to Rule 2 and created emergency Rule 29. The Division is now submitting these changes for permanent adoption. Amendments are being made to Rules 4 and 20 as a result of mandatory yearly Rule review and stakeholder comments. Promulgation of rules for a new game of blackjack, Pocket Rockets Blackjack. Amendments to Rule 10 regarding timed rakes, calls, tournament entry fees & player buy-ins, and variations allowed during poker tournaments. Amendments to Rule 12 to update the definition of "par sheet", to update the requirements for control programs, to allow commonly owned casinos to use and process each other's tickets etc., and to promulgate rules to allow for cashless system technology. Amendments to Rule 16 to define "commonly owned casinos", and to update requirements for AGP computations. Amendments to Regulation 30-2115 to add progressive wagers and pay tables to the game TriLux Blackjack.

Statutory authority

Sections 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-301, C.R.S., 44-30-302, C.R.S., 44-30-501, C.R.S., 44-30-502, C.R.S., 44-30-507, C.R.S., 44-30-510, C.R.S., 44-30-521, C.R.S., 44-30-522, C.R.S., 44-30-526, C.R.S., 44-30-528, C.R.S., 44-30-531, C.R.S., 44-30-602, C.R.S., 44-30-806, C.R.S., 44-30-816, C.R.S., 44-30-818, C.R.S., 44-30-827, C.R.S., 44-30-833, C.R.S., 44-30-1103, C.R.S., 44-30-1509, C.R.S., 44-30-1701, C.R.S., 44-30-1702, C.R.S., 44-30-1703, C.R.S., and 24-4-105, C.R.S.

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BASIS AND PURPOSE FOR RULE 2

The purpose of Rule 2 is to delegate certain authority to the Director or other Division agent; provide for the review of any action taken pursuant to such authority; provide for the reference by the Director of matters delegated to the Director back to the Commission; and to establish procedures for Commission actions and hearings. Rule 2 also empowers the Commission to contract for legal counsel, and directs the Licensee to obtain moneys owed to a deceased patron and properly distribute such moneys. The statutory basis for Rule 2 is found in sections 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-301, C.R.S., 44-30-302, C.R.S., 44-30-501, C.R.S., 44-30-502, C.R.S., 44-30-507, C.R.S., 44-30-1103, C.R.S., 44-30-1509, C.R.S., 44-30-1701, C.R.S., and 44-30-1702, C.R.S., and 24-4-105, C.R.S. *Amended 10/20/22*

RULE 2 POWERS AND DUTIES OF COMMISSION AND DIRECTOR *Amended 1/14/15*

30-215 RESPONSIBLE GAMING GRANT PROGRAM.

(1) RESPONSIBLE GAMING GRANT PROGRAM CREATION.

THE COMMISSION SHALL OPERATE A PROGRAM TO ADMINISTER GRANTS FROM THE RESPONSIBLE GAMING GRANT PROGRAM CASH FUND. THE COMMISSION IN COLLABORATION WITH THE BEHAVIORAL HEALTH ADMINISTRATION, SHALL ADMINISTER THE GRANT PROGRAM, AND SHALL AWARD GRANTS. THE PROGRAM SHALL PROVIDE GRANTS FOR SUPPORTING EFFORTS THAT IMPACT, IMPROVE AND SUPPORT RESPONSIBLE GAMING AND PROBLEM GAMBLING PROGRAMS AND THE ISSUES THAT COME WITH INCREASED GAMING AND GAMING OPTIONS. THE RESPONSIBLE GAMING GRANT PROGRAM IS MEANT TO PROVIDE MEANINGFUL FUNDING AND ENCOURAGE PREVENTION, EDUCATION ON GAMBLING ADDICTION, ADDITIONAL GAMBLING ADDICTION COUNSELORS, PUBLIC AWARENESS, TREATMENT, RECOVERY, DATA AND RESEARCH. ADDITIONALLY, THE COMMISSION SHALL ENSURE THAT THE GRANTEES USE THE MONEY FOR WHICH THE MONEY WAS AWARDED AND REPORT TO THE COMMISSION THE RESULTS OF WHETHER THE OBJECTIVES OF THE GRANT WERE ACHIEVED. THE TERMS OF GAMING AND GAMBLING ARE SYNONYMOUS FOR THE PURPOSES OF THIS RULE.

(A) IN ADDITION TO ANY MONIES APPROPRIATED BY THE GENERAL ASSEMBLY, ANY ADDITIONAL FUNDS, GRANTS, GIFTS AND DONATIONS RECEIVED BY THE COMMISSION SHALL BE TRANSFERRED TO THE STATE TREASURER AND CREDITED TO THE FUND.

(B) THE COMMISSION MAY EXPEND MONEY FROM THE FUND TO PAY DIRECT AND INDIRECT ADMINISTRATIVE EXPENSES INCURRED BY THE COMMISSION IN ADMINISTERING THE GRANT PROGRAM. THE COMMISSION MAY NOT EXPEND MORE THAN 5% OF THE TOTAL AMOUNT OF GRANT MONEY AWARDED BY THE COMMISSION IN THAT STATE FISCAL YEAR.

(C) EACH YEAR AT THE BEGINNING OF THE GRANT APPLICATION PROCESS, THE COMMISSION SHALL RECEIVE A REPORT FROM THE DIVISION ON AVAILABLE FUNDS FOR THAT YEAR'S GRANT PROCESS.

(D) TO BE ELIGIBLE FOR THE INITIAL GRANT PROCESS, THE APPLICANT MUST HAVE THEIR APPLICATION IN ON OR BEFORE DECEMBER 1, 2022. APPLICATION DEADLINES FOR SUBSEQUENT GRANT DISTRIBUTIONS, PROVIDED THAT GRANT MONEY IS AVAILABLE, SHALL BE RECEIVED BY DECEMBER 1ST OF THAT GRANT YEAR.

(E) GRANT APPLICATIONS SHALL BE REVIEWED BY THE DIVISION AND PRESENTED TO THE COMMISSION FOR ITS CONSIDERATION NO LATER THAN MARCH 1ST OF THE UPCOMING CALENDAR YEAR. IF FOR ANY REASON, AFTER RELEASING INITIAL GRANT FUNDING, THE COMMISSION HAS FUNDS AVAILABLE IN THE FUND. THE COMMISSION MAY, AT THEIR SOLE DISCRETION, DECIDE TO TAKE APPLICATIONS FOR ADDITIONAL GRANT FUNDING. IF THE

Commission elects to take additional applications it shall also set the time frame for applications and distribution.

(2) Responsible gaming grant application.

Eligible applicants for responsible gaming grants must file an approved application by the date set by the Commission. All applications must be received by the Division of gaming on or before the date set by the Commission. Applications will be reviewed by the Division for completeness, content and eligibility. Applications must include the following information:

(a) Information as required on the application on the person, persons, nonprofit or governmental entity making application;

(b) The amount of grant money requested by the eligible applicant;

(c) How the eligible applicant will spend the grant money to address problem gambling or increase awareness of responsible gaming;

(d) The timeline for spending any awarded grant money, and the programs expected milestones during that timeline;

(e) Information concerning any current or past projects in which the eligible applicant has participated that addressed responsible gambling or problem gaming;

(f) Acknowledge that the grant applicant or if the applicant is a nonprofit, that the applicant and any board members are not fundamentally opposed to gaming; and

(g) Acknowledge that the grant applicant or if the applicant is a nonprofit, that the applicant and/or a majority of board members are not affiliated with a person licensed under article 44-30;

(h) Grant applications shall be reviewed by the Division and presented to the Commission no later than March 1st of the upcoming calendar year. If for any reason, after releasing initial grant funding, the Commission has funds available in the fund. the Commission may, at their sole discretion, decide to take applications for additional grant funding. If the Commission elects to take additional applications it shall also set the time frame for applications and distribution.

(3) Reviewing responsible gaming grant applications and criteria for awarding grants.

When awarding grants, the Commission shall employ a process for collaboration with the behavioral health administration. In consideration of awarding grants, the Commission shall consider the following criteria:

(a) The current needs of the state relating to responsible or problem gambling;

(b) The overall impact that the proposed grant may have on responsible gaming or problem gambling;

(c) The amount of money in the fund;

(d) Whether the eligible applicant intends to use grant money for any of the following purposes:

(I) Prevention or education services concerning gambling addiction;

(II) Certification of gambling addiction counselors;

(III) Public awareness of services concerning gambling addiction;

(IV) Treatment of gambling addiction disorders;

(V) Recovery services;

(VI) Data reporting and data systems;

(VII) For a portion of the costs associated with the national problem gambling helpline, website, chat or text for service;

(VII) Research for problem gambling or gambling addiction; and

(VIII) Costs associated with research for problem gaming or gambling addiction.

(E) When considering the current needs of the state related to responsible gaming and/or problem gambling, the Commission may establish additional purposes for awarding grants;

(4) Duties and responsibilities of the grantee.

The following are the duties and responsibilities of the grantee during the calendar year grant money was awarded:

(A) Grantees shall use grant money only for the purpose for which the grant money was awarded;

(B) On or before September 1, 2023, and on or before September 1 each year thereafter, each grantee shall submit a report to the Commission. At a minimum, the report must include the following information:

(I) An indication of whether the grantee achieved or is making significant progress in achieving the objectives the grantee described in its application or a grant;

(II) Evaluation of the results of the grantee's grant-funded project;

(III) A description of the impact of the grantees use of grant money on the community with regards to responsible gaming or problem gambling;

(IV) Total amount of the grant money received and the total amount of grant money expended by the grantee; and

(V) Any additional reporting requirements required by the Commission when the grant was awarded;

(C) Prior to any grant money being dispersed, once the Commission has made it's grant decisions, grantees must cooperate to finalize all needed state purchasing contract paperwork.

(5) Reporting responsibilities of the Commission and Division.

THE FOLLOWING ARE THE REPORTING RESPONSIBILITIES OF THE COMMISSION AND DIVISION:

(A) ON OR BEFORE DECEMBER 1, 2023 AND ON OR BEFORE DECEMBER 1 EACH YEAR THEREAFTER THE COMMISSION SHALL CREATE AND SUBMIT A SUMMARIZED REPORT IN ACCORDANCE WITH C.R.S. 44-30-1702(7)(B). A MINIMUM REPORT MUST INCLUDE THE FOLLOWING INFORMATION:

(I) TOTAL NUMBER OF GRANTS, AND THE TOTAL AMOUNT OF GRANT MONEY, AWARDED BY THE COMMISSION IN THE PRECEDING STATE FISCAL YEAR;

(II) THE IDENTITY OF EACH GRANTEE AND THE TOTAL AMOUNT OF GRANT MONEY AWARDED TO EACH GRANTEE IN THE PRECEDING STATE FISCAL YEAR;

(III) THE INFORMATION REPORTED BY EACH GRANTEE PURSUANT TO 30-215 (4); AND

(IV) FINANCIAL STATEMENTS CONCERNING THE STATUS OF, AND ACTIVITIES CONCERNING, THE RESPONSIBLE GAMING GRANT FUND.

BASIS AND PURPOSE FOR RULE 4

The purpose of Rule 4 is to specify the rights, responsibilities, and duties of licensees; specify certain duties of licensees related to permitting access to the Division of information, records, and premises controlled by the licensee; require licensees to maintain sufficient financial reserves; establish restrictions on the use of shills and proposition players; require that certain information be publicly posted; direct the licensee to prohibit certain conduct; and establish procedures for patron disputes, dissolution of corporations, transfers of interests and terminations of licensee employment or licensure. The statutory basis for Rule 4 is found in sections 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-301, C.R.S., and 44-30-502, C.R.S., 44-30-510, C.R.S., 44-30-528, C.R.S., and 44-30-833, C.R.S. *Amended 12/15/16*

RULE 4 RIGHTS AND DUTIES OF LICENSEES

30-402 Discovery of violations.

Each licensee must immediately notify the Division of the discovery of a violation or of a suspected violation of article 30 of title 44, C.R.S., or the rules and regulations promulgated thereunder~~, or any other criminal violation occurring at a casino establishment~~. *Amended 12/15/16, corrected 5/3/17*

30-405 Information to be furnished by licensee.

(3) Each licensed retailer, operator, associated equipment supplier, manufacturer or distributor must ~~immediately~~ report to the Division the name, date of birth, and social security number of all persons who obtain an ownership, financial, or equity interest in the licensee of five percent or greater, or who have the ability to control the licensee, or who have the ability to exercise significant influence over the licensee WITHIN TEN (10) DAYS AFTER SUCH PERSON ACQUIRES THE OWNERSHIP, FINANCIAL, OR EQUITY INTEREST, or who loan any money or other thing of value to the licensee. (30-405(3) perm. 10/30/99) *Amended 11/30/2012, Amended 2/14/14*

30-414 Player rules.

A retail licensee must post the following rules on the licensed areas:

(1) Players ~~in the gaming area~~ must be at least 21 years of age;

BASIS AND PURPOSE FOR RULE 8

The purpose of Rule 8 is to establish playing rules for blackjack and procedures for conducting blackjack games in compliance with section 44-30-302 (2). The statutory basis for Rule 8 is found in sections 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., 44-30-816, C.R.S., and 44-30-818, C.R.S.

RULE 8 RULES FOR BLACKJACK

30-899.28 THE PLAY - POCKET ROCKETS BLACKJACK.

POCKET ROCKETS BLACKJACK IS A TRADEMARKED AND PATENT-PENDING BLACKJACK VARIATION GAME, THE RIGHTS TO WHICH ARE OWNED BY CASINO GAMING DEVELOPMENT OF WESTMINSTER, CO AND WHICH MAY BE TRANSFERRED OR ASSIGNED. POCKET ROCKETS BLACKJACK SHALL BE DEALT AND PLAYED FOLLOWING THE STANDARD RULES OF BLACKJACK, EXCEPT AS FOLLOWS:

(1) POCKET ROCKETS BLACKJACK MAY BE PLAYED ONLY ON TABLES UTILIZING A POCKET ROCKETS BLACKJACK STYLE TABLE LAYOUT AND OR THE ACE BUSTER OPTIONAL WAGERING SPOT. AT THE DISCRETION OF THE RETAIL LICENSEE, THE GAME CAN BE PLAYED WITH THE OPTION OF USING SIX, OR EIGHT STANDARD 52 CARDS DECKS AND IS DEALT FROM A DEALING SHOE. ALL POCKET ROCKETS AND ACE BUSTER WAGERS WILL BE PAID FROM THE ACCOMPANYING AND APPROVED PAY TABLES.

(2) POCKET ROCKETS BLACKJACK FEATURE IS AN OPTIONAL WAGER THAT PAYS ON THE OUTCOME OF THE FIRST TWO CARDS DEALT TO THE PLAYER.

IF THE FIRST TWO CARDS DEALT TO THE PLAYER ARE A TOTAL OF ELEVEN OR LESS THE WAGER PAYS 1 TO 1 (EVEN MONEY).

IF THE FIRST TWO CARDS DEALT TO THE PLAYER HAVE ONE ACE CARD, THE WAGER PAYS 1 TO 1 (EVEN MONEY).

IF THE FIRST TWO CARDS DEALT TO THE PLAYER ARE AN ACE CARD & A VALUE OF 10 CARD (BLACKJACK) THE WAGER PAYS 3 TO 2.

IF THE FIRST TWO CARDS DEALT TO THE PLAYER ARE TWO ACE CARDS, THE WAGER PAYS 10 TO 1.

IF THE FIRST TWO CARDS DEALT TO THE PLAYER ARE TWO SUITED ACE CARDS, THE WAGER PAYS 100 TO 1.

(3) THE POCKET ROCKETS WAGER MAY NOT EXCEED THE AMOUNT OF THE ORIGINAL BLACKJACK WAGER UNLESS THE LICENSEE USES A CONTINUOUS SHUFFLER FOR GAME PROTECTION PURPOSES. WITH A CONTINUOUS SHUFFLER, THE RETAIL LICENSEE MAY ALLOW THE PLAYER TO PLACE A POCKET ROCKETS WAGER AND THE ACE BUSTER WAGERS THAT EXCEEDS THE MAIN BLACKJACK WAGER. THE POCKET ROCKETS WAGER **MUST** BE PLACED BEFORE ANY CARDS ARE DEALT.

ONCE ALL PLAYERS' AND DEALER'S INITIAL FIRST TWO CARDS ARE DEALT, THE POCKET ROCKETS WAGER OUTCOME WILL BE DETERMINED BY THE DEALER AND PAID OR TAKEN ACCORDINGLY. ONE PAYOUT PER HAND AND HIGHEST HAND WILL BE PAID.

(4) THE DEALER WILL THEN FOLLOW STANDARD BLACKJACK PLAY.

(5) THE ACE BUSTER OPTIONAL WAGER PAYS OUT ON THE OUTCOME OF THE DEALER EXCEEDING 21 (BUST).

Once all players have acted on their hands, but prior to the dealer acting on his/her hand, players have the option of placing a second additional optional wager, otherwise known as "Ace Buster". This wager must be made in an even dollar amount and may be made only by players who still have an active hand (i.e., the player did not bust his/her hand). The minimum and maximum amounts of the optional Ace Buster wagers permitted shall be posted on the table signage.

As wagers on the standard game of blackjack are settled, the dealer shall also settle the Ace Buster wagers according to the pay table below.

(6) At the discretion of the retail licensee, players may be permitted to place tip bets for the dealer on their Pocket Rockets wager and or the Ace Buster wager. If such tip wagers are accepted, winning wagers must be paid at the same odds as the players' winning wagers. The retail licensee may require tip wagers to be in an even dollar amount and may limit the maximum amount of such tip wagers. Notice of any such restrictions shall be provided by table signage.

(7) Even money may be offered to the player if the player receives a blackjack and the dealer is showing an ace. If the player and the dealer both have a blackjack, the hand and the Pocket Rockets wager results in a push.

Pocket Rocket Pay Table

Player Wins	Pay out
Total of 11 or Less	1 to 1
One Ace	1 to 1
Blackjack	3 to 2
Two Aces	10 to 1
Two Suited Aces	100 to 1

Ace Buster Pay Table: Bust with Dealer Up Card: Ace to 6

Bust with no Aces	1 to 1
Bust with 1 Ace	3 to 1
Bust with 2 Aces	5 to 1
Bust with 3 Aces	10 to 1
Bust with 4 or more Aces	50 to 1

Bust with Dealer up Card: 7 to King

Bust with no Aces	2 to 1
Bust with 1 Ace	6 to 1
Bust with 2 Aces	10 to 1
Bust with 3 Aces	20 to 1
Bust with 4 or more Aces	100 to 1

BASIS AND PURPOSE FOR RULE 10

The purpose of Rule 10 is to establish playing rules for authorized types of poker and management procedures for conducting poker games in compliance with section 44-30-302 (2), C.R.S. The statutory

basis for Rule 10 is found in sections 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., 44-30-816, C.R.S., and 44-30-818, C.R.S. *Amended 8/14/16*

RULE 10 RULES FOR POKER

30-1012 Rake.

(1) Rake may not exceed ten (10) percent of the pot. Rake may only be pulled from the pot by the dealer in an obvious manner after each wager and call or at the completion of the hand. The rake must be placed and remain in a designated rake area or on the rake slide until the conclusion of the hand. The rake must then be dropped into the drop box. The designated rake area must be clearly visible to all players.

(2) AT THE DISCRETION OF THE LICENSEE, TIMED RAKES MAY BE OFFERED ON ONE OR MORE INDIVIDUAL POKER TABLES. THE TIMED RAKE MAY BE ASSESSED ON A PER-PLAYER BASIS OR ON A PER-TABLE BASIS. IF TAKEN ON A PER-PLAYER BASIS, INACTIVE PLAYERS SEATED AT THE TABLE MAY ALSO BE ASSESSED AT THE DISCRETION OF THE LICENSEE. THE TIMED RAKE MAY BE ASSESSED EITHER BY THE HOUR OR FRACTIONALLY EVERY 20 OR 30 MINUTES AS DETERMINED BY THE LICENSEE. THE TIMED RAKES COLLECTED SHALL BE IMMEDIATELY PLACED BY THE DEALER INTO THE DROP BOX. THE LICENSEE MUST POST THE TYPE AND AMOUNT OF THE TIMED RAKE TO BE COLLECTED AT OR NEAR THE TABLE IN WHICH IT APPLIES TO.

(23) In addition to any rake authorized by paragraph (1) of this section, if a retail licensee offers a player banked jackpot award, the dealer may pull a jackpot rake which may not exceed $2.00. The jackpot rake shall be handled in the manner described above, except that monies from the rake and the jackpot rake may not be commingled. A separate rake circle or slide and a separate drop box must be used for the jackpot rake.

(30-1018, perm. 3/31/96; (1) amended perm. 09/30/99; amended 12/30/04; 30-1018 relocated and renumbered as 30-1012, effective 12/15/17)

30-1023 Procedure for calls.

Players who put fewer chips into the pot than are needed to call must EITHER complete the call OR FOLD, FORFEITING THE CHIPS PLACED ON THE TABLE OF THEIR ORIGINAL CALL WAGER. IF THE PLAYER CONTINUES TO SHORT THE POT ON CALLS, THE POKER SUPERVISOR MAY REQUIRE THE PLAYER TO CALL THE ENTIRE WAGER. A PLAYER WHO THROWS IN ONE (1) CHIP AS A CALL, WILL BE REQUIRED TO CALL THE ENTIRE BET THAT IS TO THEM. ~~If substantial action has taken place, the player is responsible for completing such player's bet, even if the player might have been unaware of the raise.~~ Players may assemble chips in front of them before acting. A player makes a bet if such player pushes assembled chips forward or releases chips into the pot at a sufficient distance from the player to make it obvious that the intent is to bet. If the situation is unclear and a player allows the dealer to pull the player's chips into the pot without making an immediate objection, it is a bet. *Amended 11/14/21*

A player must place the entire bet in front of the player at one time. Unless a player has placed the amount of chips required to call a bet and to signify a raise, the player may not place additional chips for a raise. (30-1029, perm. 3/31/96; 30-1029 relocated and renumbered as 30-1023, effective 12/15/17)

30-1045.06 Entry fee and player buy-in.

~~Neither the amount of the tournament entry fee nor the amount of all allowable player buy-ins may exceed $100,000. If both an entry fee and buy-ins are used, then the combined amount of both the entry fee and all allowable buy-ins shall not exceed $100,000.~~ ~~*Amended 03/16/2012*~~

All buy-ins for the tournament are combined to create the tournament prize pool. The licensee may create a prize pool for each event provided that any funds not awarded from that prize pool are carried forward to and awarded in future events of the tournament. *Effective 10/30/2008*

All buy-ins collected must be paid out to the winners of the tournament or events by the conclusion of the tournament. The licensee may not retain any amount collected as buy-ins. The licensee is allowed to offer complimentary buy-ins provided the dollar value is added to the prize pool. If the buy-in is a non-cash item such as a toy, food card, canned good, etc., the licensee must establish a pre-determined cash value (equivalent to the cash buy-in for the event) of the items and record the value as the buy-in on the required tournament form. *Effective 10/30/2008*

Licensees may offer at the end of an event a prize voucher that can be used to enter future events within the same tournament. If the prize voucher is used as an entry fee and buy-in at the future event in which an entry fee and buy-in are offered, the entry fee value of the voucher and the buy-in value of the voucher shall be documented on the required tournament form. The prize voucher shall be considered a prize pay out and shall be documented on the prize pay out form required by the Division. *Effective 10/30/2008*

If the prize voucher is used to guarantee a spot in a future event in which no entry fee and buy-in are offered, the prize voucher shall be considered a buy-in and applied to the prize pool. In this situation, the prize voucher is not considered a prize pay out. *Effectuve 10/30/2008*

Prize vouchers may only be redeemed by the patron that won the voucher in a previous event. *Effective 10/30/2008*

(30-1056 relocated and renumbered as 30-1045.06, effective 12/15/17)

30-1045.07 Tournament rules of play.

The rules of play of each tournament game shall follow the standard rules of play of each game as set forth in Rule 10. VARIATIONS TO THE DEFINITION OF THE BUTTON IN RULE 10, THE NUMBER OF CARDS IN A STANDARD DECK OF CARDS AND THE STANDARD RULES OF EACH GAME AS SET FORTH IN THIS RULE 10 MAY BE PLAYED DURING THE PLAY OF TOURNAMENTS. The rules for the conduct of each tournament shall be reduced to writing and a copy shall be provided to all tournament players. A copy of the rules must also be provided to the local office of the Division of Gaming at least five days in advance of the scheduled start of the tournament. The Division shall notify the retail licensee of any proposed tournament rules which the Division finds to be unacceptable, and the licensee shall not offer a tournament using the rules found unacceptable. (30-1057 temp. 5/13/93, perm. 6/30/93) (30-1057 perm. 3/31/96) (30-1057 amended perm. 03/30/02) (30-1057 amended 12/30/04) (30-1057 relocated and renumbered as 30-1045.07, effective 12/15/17) *(Amended 6/14/21)*

BASIS AND PURPOSE FOR RULE 12

The purpose of Rule 12 is to establish a procedure for the testing and approval by the Commission of gaming devices and equipment, to establish requirements for the gaming devices and equipment to be used in limited gaming in Colorado, and to establish procedures for the storage of gaming devices and equipment in compliance with section 44-30-302 (2), C.R.S. The statutory basis for Rule 12 is found in sections 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., and 44-30-806, C.R.S.

RULE 12 GAMING DEVICES AND EQUIPMENT

30-1221 Definitions for slot machines.

(3) "Par sheet" means documentation which depicts the possible outcomes from the play of a slot machine~~, the probability of occurrence for the advertised awards, and the contribution of each winning outcome to~~AND THE TOTAL the payback percentage of a slot machine. The documentation must also list the applicable game and personality program version(s), as well as the pay table identification numbers (as identified in the machine's configuration menus and/or display) of the media operating within the slot machine. The Division may approve variations to the specific par sheet requirements, provided the slot machine manufacturer's documentation satisfies the objectives of this regulation. *Eff 03/02/2007, Amended 11/30/14, Amended 1/14/20*

30-1222 Control program requirements.

(2) ~~The program residing in the slot machine must be contained in a media storage device which is not alterable through any use of the circuitry or programming of the slot machine itself. Hard disk, CD ROM, and other media storage devices in lieu of EPROMs may be acceptable; however, the media storage device must be approved by the Division. Non-volatile memory chips (e.g., a flash EPROM) may be used for the bill validator, ticket printer, sound and graphic programs if the procedure used to send information to the flash EPROM is secure from unauthorized tampering and the procedure has been approved by the Division. Flash EPROMs must not contain any information related to the security, operation, or metering of the game except as directly related to the operation of the bill validator, ticket printer, sound and graphics routines.~~GAMING DEVICES WHICH HAVE CRITICAL CONTROL PROGRAMS RESIDING IN ONE OR MORE EPROMS SHALL EMPLOY A MECHANISM TO VERIFY CRITICAL CONTROL PROGRAMS AND DATA. THE MECHANISM SHALL USE, AT A MINIMUM, A CHECKSUM; HOWEVER, IT IS RECOMMENDED THAT A CYCLIC REDUNDANCY CHECK (CRC) BE USED THAT IS AT LEAST 16-BIT AND THE PROGRAM STORAGE DEVICE (PSD) DEVICE MUST BE APPROVED BY THE DIVISION. NON-VOLATILE MEMORY CHIPS (E.G., A FLASH EPROM) MAY BE USED FOR THE BILL VALIDATOR, TICKET PRINTER, SOUND AND GRAPHIC PROGRAMS IF THE PROCEDURE USED TO SEND INFORMATION TO THE FLASH EPROM IS SECURE FROM UNAUTHORIZED TAMPERING AND THE PROCEDURE HAS BEEN APPROVED BY THE DIVISION. *Eff 03/02/2007, Amended 11/30/14, Amended 1/14/20*

(A) FOR NON-EPROM PSDS, THE GAMING DEVICE SHALL PROVIDE A MECHANISM FOR THE DETECTION OF UNAUTHORIZED OR CORRUPT SOFTWARE ELEMENTS UPON ANY ACCESS AND SHALL PREVENT THE EXECUTION OR USAGE OF THOSE ELEMENTS BY THE GAMING DEVICE. THE MECHANISM SHALL EMPLOY A HASHING ALGORITHM WHICH PRODUCES A MESSAGE DIGEST OUTPUT OF AT LEAST 128 BITS.

(B) ALTERABLE MEDIA SHALL MEET THE FOLLOWING RULES, (I) AND (II), IN ADDITION TO THE REQUIREMENTS STATED IN ITEM (B) IMMEDIATELY ABOVE:

(I) EMPLOY A MECHANISM WHICH TESTS ACCESSIBLE AREAS OF THE ALTERABLE MEDIA FOR UNINTENDED PROGRAMS OR DATA AND TESTS THE STRUCTURE OF THE MEDIA FOR INTEGRITY. THE MECHANISM SHALL PREVENT FURTHER PLAY OF THE GAMING DEVICE IF UNEXPECTED DATA OR STRUCTURAL INCONSISTENCIES ARE FOUND.

(II) EMPLOY A MECHANISM FOR KEEPING A RECORD ANY TIME A CRITICAL CONTROL PROGRAM COMPONENT IS ADDED, REMOVED, OR ALTERED ON ANY ALTERABLE MEDIA. THE RECORD SHALL CONTAIN A MINIMUM OF THE LAST TEN (10) MODIFICATIONS TO THE MEDIA. EACH RECORD SHALL CONTAIN THE DATE AND TIME OF THE ACTION, IDENTIFICATION OF THE COMPONENT AFFECTED, THE REASON FOR THE MODIFICATION, AND ANY PERTINENT VALIDATION INFORMATION SUCH AS THE CORRESPONDING SIGNATURES OF THE CHANGED COMPONENTS.

(C) FOR ALL MEDIA TYPES, IN THE EVENT OF A FAILED AUTHENTICATION (I.E., PROGRAM MISMATCH OR AUTHENTICATION FAILURE), THE GAMING DEVICE SHALL IMMEDIATELY ENTER AN ERROR/TILT

CONDITION, CEASE OPERATION, DISPLAY AN APPROPRIATE ERROR MESSAGE, DISABLE CREDIT ACCEPTANCE, AND SOUND AN ALARM AND/OR ILLUMINATE THE TOWER LIGHT. THIS ERROR CONDITION SHALL BE COMMUNICATED TO THE ON-LINE SYSTEM WHEN SUCH A COMPATIBLE SYSTEM AND PROTOCOL IS SUPPORTED. ADDITIONALLY, THE ERROR CONDITION SHALL REQUIRE OPERATOR INTERVENTION TO CLEAR, AND SHALL NOT CLEAR UNTIL THE PROGRAM DATA AUTHENTICATES PROPERLY FOLLOWING THE OPERATOR INTERVENTION, OR THE MEDIA IS REPLACED OR REPAIRED. ANY PSD CRITICAL CONTROL PROGRAM THAT FAILS AUTHENTICATION SHALL NOT BE LOADED INTO GAMING DEVICE NV MEMORY.

30-1268 Validity of tickets, slot coupons and purchase tickets. *Amended 10/15/20*

(1) Casinos may offer ticketing systems whereby TITO-enabled gaming devices, cashier cages, kiosks and table games accept tickets, purchase tickets and slot coupons and issue tickets in exchange for cash, chips, tokens, credits, or tickets using TITO systems. *Amended 10/15/20*

(2) "COMMONLY OWNED CASINOS" MEANS CASINO LICENSEES OWNED BY THE SAME COMPANY.

(~~2~~3) A gaming system shall not use, permit the use of, validate, or redeem tickets, purchase tickets or slot coupons issued by another licensee. *Amended 11/30/14; Amended 10/15/20*

(A) IN THE CASE OF COMMONLY OWNED **COLORADO** CASINOS WITH A GAMING SYSTEM THAT CAN PROPERLY ACCOUNT FOR AGP BY LICENSEE, TICKETS, PURCHASE TICKETS, OR SLOT COUPONS MAY BE USED, VALIDATED OR REDEEMED BY THE COMMONLY OWNED LICENSEES.

(~~3~~4) If a gaming device, cage validation unit, table game validation unit, or kiosk cannot validate the ticket, purchase ticket, or slot coupon, it must reject the ticket, purchase ticket, or slot coupon. *Amended 10/15/20*

(~~4~~5) The gaming system's validations unit(s) must have the ability to identify invalid tickets, purchase tickets, and slot coupons, and notify the cashier or dealer, whichever is applicable, if: *Amended 11/30/14; Amended 10/15/20*

(a) The validation number cannot be found;

(b) The ticket, purchase ticket or slot coupon has already been redeemed; or *Amended 10/15/20*

(c) The amount on file for the ticket, purchase ticket or slot coupon does not match. *Amended 10/15/20*

30-1269 General ticketing standards.

(1) TITO-enabled gaming devices must be capable of issuing and accepting only the TICKETS FOUND IN COMMONLY OWNED COLORADO casino's ~~tickets~~GAMING systems. The Division must approve the design of all tickets. *Eff 03/02/2007; Amended 10/15/20*

30-1296 CASHLESS SYSTEMS.

(1) A CASHLESS SYSTEM ALLOWS PLAYERS TO PLAY SLOT MACHINES OR AUTHORIZED GAMES THROUGH THE USE OF A PLAYER CARD OR OTHER APPROVED INTERFACE METHOD, WHICH ACCESSES A PLAYER'S ACCOUNT AT THE GAMING SYSTEM OR OTHER APPROVED SYSTEM. FUNDS MAY BE ADDED TO THIS PLAYER CASHLESS ACCOUNT VIA COINS, TICKETS, VOUCHERS, BILLS, COUPONS, AND DIGITAL/ELECTRONIC WALLETS AND ANY OTHER FUNDS APPROVED BY THE DIRECTOR. THE ACCOUNT VALUE MAY BE REDUCED EITHER THROUGH DEBIT TRANSACTIONS AT A SLOT MACHINE OR BY CASHING OUT AT A CASHIER'S CAGE. A CASHLESS SYSTEM IS CHARACTERIZED AS A SYSTEM WHEREBY A PLAYER MAINTAINS AN ELECTRONIC ACCOUNT ON THE CASINO'S DATABASE. A CASINO ISSUES A PATRON WITH A

process to access cashless accounts, including password and multi-factor authentication for mobile devices. All monetary transactions between a supporting gaming machine and the approved cashless system must be secured. After the player's identity is confirmed, the device must visibly display the present transfer options to the patron, which requires selection using a keypad/touch screen, or other approved interface method, before occurring. Such options shall include how many credits the player wishes to withdraw and place on the machine the player is playing. A system will debit the patron defined amount and add the credits to the gaming device for play or for purchase of chip/tokens. Once play is complete the player may move some of the credits back to the player's account or cash out some credits. A system may require that the entire credit value be transferred back to the system. The cashless system will define a period of time with no activity, after which, a gaming device is considered idle. Once idle, the system will transfer the remaining credits back to the player's account.

Cashless systems must include the ability for the patron to set limits on the amount of credits transferred from cashless accounts. The system must include initial patron transfer limits that the patron may change. These limits shall first be available to the patron at the time of account registration and any time the account remains open. These limits must include the amount allowed to be transferred, the total number of transfers in a 24-hour period, and a self-impose "cooling off period" once these limits are met.

(2) Patron accounts. In order to establish a cashless account, players must provide the following:

(a) Legal name;

(b) Date of birth;

(c) Social security number, but at a minimum must be the last four digits thereof, or an equivalent identification number for a noncitizen patron, such as a passport or taxpayer identification number;

(d) Residential address; a post office box is not acceptable;

(e) Electronic mail address;

(f) Telephone number;

(g) Any other information collected from the patron used to verify his or her identity;

(h) Acknowledgement of the terms and conditions of the cashless system; and

(i) Acknowledgement of the penalties for violation of gaming regulations.

Using this information, licensees must verify the player's identity, and then establish the patron account. To ensure that patron information remains up-to-date, this information must be updated, at the minimum, once every 18 months.

Personal information, like a patron's social security, taxpayer identification number, and player access code must be encrypted.

(3) Currency transaction reporting. Licensees that allow players to use a cashless gaming system must establish internal control minimum procedures to comply with FinCEN and Bank Secrecy Act requirements.

(4) Phases of certification. For the approval of cashless systems see Regulation 30-1202.

(5) Configuring cashless transactions on a gaming device. Since a cashless feature impacts the electronic accounting meters, all communications between gaming devices and the cashless system must be robust and stable enough to secure all transactions such that all transaction can be identified and logged for subsequent audit and reconciliation.

(6) Audit trails for cashless transactions. A gaming device configured for cashless functionality must have the ability to recall at least 25 monetary transactions received from the gaming system or cashless system, and at least 25 monetary transactions transmitted to the gaming system or cashless system. However, if a gaming device has promotional or host-bonusing features, or both, enabled simultaneously with cashless features, a single 100-event log is sufficient. The following information must be displayed:

(a) The type of transaction (upload/download);

(b) The nature of the transaction (e.g. promotion, bonus, cash);

(c) The transaction value;

(d) The time and date; and

(e) The player's account number or a unique transaction number, either of which can be used to authenticate the source of the funds.

(7) Transaction confirmation. The gaming device, system display or mobile device, must be capable of providing confirmation or denial of every cashless transaction initiated. This confirmation or denial must include:

(a) The type of transaction (upload or download);

(b) The transaction value;

(c) The time and date (if printed confirmation);

(d) The player's account number or a unique transaction number, either of which can be used to authenticate the source of the funds; and

(e) A descriptive message as to why the transaction was not completed as initiated. This applies only to the denied transactions.

(8) Error conditions. The following subdivisions outline the error conditions that apply to the:

(A) Host system. The following conditions must be monitored and a message must be displayed to the player at the host card reader, for the following:

(I) Invalid player access code or Player ID (prompts for reentry up to a certain number of times); and

(II) Account unknown; and

(B) Any credits on the cashless gaming device that are attempted to be transferred to the host system, that result in a communication failure for which this is the only available payout medium for the player to cash out, must result in an error condition on the gaming device.

(9) Transfer of transactions. If a player initiates a cashless transaction and that transaction exceeds game configured limits including the credit limit, the transaction may only be processed provided that the player is clearly notified that the player has received or deposited less than requested to avoid player disputes.

(10) Identifying a cashless device. A player shall be able to identify each cashless compatible gaming device by a means left to the discretion of the Division. With the Division's approval the licensee may remove display menu items that pertain to cashless operation for gaming devices not participating; provide a host message indicating cashless capability; or affix a specific sticker on gaming machines to indicate participation or non-participation.

(11) Systems in a cashless environment. The gaming system and/or other approved system, must allow for changing of any of the associated parameters or accessing any player account. Additionally, the communication process used by the cashless gaming device and the gaming system and/or other approved system, must be robust and stable enough to secure each cashless transaction such that any failure event may be identified and logged for subsequent audit and reconciliation.

Each casino licensee shall perform an annual system integrity and security assessment conducted by an independent professional selected by the licensee, subject to the approval of the Division. The independent professional's report on the assessment shall be submitted to the Division annually and shall include:

(A) The scope of review;

(B) The name and company affiliation of the individual(s) who conducted the assessment;

(C) The date of the assessment;

(D) The findings;

(E) The recommended corrective action, if applicable; and

(F) The casino licensee's response to the findings and recommended corrective action.

(12) Modification of player information. Player information may only be changed by an authorized, licensed, employee, or patron. Security of this information, including a player access code or equivalent player identification must be guaranteed at all times.

(13) Balance adjustments. Licensees must establish the amount of an adjustment to an account balance that requires a supervisor's approval with each adjustment being logged or reported, or both, indicating who, what, when, and the item value before the adjustment, including the reason for the adjustment.

(14) Security levels. The host system must have the ability to structure permission levels and logins so that user roles may be separated.

(15) Prevention of unauthorized transactions. The following minimal controls shall be implemented to ensure that each game is prevented from responding to any command for crediting outside of a properly authorized cashless transaction:

(a) The network hub is secured either in a locked and monitored room or area and no access is allowed on any node without valid login and password;

(b) The number of stations where critical cashless applications or associated databases may be accessed is limited; and

(c) The procedures shall be in place on the system to identify and flag suspect player and employee accounts to prevent unauthorized use including:

(i) Establishing a maximum number of incorrect PIN entries before account lockout;

(ii) Flagging of hot accounts where cards have been stolen;

(iii) Invalidating accounts and transferring balances into a new account; and

(iv) Establishing limits for maximum cashless activity in and out as a global or individual variable to preclude money laundering.

(16) Diagnostic tests on a cashless gaming device. Any testing or test account must be logged by the host system. No person may perform any cashless activity without being logged by the system.

(17) Cashless system technology. The host system may allow a player to access the player's account using any tested and certified technology, including but not limited to magnetic strip and smart cards, and mobile devices (e.g., cell phones.)

(18) Loss of communication. If communication between the cashless accounting system and the cashless gaming device is lost, the game or system display must display a message to the player that cashless transfers cannot currently be processed.

(19) Encryption. All communication relating to cashless operation must employ encryption technology, which technology must be reviewed and approved by the Division. This section does not apply to any communication between the slot machine and the interface element.

(20) Cashless system logs. The host system shall be able to produce logs for all pending and completed cashless transactions. These logs shall be capable of being filtered by:

(a) Machine number;

(b) Player account; and

(c) Time and date.

(21) Cashless system reports. The host system shall be able to produce the following financial and player reports:

(a) Player account summary and detail report. This report shall be immediately available to a player upon request. The report shall include beginning and ending account balance, transaction information depicting gaming machine number, dollar or credit amount, and date and time;

(b) Liability report. This report is to include previous days ending value or today's starting value of outstanding cashless liability, total cashless-in and total cashless-out and the current day's ending cashless liability;

(c) Cashless meter reconciliation summary and detail report. This report shall reconcile each participating slot machine's cashless meter against the host system's cashless activity; and

(d) Cashier summary and detail report. This report shall include player account, buy-ins and cash-out, amount of transaction, and the date and time of transaction.

(22) Monetary transactions. Any monetary transaction between a supporting cashless gaming device and the host system must be secured by an approved access method. After the player's identity is confirmed, the device must present transfer options to the patron which requires selection using a keypad or touch screen before occurring. Such options may include how much money the player wishes to withdraw after ensuring the player-imposed limits are not exceeded, and be placed on the cashless gaming device. A host system may move the entire player's balance to the machine for play, if doing so does not exceed the player imposed limits. Once play is complete the player may have the option to move some of the credits back to the account or cash out. A host system may require that the entire currency value of the credit balance be transferred back to the cashless system.

(23) Adding money to a player's account. Money may be added to the player's account via a cashier station or any system-controlled kiosk. The system-controlled kiosk must be tested and certified. Money may also be added by any supporting cashless gaming device through credits won, the insertion of coins, vouchers, dollar currency, or coupons.

(24) Removing money from a player's account. Money may be removed from a player's account either through downloading of credits to the cashless gaming device, by cashing out at a cashier's cage, system-controlled kiosk, or the originating digital/electronic wallet.

(25) Movement of money. A player may be provided the option of moving the player's system credit to a cashless gaming device through withdrawal from the player's account, which

IS MAINTAINED BY THE HOST SYSTEM. WHEN THE PLAYER IS FINISHED PLAYING, THE PLAYER MAY DEPOSIT THE BALANCE FROM THE MACHINE ONTO THE PLAYER'S ACCOUNT.

(26) PLAYER ACCOUNT BALANCE. CURRENT PLAYER ACCOUNT BALANCE INFORMATION SHALL BE AVAILABLE ON DEMAND FROM ANY PARTICIPATING SLOT MACHINE VIA THE ASSOCIATED CARD READER OR ITS EQUIVALENT, AFTER CONFIRMATION OF PLAYER IDENTITY. THE PLAYER ACCOUNT BALANCE SHALL BE PRESENTED IN TERMS OF CURRENCY TO THE PLAYER.

BASIS AND PURPOSE FOR RULE 16

The purpose of Rule 16 is to establish accounting and internal control procedures for licensees which will include various report and statement requirements for reporting and paying gaming taxes and fees, records of ownership requirements, standard financial and audited financial statements, procedures for handling cash and meeting minimum bankroll requirements, adjusted gross proceeds computations, and record retention requirements. The statutory basis for these requirements is found in sections 44-30-102, C.R.S., 44-30-201, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., 44-30-602, C.R.S., and 44-30-806, C.R.S.

RULE 16 ACCOUNTING REGULATIONS

30-1601 Definitions for accounting regulations.

In addition to definitions previously set forth in these rules and regulations, the following definitions apply to accounting regulations as established in Rule 16:

(1) "Business Year" means the annual period used by a licensee for internal accounting purposes.

(2) "COMMONLY OWNED CASINOS" MEANS CASINO LICENSEES OWNED BY THE SAME COMPANY.

(~~2~~3) "Examination or Examine" means an audit, review, or other Division examination procedures.

(~~3~~4) "Fiscal Year" means a period beginning on July 1st and ending June 30th of the following year.

(~~4~~5) "Group A" means a licensee who has 1 to 74 slot machines only.

(~~5~~6) "Group B" means a licensee who has 75 to 299 total devices or at least one table game.

(~~6~~7) "Group C" means a licensee who has 300 or more total devices.

(~~7~~8) "Slot Route Operator" means a licensed operator who places slot machines on another licensed retailer's property.

(~~8~~9) Deleted Pursuant to S.B. 92-132

(~~9~~10) Deleted Pursuant to S.B. 92-132

30-1603 Adjusted gross proceeds computations.

(2) For each gaming device, adjusted gross proceeds equals:

(A) Ddrop, plus tickets DROPPED, plus slot coupons dropped, plus cashable electronic promotion in, plus non-cashable electronic promotion in, plus tournament adjusted gross proceeds~~,~~; AND

(B) M~~m~~inus fills to the machine, minus hand pay jackpot payouts, minus hand pay external bonus payouts and accumulated credits, minus non-cashable electronic promotion out, and minus tickets redeemed OR MINUS TICKETS ISSUED THAT ARE NOT YET EXPIRED.

LICENSEES THAT USE TICKETS ISSUED AS A TAX DEDUCTION MUST MAKE AN ADJUSTMENT TO THEIR TAX RETURNS FOR UNREDEEMED EXPIRED TICKETS. LICENSES MUST ALSO INFORM THE DIVISION'S AUDIT SECTION AS TO WHICH DEDUCTION METHOD THEY ARE USING - TICKETS REDEEMED OR TICKETS ISSUED.

The initial hopper load is not a fill and does not affect adjusted gross proceeds. The difference between the initial hopper load (or the amount in the hopper at the time of the previous hopper count if the coins/tokens counted were returned to the hopper) and the total amount that is in the hopper at the time the hopper is currently counted must be adjusted accordingly as additional revenues or a credit adjustment when calculating adjusted gross proceeds. This amount is reported on the monthly gaming tax return for the month in which the hopper count was conducted and is reflected in the hopper adjustment column for the corresponding denomination. Hoppers must also be counted, and the corresponding adjustment reflected on the gaming tax returns at other times as specified in the internal control minimum procedures. If a licensee does not make or makes inaccurate additions or subtractions when calculating adjusted gross proceeds, the Division may compute an estimated total amount in the gaming device hoppers and may make reasonable adjustments to adjusted gross proceeds during the course of an audit, review, or other examination procedures. *Rev effective 1/14/2012, Amended 12/15/13, Amended 7/15/14; Amended 10/15/20*

(8) A LICENSEE CAN CANCEL UNCLAIMED JACKPOT RECEIPTS AND THE RELATED JACKPOT SLIPS THREE YEARS AFTER THE DATE THE UNCLAIMED SLIPS WERE GENERATED. AN UNCLAIMED JACKPOT RECEIPT IS COMPLETED WHEN A PATRON IS UNABLE TO PROVIDE PROPER IDENTIFICATION FOR JACKPOT PAYOUTS GREATER THAN OR EQUAL TO $1,200.

BASIS AND PURPOSE FOR RULE 20

The Statutory authority for the promulgation and amendment of these rules is sections 44-302, 521, 522, and 526, C.R.S.

The Commission conducts hearings in a quasi-judicial capacity when determining whether to deny, condition, or issue licensure and other approvals. These rules will define standards of conduct and the manner of proceeding before the Commission in those hearings, and in pre-hearing practice. These procedures will provide for a consistent set of standards to be followed and to remove uncertainty about how to practice before the Commission.

Licensees and license applicants are under a continuing statutory duty to provide any and all information requested by the Division. These discovery policies and practices address party requests of information from the Division, and party requests of information from others.

Gaming is an industry not imbued with rights and privileges inherent in more traditional occupations. Public confidence and trust in the secure regulation of the gaming industry is extremely sensitive to appearances of impropriety pertaining to the suitability of those associated with the industry. Accordingly, the Commission is adopting standards of consideration for evidence of reputation and character.

RULE 20 COMMISSION HEARINGS AND PRACTICE

30-2003 Contested hearing procedure.

(2) Hearings shall be conducted by the Commission, sitting *en banc*, or by a designated or duly appointed administrative law judge.

(D) THE HEARING OFFICER MAY HOLD A PRE-TRIAL HEARING AND THE EVIDENTIARY HEARING VIRTUALLY, IN-PERSON, OR A HYBRID VARIATION THEREOF. AT THE DISCRETION OF THE HEARING OFFICER, A WITNESS MAY TESTIFY VIRTUALLY OR BY PHONE.

(3) Evidentiary procedure.

(g) ~~Except in matters of exigency, no witness may testify by electronic means without prior approval of the Commission, upon motion timely made and good cause shown~~ A WITNESS MAY TESTIFY VIRTUALLY OR BY TELEPHONE UNLESS OTHERWISE ORDERED BY THE HEARING OFFICER OR THE COMMISSION.

BASIS AND PURPOSE FOR RULE 21

The purpose of Rule 21 is to establish playing rules for authorized types of games which combine the play of blackjack with the play of poker, and management procedures for conducting blackjack-poker combination games in compliance with section 44-30-302 (2), C.R.S. The statutory basis for Rule 21 is found in sections 44-30-201, C.R.S., 44-30-302, C.R.S., 44-30-816, C.R.S., and 44-30-818, C.R.S. *Amended 8/14/16*

RULE 21 RULES FOR BLACKJACK-POKER COMBINATION GAMES

30-2115 The play – TriLux Blackjack. *Effective 1/14/22*

TriLux Blackjack is a copyrighted and patent-protected blackjack and poker variation game, the rights to which are owned by SG Gaming Inc. of Las Vegas, Nevada, and which may be transferred or assigned.

TriLux Blackjack is an optional bonus wager for blackjack. ~~This~~THESE optional wagerS may include a TriLux Bonus, TriLux Super 3 and/or TriLux Bust Bonanza AS WELL AS THE CHOSEN PROGRESSIVE WAGER BET AMOUNT AS STATED BELOW IN THE PAY TABLE CONFIGURATION. TriLux Blackjack may be played only on tables displaying the TriLux Blackjack layout. TriLux Blackjack uses a standard 52 card deck. Refer to pay tables below for the corresponding number of decks to be used for each of the bonus options.

(1) At the same time a player makes his/her standard blackjack wager, the player has an opportunity to make the optional TriLux Bonus, TriLux Super 3 and/or TriLux Bust Bonanza AS WELL AS THE APPROVED PROGRESSIVE wagerSING OPTIONS. However, players must make the TriLux Bonus wager to be eligible to make the TriLux Super 3 wager. All wagers must be in an amount between the posted table minimum and the table maximum. Wager limits are determined by the house and in accordance with applicable law.

(a) If the casino rules allow, a player may play multiple hands.

(b) A player playing multiple hands may place TriLux Bonus, TriLux Super 3 and TriLux Bust Bonanza AS WELL AS THE PROGRESSIVE wagers on none, one or all of his/her hands.

(c) Dealer tip wagers may be placed on the TriLux Bonus, TriLux Super 3 and TriLux Bust Bonanza wagers by placing the dealer tip in front of the player's TriLux Bonus, TriLux

Super 3 and TriLux Bust Bonanza wagers. Any restrictions on dealer tip wagers must be posted at the table or as wall signage.

(2) The dealer then follows house procedures for dealing blackjack.

(3) Once each player has received two cards, the dealer settles all TriLux Bonus and TriLux Super 3 wagers, AS WELL AS PAYING ANY WINNING PROGRESSIVE WAGERS, according to house procedures. ALL OPTIONAL WAGERS ARE INDEPENDENT OF EACH OTHER, INCLUDING ALL PROGRESSIVE WAGERS AND SHALL BE PAID ACCORDINGLY. If a player's first two cards and the dealer's up card are at least a Pair or Flush depending on the pay table, he or she wins the TriLux Bonus wager according to the posted pay table. If the player's first two cards and the dealer's up card are not at least a Flush, he or she loses his or her TriLux Bonus wager. If a player's first two cards and the dealer's up card are at least a Three of a Kind, he or she wins the TriLux Super 3 wager according to the posted pay table. If the player's two cards and the dealer's up card are not at least a three of a kind, he or she loses his or her TriLux Super 3 wager.

(a) When the cards are dealt face up, the TriLux Bonus and TriLux Super 3 wagers will be settled immediately after all players receive their first two cards and the dealer has received his/her first two cards. Winners will be paid and losing wagers will be picked up in order of placement, from the dealer's right to left. Normal blackjack play will then continue.

(b) When the cards are dealt face down, the TriLux Bonus and TriLux Super 3 wagers will be settled on a hand to hand basis, as the dealer goes from left to right asking for hit/stand determinations.

(4) Players may make the TriLux Bust Bonanza wager after they have acted on their hands, but before the dealer acts on the dealer hand. If the dealer busts, the player wins according to the posted pay table. If the dealer does not bust, the player loses his/her TriLux Bust Bonanza wager.

(a) Player blackjacks are paid prior to the dealer resolving the dealer hand and are not eligible to make the TriLux Bust Bonanza wager.

(b) Player's with hands that bust are not eligible to make the TriLux Bust Bonanza wager.

(5) Winning TriLux Bonus, TriLux Super 3 and TriLux Bust Bonanza wagers will be paid in front of the betting area and pushed off toward the player.

(6) Lucky George OR DEALER ENVY: The Lucky George OR DEALER ENVY is a pay out for the dealer as a tip, when a qualifying hand is won by a player.

(7) Pay Tables:

TriLux Bonus (without Lucky George OR DEALER ENVY):

Hand	**TRI-01**	**TRI-02**	**TRI-05**
	Pays	Pays	Pays
Three of a Kind	9 to 1	2.5 to 1	7 to 1
Straight Flush	9 to 1	2.5 to 1	7 to 1
Straight	9 to 1	2.5 to 1	7 to 1
Flush	9 to 1	2.5 to 1	7 to 1
Pair	N/A	2.5 to 1	Push
Deck Type	2-8 decks	2 decks	2-8 decks

Hand	**TRI-03**	**TRI-04**	**TRI-06**	**TRI-07**

Mini Royal (A, K, Q Suited)	100 to 1	N/A	100 to 1	50 to 1
Straight Flush	35 to 1	30 to 1	30 to 1	30 to 1
Three of a Kind	33 to 1	20 to 1	20 to 1	20 to 1
Straight	10 to 1	10 to 1	10 to 1	10 to 1
Flush	5 to 1	5 to 1	5 to 1	5 to 1
Deck Type	2-8 decks	2-8 decks	2-8 decks	2-8 decks

TriLux Bonus (With Lucky George OR DEALER ENVY):

Hand	**TRILG-01**		**TRILG-02**		**TRILG-03**		**TRILG-04*** **	
	Pays*	Lucky George**	Pays*	Lucky George **	Pays*	Lucky George **	Pays*	Lucky George **
Straight Flush	8 to 1	$1	25 to 1	$10	25 to 1	$10	25 to 1	$10
Three of a Kind	8 to 1	$1	15 to 1	$5	15 to 1	$5	15 to 1	$5
Straight	8 to 1	$1	8 to 1	$2	10 to 1	$2	10 to 1	$2
Flush	8 to 1	$1	5 to 1	$1	5 to 1	N/A	5 to 1	$1
Deck Type	1, 2, 6 and 8 decks							
* Pay table is used with the Lucky George version only. **Pay outs are fixed dollar pays. ***Pay table TRILG-04 must be a minimum of $5 only.								

TriLux Super 3:

Hand	**SUP-01***	**SUP-02***	**SUP-03***
	Pays*	**Pays**	**Pays**
Three of a Kind (Suited)	270 to 1	1,000 to 1	500 to 1
Straight Flush	180 to 1	100 to 1	150 to 1
Three of a Kind	90 to 1	70 to 1	75 to 1
Deck Type	4-8 decks	6-8 decks	5-8 decks
*TriLux Bonus wager must be made to be eligible to make the TriLux Super 3 wager			

TriLux Bust Bonanza:

Dealer up-card	**Pay Table 1**		**Pay Table 2**	
	Dealer Bust	Dealer Suited Bust	Dealer Bust	Dealer Suited Bust
2	1 to 1	25 to 1	1 to 1	25 to 1
3	1 to 1	15 to 1	1 to 1	15 to 1
4	1 to 1	10 to 1	1 to 1	10 to 1
5	1 to 1	5 to 1	1 to 1	5 to 1
6	1 to 1	3 to 1	1 to 1	3 to 1
7	2 to 1	15 to 1	2 to 1	15 to 1
8	2 to 1	10 to 1	2 to 1	10 to 1
9	2 to 1	20 to 1	2 to 1	20 to 1
10/Face Card	2 to 1	20 to 1	2 to 1	20 to 1
Ace	3 to 1	50 to 1	3 to 1	50 to 1
888*	25 to 1	N/A	25 to 1	75 to 1
Deck Type	2 decks only		6 decks only	
* Special bonus paid when dealer busts with three 8s.				

PAY TABLE 5 ALSO HAS A "DEALER BLACKJACK" PRIZE THAT MAY BE AWARDED IF NONE OF THE HIGHER PAYING OUTCOMES OCCUR AND THE DEALER HAS A BLACKJACK.

Table 1. Optional Progressive pay tables with Dealer Envy:

	Progressive Pay table 01				Progressive Pay table 05	
Hand	**Pays**	**Dlr. Envy**		**Hand**	**Pays**	**Dlr. Envy**
Mini-Royal (Spades) - AK/Q	100%	$100		Mini-Royal (Spades) - AK/Q/J	100%	$100
Mini-Royal (Other) - AK/Q	10%	$50		Mini-Royal (Spades) - AK/Q	10%	$50
Mini-Royal (Any Order)	250 for 1	$25		Mini-Royal (Other) - AK/Q	300 for 1	$25
Straight Flush	40 for 1	$20		Straight Flush	50 for 1	$20
Three-of-a-Kind	25 for 1	$5		Three-of-a-Kind	25 for 1	$5
Straight	5 for 1	$2		Straight	5 for 1	$2
Flush	2 for 1	$1		Flush	2 for 1	$1
				Dealer Blackjack	1 for 1	
Deck Type	6 or 8 decks			**Deck Type**	6 or 8 decks	

The progressive meter is incremented with every Progressive wager, and is reseeded in the event of a 100% progressive award. The details are summarized in Table 2. These details are given for a fixed $5 wager. If a higher wager amount is used, the Seed/Reseed value must be scaled accordingly.

Table 2. Progressive Configuration:

	Pay table 1	**Pay table 5**
Seed/Reseed Value	$10,000	$5,000
Increment Rate	24%	24%

Table 3. Optional Progressive pay tables without Dealer Envy:

	Progressive Pay table 06			**Progressive Pay table 07**
Hand	**Pays**			**Pays**
Three Aces (Suited)	100%		Mini-Royal (Spades) - AK/Q	100%
Three of a Kind (Suited)	125 for 1		Mini-Royal (Other) - AK/Q	10%
Straight Flush	25 for 1		Mini-Royal (Any Order)	300 for 1
Three of a Kind (Offsuit)	20 for 1		Straight Flush	50 for 1
Straight	7 for 1		Straight	5 for 1
Flush	3 for 1		Flush	2 for 1
Deck Type	6 or 8 decks		**Deck Type**	6 or 8 decks

The progressive meter is incremented with every Progressive wager, and is reseeded in the event of a 100% progressive award. The details are summarized in Table 4. These details are given for a fixed $1 wager. If a higher wager amount is used, the Seed/Reseed value must be scaled accordingly.

TABLE 4. PROGRESSIVE CONFIGURATION:

	PAY TABLE 6	**PAY TABLE 7**
SEED/RESEED VALUE	$2,000	$2,000
INCREMENT RATE	17%	24%

BASIS AND PURPOSE FOR RULE 29

THE STATUTORY BASIS FOR RULE 29 IS FOUND IN SECTIONS 44-30-201, C.R.S., 44-30-202, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., 44-30-502, C.R.S., 44-30-510, C.R.S., 44-30-528, C.R.S., 44-30-531, C.R.S., 44-30-827, C.R.S., 44-30-833, C.R.S. AND 44-30-1701, C.R.S., AND 44-30-1702, C.R.S., AND 44-30-1703, C.R.S.

RULE 29 RESPONSIBLE GAMING AND SELF-RESTRICTION

30-2901 DISPLAY OF RESPONSIBLE GAMING LOGO.

(1) EACH RETAIL GAMING LICENSEE SHALL DISPLAY A RESPONSIBLE GAMING LOGO ON THEIR WEBSITE AS WELL AS PROMINENTLY DISPLAYED WITHIN THE RETAIL CASINO, IN A MANNER APPROVED BY THE DIRECTOR OR DIRECTOR'S DESIGNEE, TO DIRECT A PATRON TO THE RETAIL GAMING LICENSEE'S RESPONSIBLE GAMING WEBPAGE OR THE DIVISIONS RESPONSIBLE GAMING WEBPAGE. RETAIL GAMING LICENSEES SHALL OPERATE UNDER THE SAME RESPONSIBLE GAMING GUIDELINES AS DETAILED IN THESE RULES, WHERE APPLICABLE. RESPONSIBLE GAMING INFORMATION SHALL BE ACCESSIBLE TO PATRONS WITHIN A LICENSED GAMING FACILITY OR ON THEIR WEBSITE AND SHALL CONTAIN, AT A MINIMUM, THE FOLLOWING:

(A) A PROMINENT MESSAGE, WHICH STATES, "GAMBLING PROBLEM? CALL OR TEXT 1-800-GAMBLER";

(B) INFORMATION ON AND A LINK TO THE WEBSITE AND OTHER INTERNET RESOURCES DEDICATED TO HELPING PEOPLE WITH POTENTIAL GAMBLING PROBLEMS AS DIRECTED BY THE COMMISSION;

(C) A CLEAR STATEMENT OF THE RETAIL GAMING LICENSEE'S POLICY AND COMMITMENT TO RESPONSIBLE GAMING ALONG WITH INFORMATION TO EACH CASINO'S SPECIFIC SELF-EXCLUSION PROGRAM ALONG WITH INFORMATION ON SELF-EXCLUSION THROUGH THE DIVISION OR DIVISION'S WEBSITE.

(2) RETAIL GAMING LICENSEE LOCATIONS MUST HAVE A POLICY IN EFFECT FOR ALL OF ITS PROPERTIES IN ADDITION TO SELF-EXCLUSION, PROVIDING OPPORTUNITIES FOR PATRONS TO REQUEST IN WRITING THE REVOCATION OF THEIR PRIVILEGES FOR SPECIFIC SERVICES SUCH AS:

(A) DIRECT GAMING PROMOTIONS;

(B) PLAYER CLUB/CARD PRIVILEGES RELATED TO GAMING;

(C) ON-SITE CHECK-CASHING; AND,

(D) COMPLIMENTARIES.

(3) RETAIL GAMING LICENSEES WITH BRICK-AND-MORTAR SPORTS BETTING LOCATIONS WITHIN THE CASINO MUST MAKE INFORMATION AVAILABLE PROMOTING RESPONSIBLE GAMING AND WHERE TO FIND

assistance, including a toll-free help line number. This information shall be available and visible in sports betting areas affixed to all sports betting kiosk and at cash access devices.

30-2902 Retail gaming licensee's self-exclusion.

Each retail gaming licensee shall establish and maintain a self-exclusion program for patrons. Each retail gaming licensee shall participate by sharing self-exclusion data with the Division in accordance with Regulation 30-2905. Each retail gaming licensee shall participate by accessing the Division's database through a secure portal or electronically importing self-excluded patron information. If a retail gaming licensee is unable to access either of these methods for registering a self-excluded patron information another method may be approved by the Director.

30-2903 Direct marketing to prohibited gaming participants.

(1) For the purpose of this Rule, "prohibited participant" shall mean individuals who have voluntarily requested to be excluded from gaming activities and individuals who are required by the Commission to be excluded or ejected from licensed gaming establishments, and sports betting individuals who are prohibited from placing wagers on certain sporting events to the extent that those individuals reside in the Division's exclusion list database

(2) A retail gaming licensee shall make all reasonable efforts to ensure that prohibited participants do not receive direct marketing from the retail gaming licensee or marketing affiliates.

(3) A retail gaming licensee will satisfy this requirement if the retail gaming licensee and/or marketing affiliates remove the prohibited participant's name and resident address and email address from the list of patrons to whom direct marketing materials are sent.

(4) A Retail gaming licensee and/or their marketing affiliates shall use the current exclusion list provided by the Division. The exclusion list or in person changes shall be used expeditiously to update all direct marketing lists to ensure that excluded and prohibited players are not directly targeted, including but not exclusive of direct mail and email.

(5) Rule 30-2903(4) shall not apply to persons identified in 44-30-1502 C.R.S. that are only prohibited from betting on a sporting event that is overseen by that person's sports governing body.

30-2904 Responsible advertising and promotions.

(1) All offers and bonuses must:

(a) Include terms and conditions that are full, accurate, clear, concise, transparent, and do not contain misleading information;

(b) Have advertising materials that include any material terms and conditions for that offer or bonus and have those material terms in close proximity to the headline claim of the offer or bonus and in reasonably prominent size;

(c) Not be described as free unless they absolutely are free. If the customer has to risk or lose their own money or has conditions attached to their own money, then the offer or bonus must disclose those terms;

(D) Not be described as risk free if the customer needs to incur any loss or risk their own money to use or withdraw winnings from the risk-free bet; and

(E) Not restrict the customer from withdrawing their own funds or withdrawing winnings from bets placed using their own funds.

(F) Players that self-exclude shall not, while on the exclusion list, be able to redeem points, bonuses, comps or freeplay.

(2) Prohibition on advertising that targets underage participants:

(A) A retail gaming licensee and/or their marketing affiliates shall not target underage persons or create advertising content that is clearly meant, because of message and graphics, for an underage audience.

(B) A retail gaming licensee and/or their marketing affiliates shall not advertise on media where the majority of the demographic audience or players/performers are known to be under the legal age to gamble. This does not apply to public venues where the demographics of a normal crowd in attendance cannot be determined.

(3) Retail gaming licensees on or before October 1, 2023, and on or before October 1 each year thereafter shall submit to the Director a report that describes the efforts of the licensee in the preceding state fiscal year (July 1ST through June 30TH) to promote responsible gaming in the state via advertising and other promotional methods and the licensee's plans concerning such promotional efforts in the current state fiscal year:

30-2905 Exclusion list – Duties and responsibilities

(1) Database creation.

The Division shall operate a program to consolidate excluded, self-excluded and prohibited individuals in one interactive database repository in order to keep those individuals from participating in Colorado gaming. The program shall provide an interactive protected database for retail gaming licensees, sports betting operations, sports leagues and individuals that participate in gaming in Colorado. The sole purpose of the exclusion list and database is to ensure timely updates of individuals that may not participate in gaming for all gaming operations in Colorado. The exclusion list shall only be used for the purpose of identifying those individuals who are prohibited from gaming and those that may have excluded themselves because of their gambling problem. Licensees that receive data from the Division shall use it solely to update their database. The information contained in the database and updates provided to the licensees are confidential and shall only be used for its intended purpose. Limited information may be shared with affiliates for the purpose of ensuring those identified do not receive direct marketing. It is a violation for any licensee to use the confidential data in any other way. The Director shall determine how each licensee, league or individual interacts with the database.

Retail gaming licensees shall make available a self-exclusion form to a patron requesting to self-exclude. the retail gaming licensee shall input the self-exclusion information provided through the secure Division portal, direct the player to a dedicated computer on the licensees property where the player can access the Division's website directly for self-exclusion or if the portal is not available direct the player to the Divisions website for self-exclusion at a later time.

(B) Retail gaming licensees that receive updates daily from the Division shall update all new excluded persons within their database. the Director shall provide one or

more excluded or prohibited player lists to retail gaming licensees. Data records will be in a format detailed by the Director or designee. The retail gaming licensee shall use best efforts to determine whether or not new and existing players club members or patrons are on an exclusion list either through the casino's own database or by checking the secure Division portal prior to issuing a players card.

(c) Retail gaming licensees shall only update the Division database with self-excluded persons that have opted in after January 1, 2023 as determined by the Director. The retail gaming licensees shall make information for players that have self-excluded prior to January 1, 2023 upon request.

(2) Database inclusion.

(a) The following persons shall be included and maintained in the Division database, updated and transferred to retail gaming licensees and Sports Betting Operators:

(i) Individuals that have voluntarily self-excluded from any operator, retail casino or through the Division.

(ii) Sports betting individuals who are prohibited from placing wagers on certain sporting events to the extent that those individuals reside in the Division's exclusion list database.

(iii) Individuals who are required by the Commission to be excluded or ejected from licensed gaming establishments, to the extent that those individuals reside in the Division's exclusion list database.

(b) Persons on the exclusion and prohibited list may not participate or collect winnings from the gaming in Colorado on which they are prohibited. Players that self-exclude shall not, while on the exclusion list, be able to redeem points, bonuses, comps or freeplay.

(3) Inclusion on the exclusion list.

(a) Individual self-exclusion means that an individual has made a conscious voluntary effort to exclude themselves, from not only that form of gaming but from all forms of gaming under the regulatory purview of the Colorado limited gaming control Commission and the Colorado Division of gaming. Self-exclusion may only be accomplished by an individual acting in their own interest, in the following ways:

(i) Self-exclusion by an individual through the Division of gaming. An individual self-excluding either in person or through a web-based application. All self-exclusions by individuals through the Division either in person or web-based, will have their identity verified prior to being included on the exclusion list.

(ii) Self-exclusion from an Internet Sports Betting operator. An individual who on an Internet sports betting mobile app chooses an option to electronically self-exclude, and has been directed to the Division website.

(iii) Self-exclusion from a sports betting operator (retail sports book). An individual requesting self-exclusion from a retail sports book shall fill out a self-exclusion form provided by the sports book. The sports book

shall enter the self-exclusion into the secure Division portal, direct the player to a dedicated computer on the licensees property where the player can access the Division's website directly for self-exclusion or if the portal is not available direct the player to the Divisions website for self-exclusion at a later time.

(IV) Self-exclusion from a retail gaming licensee (casino). An individual requesting self-exclusion from a casino shall fill out a self-exclusion form provided by the casino. The casino shall enter the self-exclusion into the secure Division portal direct the player to a dedicated computer on the licensees property where the player can access the Division's website directly for self-exclusion or if the portal is not available direct the player to the Divisions website for self-exclusion at a later time. or use their electronic database procedure.

(B) Individuals wishing to self-exclude in person or through the Divisions web-based application shall fill out all required information on the form. Incomplete forms where an individual cannot be identified will not be processed.

(C) Individuals that self-exclude from gaming corporations that have gaming operations in other states may be included on their corporate exclusion list and may be included in other state exclusion programs. An individual self-excluding in Colorado shall be informed prior to being place on a corporate exclusion list.

(4) Exclusion period.

(A) Individuals that have voluntarily self-excluded from any sports betting operation, retail casino or through the Division shall select the period of exclusion to include:

(I) One (1) year

(II) Three (3) years

(III) Five (5) years

(B) An individual who is on the list may submit a request, to the Division, to increase the minimum length of exclusion.

(5) Removal from the exclusion list.

(A) Individuals that have self-excluded or are on the excluded list will need to fill out and file the form with the Division of gaming Director prior to being removed from the exclusion list. No person is automatically removed from the exclusion list when the selected or directed time period ends.

(B) Sports betting individuals who are prohibited from placing wagers on certain sporting events to the extent that those individuals reside in the Division's exclusion list database may be removed from the list by their governing body/league or by filling out and filing the form with the Division of gaming's Director.

(C) Individuals that are on the exclusion list and have not completed their self-selected period of self-exclusion may petition the Division of gaming's Director for removal from the list. The Division may require self-evaluation or evaluation by a professional to ensure the problem gambling or financial issues that led to

THE SELF-EXCLUSION HAVE CORRECTED THEMSELVES. REMOVAL FROM THE EXCLUSION LIST PRIOR TO THE SELF-SELECTED TIME PERIOD IS AT THE COMPLETE DISCRETION OF THE GAMING DIVISION DIRECTOR. IF AN INDIVIDUAL'S PETITION TO BE REMOVED FROM THE EXCLUSION LIST PRIOR TO THE SELF-SELECT EXCLUSION PERIOD IS NOT APPROVED BY THE DIRECTOR, THE INDIVIDUAL MAY NOT RE-PETITION THE DIRECTOR AGAIN FOR THE PERIOD OF ONE YEAR.

30-2906 ESTABLISHMENT OF RESPONSIBLE GAMING BEST PRACTICES.

(1) RETAIL GAMING LICENSEES SHALL SUBMIT TO THE DIVISION THEIR STRATEGY FOR THE IMPLEMENTATION OF A RESPONSIBLE GAMING PROGRAM. THE RESPONSIBLE GAMING STRATEGY SHALL NOT ONLY INCLUDE SELF-DIRECTED LIMITS BY PLAYERS, IT SHALL ALSO INCLUDE THE LICENSEE'S COMMITMENT AS A COMPANY TO A ROBUST RESPONSIBLE GAMING PLATFORM. THE PLAN FOR IMPLEMENTATION SHALL BE SUBMITTED TO THE DIVISION NO LATER THAN APRIL 1, 2023. RETAIL GAMING LICENSEES THAT BEGIN OPERATING AFTER APRIL 1, 2023 SHALL HAVE A RESPONSIBLE GAMING STRATEGY IN PLACE PRIOR TO LIVE OPERATIONS. BEGINNING OCTOBER 1, 2023 AND ON OR BEFORE OCTOBER 1 EACH YEAR THEREAFTER, RETAIL GAMING LICENSEES SHALL SUBMIT TO THE DIVISION ANY UPDATES TO ITS STRATEGIC IMPLEMENTATION PLAN THE STRATEGIC IMPLEMENTATION PLAN SHALL INCLUDE BUT IS NOT LIMITED TO THE FOLLOWING:

(A) A DETAILED EXPLANATION OF THE OPTIONS AVAILABLE FOR PLAYER CARD CUSTOMERS AND WITH ANY CASHLESS SYSTEMS AND ACCOUNT WAGERING THE ABILITY TO SET SELF-DIRECTED LIMITS ON ALL ASPECTS OF THEIR PLAY INCLUDING DEPOSITS, WITHDRAWALS, LIMITS ON BETTING AND TIME FRAMES THOSE LIMITS TAKE PLACE. ADDITIONALLY, AN EXPLANATION OF ALL RESPONSIBLE GAMING TOOLS THAT ARE AT THE PLAYERS DISPOSAL.

(B) A DETAIL OF THE STAFFING LEVEL, INCLUDING THE LEAD STAFF POSITION FOR THE RESPONSIBLE GAMING PROGRAM, STAFFING POSITIONS DEDICATED TO RESPONSIBLE GAMING, EMPLOYEE EDUCATION AND OUTREACH TO PLAYERS IDENTIFIED AS PROBLEM GAMBLERS OR PLAYERS THAT ARE AT RISK OR SHOW SIGNS OF PROBLEMS GAMING.

(C) A DETAIL OF THE USE OF PLAYER DATA AND TECHNOLOGY TO AID IN IDENTIFYING POTENTIAL PROBLEM GAMBLERS. DETAIL SHOULD BE PROVIDED ON HOW THE OPERATORS OR A CONTRACTED THIRD PARTY'S TECHNOLOGY WILL PROVIDE AUTOMATED TRIGGERS ON POTENTIAL PROBLEM GAMBLERS. THE LIST SHOULD PROVIDE DETAIL ON WHAT TRIGGERS ARE BEING IDENTIFIED AND HOW THE RETAIL GAMING LICENSEE HAS IDENTIFIED THOSE AS CRITICAL MATRIX TO FOLLOW. ADDITIONALLY, WHAT PLANS THE RETAIL GAMING LICENSEE IS ENGAGED IN TO CONTINUALLY UPDATE AND LEARN THE BEST WAY TO IDENTIFY PROBLEM GAMBLERS IN THEIR CASINO.

(D) A DETAIL OF THE LEVELS OF INTERVENTION AND EDUCATION PROVIDED TO IDENTIFIED AT RISK PLAYERS. PROVIDE EXAMPLES OF MATERIALS AND/OR MEDIA USED FOR INTERVENTION AND EDUCATION.

(E) DETAIL INTERNAL CONTROLS TO IDENTIFY THOSE PERSONS WHO ENGAGE IN GAMING AND SPORTS BETTING ACTIVITY, CONTROLLED BY THE LICENSEE, WHO ARE INCLUDED ON THE EXCLUSION LIST. INTERNAL CONTROLS SHOULD INCLUDE PROHIBITING OR STOPPING PERSONS ON THE EXCLUSION LIST AND CONTROLS IN PLACE TO PREVENT COLLECTION OF WINNINGS BY AN EXCLUDED PERSON.

(F) ADDITIONALLY, PROVIDE ANY INFORMATION RELEVANT TO THE COMPANY AS A WHOLE ON STRATEGIC DIRECTION FOR RESPONSIBLE GAMING.

Notice of Proposed Rulemaking

Tracking number

2022-00737

Department

200 - Department of Revenue

Agency

207 - Division of Gaming - Rules promulgated by Gaming Commission

CCR number

1 CCR 207-2

Rule title

SPORTS BETTING REGULATIONS

Rulemaking Hearing

Date

12/15/2022

Time

09:15 AM

Location

1707 Cole Blvd, Redrocks Conference Room, Lakewood, CO 80401, and virtually

Subjects and issues involved

Amendments to Sports Betting Rule 7 to include procedures for the calculation of taxes regarding free bets tax reduction. Pursuant to the passing of HB 22-1402, and to meet the effective date set therein, the Gaming Commission adopted emergency Rule changes to Sports Betting Rule 9. The Division is now submitting these changes for permanent adoption.

Statutory authority

Sections 44-30-102, C.R.S., 44-30-201, C.R.S., 44-30- 202, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., 44-30-502, C.R.S., 44-30-503, C.R.S., 44-30-510, C.R.S., 44-30-528, C.R.S., 44-30-531, C.R.S., 44-30-827, C.R.S., 44-30-833, C.R.S., 44-30-1501, C.R.S, 44-30-1701, C.R.S., 44-30-1702, C.R.S., 44-30-1703, C.R.S., and part 15 of article 30 of title 44, C.R.S.

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DEPARTMENT OF REVENUE

Division of Gaming

SPORTS BETTING REGULATIONS

1 CCR 207-2

BASIS AND PURPOSE FOR RULE 7

The purpose of Rule 7 is to establish a Sports Betting Operations Fee to defray the cost of regulating the sports betting industry, specify the requirements regarding the certification, assessment and security of sports betting systems and kiosks, and direct Sports Betting Operations to establish internal control procedures, including accounting controls, outline reporting requirements and the computation of taxes, establish geofence and sports betting account requirements, and to outline procedures for change control. The statutory basis for Rule 7 is found in sections 44-30-102, C.R.S., 44-30-201, C.R.S., 44-30- 202, C.R.S., 44-30-203, C.R.S., 44-30-302, C.R.S., 44-30-503, C.R.S., 44-30-510, C.R.S., 44-30-528, C.R.S., 44-30-833, C.R.S., 44-30-1501, C.R.S, and part 15 of article 30 of title 44, C.R.S.

RULE 7 REQUIREMENTS OF SPORTS BETTING OPERATIONS *Effective 4/14/20*

7.8 Sports betting reports; betting revenue; computation of taxes; reconciliation.

(2) Calculation of taxes.

(C) SPORTS BETTING FREE BETS REDUCTION.

(I) UNTIL JANUARY 1, 2023, WHEN CALCULATING "NET SPORTS BETTING PROCEEDS" EACH MONTH, A SPORTS BETTING OPERATOR OR INTERNET SPORTS BETTING OPERATOR MAY:

(A) INCLUDE ALL FREE BETS PLACED BY PLAYERS WITH THE SPORTS BETTING OPERATOR OR; AND

(B) CARRY FORWARD ANY UNUSED FREE BET CREDITS ACCUMULATED ON OR BEFORE NOVEMBER 30, 2022.

(II) ON AND AFTER JANUARY 1, 2023, WHEN CALCULATING "NET SPORTS BETTING PROCEEDS" EACH MONTH, A SPORTS BETTING OPERATOR OR INTERNET SPORTS BETTING OPERATOR SHALL INCLUDE ONLY A PORTION OF THE TOTAL FREE BETS PLACED BY PLAYERS WITH THE SPORTS BETTING OPERATOR OR INTERNET SPORTS BETTING OPERATOR, AS FOLLOWS:

(A) ON AND AFTER JANUARY 1, 2023, THROUGH JUNE 30, 2024, NO MORE THAN TWO AND ONE-HALF PERCENT OF THE TOTAL AMOUNT OF ALL BETS PLACED BY PLAYERS WITH THAT SPORTS BETTING OPERATOR OR INTERNET SPORTS BETTING OPERATOR EACH MONTH;

(B) ON AND AFTER JULY 1, 2024, THROUGH JUNE 30, 2025, NO MORE THAN TWO AND ONE-FOURTH PERCENT OF THE TOTAL AMOUNT OF ALL BETS PLACED BY PLAYERS WITH THAT SPORTS BETTING OPERATOR OR INTERNET SPORTS BETTING OPERATOR EACH MONTH;

(C) On and after July 1, 2025, through June 30, 2026, no more than two percent of the total amount of all bets placed by players with that sports betting operator or Internet Sports Betting Operator each month; and

(D) On and after July 1, 2026, no more than one and three-quarters percent of the total amount of all bets placed by players with that sports betting operator or Internet Sports Betting Operator each month.

(III) On or after January 1, 2023, a sports betting operator or Internet Sports Betting Operator shall not:

(A) Carry over to the next month any free bets placed in excess of the deduction allowed for any month; or

(B) Carry forward any unused free bet credits accumulated before January 1, 2023.

BASIS AND PURPOSE FOR RULE 9

The purpose of Rule 9 is to specify the requirements of Sports Betting Operations and responsible gaming, patron responsible gaming, and to specify certain duties of licensees and patrons related to self-restriction. The statutory basis for Rule 9 is found in sections 44-30-201, C.R.S., 44-30-202, C.R.S., 44- 30-203, C.R.S., 44-30-302, C.R.S., 44-30-502, C.R.S., 44-30-510, C.R.S., 44-30-528, C.R.S., 44-30-531, C.R.S., 44-30-827, C.R.S., 44-30-833, C.R.S., 44-30-1701, C.R.S., 44-30-1702, C.R.S., 44-30-1703, C.R.S., and part 15 of article 30 of title 44, C.R.S.

RULE 9 RESPONSIBLE GAMING AND SELF-RESTRICTION *Effective 4/14/20*

9.1 Display of responsible gaming logo.

(1) Each sports betting website, mobile application, and self-service gaming device (kiosk) shall display a responsible gaming logo in a manner approved by the Director or Director's designee to direct a patron to the Sports Betting Operator's responsible gaming webpage. Master, Sports Betting Operator, and Internet Sports Betting Operator licensees shall operate under the same responsible gaming guidelines as detailed in these Rules, where applicable. The responsible gaming webpage shall be accessible to a patron during a sports betting patron session and shall contain, at a minimum, the following:

(a) A prominent message that states, "Gambling problem? Call or TEXT1-800-~~522-4700~~GAMBLER";

(b) A direct link to the website and other internet resources dedicated to helping people with potential gambling problems as directed by the Commission;

(c) A clear statement of the Sports Betting Operation's policy and commitment to responsible gaming along with a link to the Sports Betting Operator's specific self-exclusion program along with information on self-exclusion through the Division or Division's website.

(2) Sports Betting Operations with brick-and-mortar locations must have a policy in effect for all of its properties IN ADDITION TO SELF-EXCLUSION, providing opportunities for patrons to request in writing the revocation of their privileges for specific services such as:

9.2 Sports Betting Operations self-exclusion.

Each Sports Betting Operation shall establish and maintain a self-exclusion program for patrons ~~specific to that Sports Betting Operator~~. EACH SPORTS BETTING OPERATION SHALL PARTICIPATE BY SHARING SELF-EXCLUSION DATA WITH THE DIVISION IN ACCORDANCE WITH RULE 9.5. EACH SPORTS BETTING OPERATION SHALL PARTICIPATE BY ELECTRONICALLY IMPORTING SELF-EXCLUDED PATRON INFORMATION. IF A SPORTS BETTING OPERATION IS UNABLE TO ELECTRONICALLY IMPORT AND EXPORT SELF-EXCLUDED PATRON INFORMATION, ANOTHER METHOD MAY BE APPROVED BY THE DIRECTOR. THIS SELF-EXCLUSION IS NOT PART OF ANY SELF-IMPOSED LIMITS OR SHORT-TERM TIMEOUT TAKEN BY A PATRON. IT ONLY PERTAINS TO THE LIMITS SPECIFICALLY SET FORTH IN 9.5(4)(A).

9.3 Direct marketing to prohibited sports betting participants.

(1) FOR THE PURPOSE OF THIS RULE, "PROHIBITED PARTICIPANT" SHALL MEAN INDIVIDUALS WHO HAVE VOLUNTARILY REQUESTED TO BE EXCLUDED FROM GAMING ACTIVITIES AND INDIVIDUALS WHO ARE REQUIRED BY THE COMMISSION TO BE EXCLUDED OR EJECTED FROM LICENSED GAMING ESTABLISHMENTS, AND SPORTS BETTING INDIVIDUALS WHO ARE PROHIBITED FROM PLACING WAGERS ON CERTAIN SPORTING EVENTS TO THE EXTENT THAT THOSE INDIVIDUALS RESIDE IN THE DIVISION'S EXCLUSION LIST DATABASE.

(~~1~~2) A Sports Betting Operation shall make all reasonable efforts to ensure that prohibited participants do not receive direct marketing from the Sports Betting Operation or marketing affiliates.

(~~2~~3) A Sports Betting Operation will satisfy this requirement if the Sports Betting Operation and/or marketing affiliates remove the prohibited participant's name and resident address from the list of patrons to whom direct marketing materials are sent.

(4) A SPORTS BETTING OPERATION AND/OR ITS MARKETING AFFILIATES SHALL USE THE CURRENT EXCLUSION LIST PROVIDED BY THE DIVISION. THE EXCLUSION LIST OR IN PERSON CHANGES SHALL BE USED EXPEDITIOUSLY TO UPDATE ALL DIRECT MARKETING LISTS TO ENSURE THAT EXCLUDED AND PROHIBITED PLAYERS ARE NOT DIRECTLY TARGETED, INCLUDING BUT NOT EXCLUSIVE OF DIRECT MAIL AND EMAIL.

(5) REGULATION 9.3(4) SHALL NOT APPLY TO PERSONS IDENTIFIED IN 44-30-1502 C.R.S. THAT ARE ONLY PROHIBITED FROM BETTING ON A SPORTING EVENT THAT IS OVERSEEN BY THAT PERSON'S SPORT'S GOVERNING BODY.

9.4 Responsible advertising and promotions.

(1) All offers and bonuses must:

(F) PLAYERS THAT SELF-EXCLUDE SHALL NOT, WHILE ON THE EXCLUSION LIST, BE ABLE TO REDEEM POINTS, BONUSES, COMPS OR FREEPLAY.

(2) PROHIBITION ON ADVERTISING THAT TARGETS UNDERAGE PARTICIPANTS:

(A) A SPORTS BETTING OPERATION AND/OR THEIR MARKETING AFFILIATES SHALL NOT TARGET UNDERAGE PERSONS OR CREATE ADVERTISING CONTENT THAT IS CLEARLY MEANT, BECAUSE OF MESSAGE AND GRAPHICS, FOR AN UNDERAGE AUDIENCE.

(B) A Sports Betting Operation and/or their marketing affiliates shall not advertise on media where the majority of the demographic audience or players/performers are known to be under the legal age to gamble. This does not apply to public venues where the demographics of a normal crowd in attendance cannot be determined.

(3) Sports Betting Operators and Internet Sports Betting Operators on or before October 1, 2023, and on or before October 1 each year thereafter shall submit to the Director a report that describes the efforts of the licensee in the preceding state fiscal year (July 1st through June 30th) to promote responsible gaming in the state via advertising and other promotional methods and the licensee's plans concerning such promotional efforts in the current state fiscal year.

9.5 Exclusion list – Duties and responsibilities.

(1) Database creation.

The Division shall operate a program to consolidate excluded, self-excluded and prohibited individuals in one interactive database repository in order to keep those individuals from participating in Colorado gaming. The program shall provide an interactive protected database for retail gaming licensees, Sports Betting Operations, sports leagues and individuals that participate in gaming in Colorado. The sole purpose of the exclusion list and database is to ensure timely updates of individuals that may not participate in gaming for all gaming operations in Colorado. The exclusion list shall only be used for the purpose of identifying those individuals who are prohibited from gaming and those that may have excluded themselves because of a gambling problem. Licensees that receive data from the Division shall use it solely to update their database. The information contained in the database and updates provided to the licensees are confidential and shall only be used for its intended purpose. Limited information may be shared with affiliates for the purpose of ensuring those identified do not receive direct marketing. It is a violation for any licensee to use the confidential data in any other way. The Director shall determine how each licensee, league or individual interacts with the database.

(A) Sports Betting Operations shall, as part of their self-exclusion and responsible gaming program. make available to the player easily identifiable within the operators application, the link to the Divisions website for self-exclusion. the link should take the player directly to that page from the application.

(B) The Division shall provide database records, sent electronically to the Sports Betting Operations. the Director shall provide one or more excluded or prohibited player lists to Sports Betting Operations. data records will be in a format detailed by the Director or their designee.

(C) Sports Betting Operations shall receive updates daily from the Division. Sports Betting Operations shall update all new excluded persons within their database.

(D) Sports Betting Operations shall receive the Division database with self-excluded persons that have opted in on or after January 1, 2023 as determined by the Director. the Sport betting operator shall make information for players that have self-excluded prior to January 1, 2023 upon request.

(2) Database inclusion.

(A) The following persons shall be included and maintained in the Division database, updated and transferred to Sports Betting Operations and retail gaming licensees:

(I) Individuals that have voluntarily self-excluded from any operator, retail casino or through the Division.

(II) Sports betting individuals who are prohibited from placing wagers on certain sporting events to the extent that those individuals reside in the Division's exclusion list database.

(III) Individuals who are required by the Commission to be excluded or ejected from licensed gaming establishments, to the extent that those individuals reside in the Divisions exclusion list database.

(B) Persons on the exclusion and prohibited list may not participate or collect winnings from the gaming in Colorado on which they are prohibited. Players that self-exclude shall not, while on the exclusion list, be able to redeem points, bonuses, comps or freeplay.

(3) Inclusion on the exclusion list.

(A) Individual self-exclusion means that an individual has made a conscious voluntary effort to exclude themselves from not only that form of gaming but from all forms of gaming under the regulatory purview of the Colorado limited gaming control Commission and the Colorado Division of gaming. Self-exclusion may only be accomplished by an individual acting in their own interest, in the following ways:

(I) Self-exclusion by an individual through the Division of gaming. an individual self-excluding either in person or through a web-based application. All self-exclusions by individuals through the Division either in person or web-based, will have their identity verified prior to being included on the exclusion list.

(II) Self-exclusion from an Internet Sports Betting Operator. An individual who on an Internet sports betting mobile app chooses an option to electronically self-exclude, and has been directed to the Division's website.

(III) Self-exclusion from a sports betting operator (retail sports book). An individual requesting self-exclusion from a retail sports book shall fill out a self-exclusion form provided by the sports book. The sports book shall enter the self-exclusion into the secure Division portal, direct the player to a dedicated computer on the licensees property where the player can access the Division's website directly for self-exclusion or if the portal is not available direct the player to the Divisions website for self-exclusion at a later time or use their electronic database procedure.

(IV) Self-exclusion from a retail gaming licensee (casino). An individual requesting self-exclusion from a casino shall fill out a self-exclusion form provided by the casino. The casino shall enter the self-exclusion into the secure Division portal direct the player to a dedicated computer on the licensees property where the player can access the Division's website directly for self-exclusion or if the portal is not available direct

THE PLAYER TO THE DIVISIONS WEBSITE FOR SELF-EXCLUSION AT A LATER TIME OR USE THEIR ELECTRONIC DATABASE PROCEDURE.

(B) INDIVIDUALS WISHING TO SELF-EXCLUDE IN PERSON OR THROUGH THE DIVISION'S WEB-BASED APPLICATION SHALL FILL OUT ALL REQUIRED INFORMATION ON THE FORM. INCOMPLETE FORMS WHERE AN INDIVIDUAL CANNOT BE IDENTIFIED WILL NOT BE PROCESSED.

(C) INDIVIDUALS THAT SELF-EXCLUDE FROM GAMING CORPORATIONS THAT HAVE GAMING OPERATIONS IN OTHER STATES MAY BE INCLUDED ON THEIR CORPORATE EXCLUSION LIST AND MAY BE INCLUDED IN OTHER STATE EXCLUSION PROGRAMS. AN INDIVIDUAL SELF-EXCLUDING IN COLORADO SHALL BE INFORMED PRIOR TO BEING PLACED ON A CORPORATE EXCLUSION LIST.

(4) EXCLUSION PERIOD.

(A) INDIVIDUALS THAT HAVE VOLUNTARILY SELF-EXCLUDED FROM ANY SPORTS BETTING OPERATION, RETAIL CASINO OR THROUGH THE DIVISION SHALL SELECT THE PERIOD OF EXCLUSION TO INCLUDE:

(I) ONE (1) YEAR

(II) THREE (3) YEARS

(III) FIVE (5) YEARS

(B) AN INDIVIDUAL WHO IS ON THE LIST MAY SUBMIT A REQUEST, TO THE DIVISION, TO INCREASE THE MINIMUM LENGTH OF EXCLUSION.

(5) REMOVAL FROM THE EXCLUSION LIST.

(A) INDIVIDUALS THAT HAVE SELF-EXCLUDED OR ARE ON THE EXCLUDED LIST WILL NEED TO FILL OUT AND FILE THE FORM WITH THE DIVISION OF GAMING DIRECTOR PRIOR TO BEING REMOVED FROM EXCLUSION LIST. NO PERSON IS AUTOMATICALLY REMOVED FROM THE EXCLUSION LIST WHEN THE SELECTED OR DIRECTED TIME PERIOD ENDS.

(B) SPORTS BETTING INDIVIDUALS WHO ARE PROHIBITED FROM PLACING WAGERS ON CERTAIN SPORTING EVENTS TO THE EXTENT THAT THOSE INDIVIDUALS RESIDE IN THE DIVISION'S EXCLUSION LIST DATABASE MAY BE REMOVED FROM THE LIST BY THEIR GOVERNING BODY/LEAGUE OR BY FILLING OUT AND FILING THE FORM WITH THE DIVISION OF GAMING'S DIRECTOR.

(C) INDIVIDUALS THAT ARE ON THE EXCLUSION LIST AND HAVE NOT COMPLETED THEIR SELF-SELECTED PERIOD OF SELF-EXCLUSION MAY PETITION THE DIVISION OF GAMING'S DIRECTOR FOR REMOVAL FROM THE LIST. THE DIVISION MAY REQUIRE SELF-EVALUATION OR EVALUATION BY A PROFESSIONAL TO ENSURE THE PROBLEM GAMBLING OR FINANCIAL ISSUES THAT LED TO THE SELF-EXCLUSION HAVE CORRECTED THEMSELVES. REMOVAL FROM THE EXCLUSION LIST PRIOR TO THE SELF-SELECTED TIME PERIOD IS AT THE COMPLETE DISCRETION OF THE GAMING DIVISION DIRECTOR. IF AN INDIVIDUAL'S PETITION TO BE REMOVED FROM THE EXCLUSION LIST PRIOR TO THE SELF-SELECT EXCLUSION PERIOD IS NOT APPROVED BY THE DIRECTOR, THE INDIVIDUAL MAY NOT RE-PETITION THE DIRECTOR AGAIN FOR THE PERIOD OF ONE YEAR.

9.6 ESTABLISHMENT OF RESPONSIBLE GAMING BEST PRACTICES.

(1) SPORTS BETTING OPERATIONS SHALL SUBMIT TO THE DIVISION THEIR STRATEGY FOR THE IMPLEMENTATION OF A RESPONSIBLE GAMING PROGRAM. THE RESPONSIBLE GAMING STRATEGY SHALL NOT ONLY INCLUDE SELF-DIRECTED LIMITS BY PLAYERS, IT SHALL ALSO INCLUDE THE LICENSEES COMMITMENT AS A COMPANY TO A ROBUST RESPONSIBLE GAMING PLATFORM. THE PLAN FOR

implementation shall be submitted to the Division no later than April 1, 2023. Sports Betting Operations that begin operating after April 1, 2023 shall have a responsible gaming strategy in place prior to commencing live operations. Beginning October 1, 2023 and on or before October 1 each year thereafter, Sports Betting Operations shall submit to the Division any updates to its strategic implementation plan. The strategic implementation plan shall include but is not limited to the following:

(a) A detailed explanation of the options available for customers to set self-directed limits on all aspects of their deposits, withdrawals, limits on betting and time frames those limits take place. Additionally, an explanation of all responsible gaming tools that are at the players disposal.

(b) A detail of the staffing level, including the lead staff position for the responsible gaming program, staffing positions dedicated to responsible gaming, employee education and outreach to players identified as problem gamblers or players that are at risk or show signs of problems gaming.

(c) A detail of the use of player data and technology to aid in identifying potential problem gamblers. Detail should be provided on how the operators or a contracted third party's technology will provide automated triggers on potential problem gamblers. List should be provided detail on what triggers are being identified and how the operator has identified those as critical matrix to follow. Additionally, what plans the operator has to continually update and learn the best way to identify problem gamblers on their site.

(d) A detail of the levels of intervention and education provided to identified at risk players. Provide examples of materials and/or media used for intervention and education.

(e) Detail internal controls to identify those persons who engage in gaming and sports betting activity, controlled by the licensee, who are included on the exclusion list. Internal controls should include prohibiting or stopping persons on the exclusion list and controls in place to prevent collection of winnings by an excluded person.

(f) Additionally, provide any information relevant to the company as a whole on strategic direction for responsible gaming.

Notice of Proposed Rulemaking

Tracking number

2022-00735

Department

700 - Department of Regulatory Agencies

Agency

712 - Division of Professions and Occupations - Colorado Podiatry Board

CCR number

3 CCR 712-1

Rule title

PODIATRY RULES AND REGULATIONS

Rulemaking Hearing

Date

12/16/2022

Time

01:00 PM

Location

Webinar Only: https://us06web.zoom.us/webinar/register/WN_CWu8jONSSk2qW_-gZbunUA

Subjects and issues involved

The purpose of this Permanent Rulemaking Hearing is for the Colorado Podiatry Board to consider adopting revisions to Rule 1.11 (Supervision of and Practice by Physician Assistants); and new and revised rules to implement Colorado Senate Bill 22-116 (Concerning the ability of an individual to obtain an occupational credential through the occupational credential portability program); Colorado House Bill 22-1115 (Concerning the prescription drug monitoring program) and OLLS Correction to HB21-1276; Colorado House Bill 22-1284 (Concerning updates to state surprise billing laws to facilitate the implementation of surprise billing protections, and, in connection therewith, aligning state law with the federal "No Surprises Act"); Executive Order D-2022-032 (Directing State Agencies to Protect Access to Reproductive HealthCare in Colorado); and Executive Order D-2022-034 (Protecting Colorados Workforce and Expanding Licensing Opportunities).

Statutory authority

Sections 12-20-202(3), 12-20-204(1), 12-30-112(3), 12-290-106(1)(a), and 24-4-103, C.R.S.; and Executive Orders D 2022-032 and D 2022-034.

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DEPARTMENT OF REGULATORY AGENCIES

Colorado Podiatry Board

PODIATRY RULES AND REGULATIONS

3 CCR 712-1

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

Please recodify all rules into 3 CCR 712-1, that have been relocated from 3 CCR 712-1 through 3 CCR 712-21 (except rules that have been repealed prior to this rulemaking – which are not contained in this document).

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1.6 PODIATRY LICENSURE

This Rule is promulgated pursuant to sections 12-20-202, 12-20-204, 12-290-106(1)(a), 12-290-107, and 12-290-112, C.R.S.

…

B. LICENSURE BY ENDORSEMENT

In lieu of applying for an initial license to practice podiatry in Colorado, applicants who are licensed to practice podiatry in another jurisdiction, through the federal government, or who holds a military occupational specialty, as defined in section 24-4-201, C.R.S., may apply for licensure by endorsement pursuant to section 12-20-202(3), C.R.S. An applicant for licensure by endorsement must timely complete a Board approved application form establishing compliance with the following requirements:

1. Graduation from a Board approved podiatry school;

2. Passage (at the time of licensure in another jurisdiction) of the written PMLEXIS examination of the National Board of Podiatric Medical Examiners or any successor or predecessor organization as determined by scores established by the Board; except that the Board may, on a case-by-case basis, waive the requirement of this Section (B)(3) of this Rule for applicants for licensure by endorsement who have not passed the PMLEXIS examination, upon the provision of evidence satisfactory to the Board that the applicant's practice, experience, training, and/or education otherwise constitutes substantially equivalent qualifications.

3. Passage (at the time of licensure in another jurisdiction) of the basic sciences examination of the National Board of Podiatric Medical Examiners or any successor or predecessor organization, except that this requirement does not apply to applicants licensed by examination in another jurisdiction prior to 1970;

4. Compliance with training requirements comparable to those required by the Board (Colorado) at the time of the applicant's original licensure in another jurisdiction;

5. Possession of a license to practice podiatry in another jurisdiction that has not been revoked, suspended or subject to disciplinary or adverse actions; and

6. Documentation that the applicant has been engaged in the active practice of podiatry for the two years immediately preceding the date of the current Colorado application.

7. Submission of satisfactory proof that the applicant has held for at least one year a current and valid license to practice podiatry in another jurisdiction with a scope of practice that is substantially similar to the scope of practice for podiatrists as specified in Article 290 of Title 12, C.R.S., and these Rules.

87. As used in this Section (B) of this Rule, "active practice of podiatry" means the applicant has engaged in the practice of podiatry at least twenty hours per week during the preceding two years with no more than a six month continuous absence from the practice of podiatry; except that where appropriate for applicants for licensure by endorsement the Board may allow the applicant to fulfill the "active practice of podiatry" requirement by other means. It is anticipated that such exceptions shall be rare, and the decision as to what constitutes the active practice of podiatry shall be in the discretion of the Board.

98. An applicant who cannot demonstrate continued competency by compliance with the above criteria may demonstrate competence by complying with other evaluation, education, training and/or monitoring the Board may require to establish continued competence. Such requirements shall be at the discretion of the Board.

C. CREDIT FOR MILITARY, EDUCATION, TRAINING, OR EXPERIENCE

The purpose for the promulgation of this Rule is to satisfy the requirement of section 12-20-202(4), C.R.S., related to applying military education, training, and experience to qualifications for licensure.

1. An applicant for licensure may submit information about the applicant's education, training, or experience acquired during military service. It is the applicant's responsibility to provide timely and complete information for the Board's review.

2. In order to meet the requirements for licensure, such education, training, or experience must be substantially equivalent to the required qualifications that are otherwise applicable at the time the application is received by the Board.

3. The Board will determine, on a case-by-case basis, whether the applicant's military education, training, or experience meet the requirements for licensure.

4. Documentation of military experience, education, or training may include, but is not limited to, the applicant's Certificate of Release or Discharge from Active Duty (DD-214), Verification of Military Experience Training (DD-2586), military transcript, training records, evaluation reports, or letters from commanding officers describing the applicant's practice.

…

1.11 SUPERVISION OF AND PRACTICE BY PHYSICIAN ASSISTANTS (PAs)

This Rule is promulgated pursuant to sections 12-20-204, 12-290-106(1)(a), and 12-290-117(1) and (2), C.R.S. This rule governs the licensure and conduct of licensed physician assistants and not persons performing delegated podiatric tasks pursuant to section 12-290-116(6)(c), C.R.S.

A. REQUIREMENTS

Commented [KE1]: Review and compare this rule to CMB's Rule 400 regarding the supervision of PAs.

Commented [KE2]: AW from the Colorado Academy of Physician Assistants (CAPA) on 5/27/22:

Proposed Rule 290 includes two other provisions that are concerning to CAPA. First, the proposed rule refers to PAs as "certified."[1] However, PAs are licensed – not certified – by the Colorado Medical Board.[1] Additionally, Proposed Rule 290 states that a supervising podiatrist is "accountable legally for the performance of [PAs] operating under the podiatrist's direction and supervision.[1] However, all other PAs are legally responsible for the care they provide to patients once they have completed three years of practice.[1] For purposes of consistency, CAPA urges the Board to update proposed Rule 290 to reflect these provisions.

In order to engage in practice as a physician assistant under the personal and responsible direction of a licensed podiatrist pursuant to the provisions of section 12-290-117, C.R.S., a physician assistant must hold a current license to practice issued by the Colorado Medical Board.

B. EXTENT AND MANNER IN WHICH A PA MAY PERFORM DELEGATED TASKS CONSTITUTING THE PRACTICE OF PODIATRY UNDER PERSONAL AND RESPONSIBLE DIRECTION AND SUPERVISION

1. Mandatory standards to be applied in the direction and supervision of (PAs):

a. Direction and supervision of PAs must be personally rendered by a licensed podiatrist practicing in the State of Colorado and not through intermediaries.

b. The licensed podiatrist is responsible for the performance of delegated podiatric services by PAs. That responsibility requires that the licensed podiatrist assure that those delegated services are performed with a degree of care and skill that would be expected of the licensed podiatrist. The licensed podiatrist is accountable legally for the performance of such supervised persons operating under the podiatrist's direction and supervision.

c. The licensed podiatrist must provide direction to PAs in order to specify what podiatric services should be provided under the circumstances of each case. The function of the direction requirement is to assure that all decisions as to necessity, type, effectiveness and method of treatment are made by the licensed podiatrist who has the requisite skill, judgment and training to make such decisions. Such direction may be provided by written protocols, or by oral communication in person, over the telephone or by other electronic means. The ~~burden shall be on the~~ licensed podiatrist shall provide appropriate directions and confirm such directions are reasonably understood ~~to assure that appropriate directions are given and that those directions are fully understood~~ by the supervised person.

d. The licensed podiatrist must provide adequate supervision of the performance of delegated podiatric services. Supervision is intended to assure that the directions given are carried out properly. Supervision may include constant over-the-shoulder inspection of the performance of the podiatric services, after-the-fact review through viewing the patient or his chart or conferring with the PA rendering the delegated podiatric services. In determining whether such supervision is adequate, under the circumstances of each case, the licensed podiatrist and the Board shall consider the following factors: (i) the complexity of the task, (ii) the risk to the patient, (iii) the background, training and skill of the person performing the podiatric services, (iv) the adequacy of the direction in terms of its form, (i.e., written or oral) and its specificity, (v) the setting in which the podiatric services are performed (e.g., office, hospital, nursing home, rural clinic or other remote sites), (vi) the availability of the licensed responsible podiatrist or other licensed podiatrists, and (vii) the necessity for immediate attention. Thus, depending on the circumstances of each case, the degree of supervision necessary may vary within the above constraints. It should be noted, however, there is a presumption that the supervising podiatrist shall routinely be present at the location where the PA practices. In circumstances where on-site supervision is not provided, the burden shall be on the podiatrist or the PA or both to establish that the lack of such supervision was reasonable under the circumstances. Specific exemption from this presumption is made for facilities operated by the State Departments of Institutions and Corrections. ~~In addition, there is a presumption that a designated supervising podiatrist cannot adequately supervise more than four PAs or four non-physician health care providers or a~~

Commented [KE3]: KC from the United Food & Commercial Workers International Union on 5/20/22:

The current rule 290 is overly restrictive and cumbersome in two key ways. Rule 290 requires a podiatrist to cosign a note within 2 days of any patient that is seen by a PA. This means that podiatrists are co-signing PA notes rather than seeing their patients. This requirement does not improve patient safety. Further, if the podiatrist and PA believe that quality of care dictates more frequent review of notes they can do this.

Commented [KE4]: 9/9 Board: Reword/clarify paragraph, consistent with the requirements of section 12-290-117, C.R.S.

Commented [KE5]: AW from the Colorado Academy of Physician Assistants (CAPA) on 5/27/22:

The provisions in proposed Rule 290 relating to podiatrist supervision of PAs exceed the requirements for PAs in all other areas of medical practice. For instance, proposed Rule 290 states supervision "may include constant over-the-shoulder inspection of the performance of the podiatric services" and further states a supervising podiatrist must review the quality of medical services rendered by a PA every two working days.[1] Moreover, proposed Rule 290 states there is a presumption that the supervising podiatrist "shall routinely be present at the location where the PA practices" and that a supervising podiatrist is unable to adequately supervise more than four PAs.[1] These requirements create a significantly higher administrative burden for both PAs and supervising podiatrists than would be experienced by PA-physician teams in any other medical specialty.

PAs not practicing in podiatry must be supervised by a physician who performs "personal and responsible direction and supervision."[1] However, the nature of this supervision is left to the PA-physician team, provided such methods of supervision are outlined in a supervisory plan and the PA is evaluated via a performance evaluation.[1] There is no requirement that a PA's patient services be reviewed every two days. Additionally, there is no presumption that a non-podiatry PA's supervising physician will routinely be present at the practice site. Instead, the rules state a supervising physician must "provide adequate means" by which the physician and PA may communicate via telecommunication.[1] Finally, there is no presumption that a supervising physician is only able to adequately supervise up to four PAs. Instead, a physician may supervise up to eight PAs.[1] Compared to the requirements in proposed Rule 290, these provisions allow the PA-physician team greater flexibility to provide patient care.

~~combination thereof at one time, and it shall be the burden of any podiatrist wishing to supervise more than four such persons to establish, at the time of registration, the contrary to the Board under said podiatrist's particular circumstances. Finally, the licensed podiatrist must review the quality of medical services rendered by each PA every two working days by reviewing medical records to assure compliance with the licensed podiatrist's directions.~~

2. Identification of PAs:

The licensed podiatrist, as part of his supervisory duties, must assure that the PA under his or her supervision (i) is identified as a non-physician to his or her patients by wearing an identification plate upon his or her person setting forth his or her name and non-abbreviated title, and (ii) is not advertised or represented in any manner which would mislead his or her patients or the public generally.

C. PRESCRIPTION AND DISPENSING OF DRUGS

~~1. No controlled substances shall be prescribed by a licensed physician assistant.~~

2. A licensed physician assistant may issue a prescription order ~~for any non-controlled substance so long as~~:

a. The supervising podiatrist has issued written protocols ~~specifying which non-controlled substances he uses in his practice and~~ which may be prescribed by the PA on both a case-by-case and per patient visit basis. For purposes of this rule, "written protocol on a case-by-case basis" means instructions for prescribing by a PA for a new patient or a returning patient who presents new, different or additional signs or symptoms from those previously diagnosed and treated. For purposes of this rule, "written protocol on a per patient visit basis" means instructions for prescribing or refilling a prescription by a PA when a patient returns with recurrent signs or symptoms which have been previously diagnosed; and

b. The order is written, not verbal; and

c. Each and every prescription and refill order is entered on the patient's chart ~~and countersigned and dated by the supervising podiatrist within two days~~; and

d. Each written prescription order is on the supervising podiatrist's prescription order form and signed by the PA and contains in printed form the name, address and telephone number of the supervising podiatrist and the name of the PA.

3. All drugs dispensed or administered by PAs to third parties shall be prepackaged in a unit-of-use package by the supervising podiatrist, or by a pharmacist acting on the written order of the supervising podiatrist, and shall be labeled to show the name of the supervising podiatrist and the PA.

4. PA's shall not write or sign prescriptions or perform any services which the supervising podiatrist is not qualified or authorized to prescribe or perform.

5. No drug which a PA is authorized to prescribe, dispense, administer or deliver shall be obtained by said PA from a source other than a supervising podiatrist, ~~or a~~ pharmacist, or pharmaceutical representative.

D. REPORTING REQUIREMENTS

Commented [KE6]: AW from the Colorado Academy of Physician Assistants (CAPA) on 5/27/22:

The prescribing provisions in proposed Rule 290 also far exceed those affecting non-podiatry PAs. In particular, the language prohibiting PAs from prescribing controlled substances[1] is overly restrictive and appears to conflict with statutory language that seemingly acknowledges that PAs can prescribe these medications.[1] However, the provisions requiring "each and every prescription and refill order" to be countersigned by the supervising podiatrist within two days and requiring the PA to use the podiatrist's prescription order form are also much more burdensome than the requirements for all other PAs.[1]

In contrast to the provisions in proposed Rule 290, PAs practicing in all other medical specialties are authorized to prescribe Schedule II-V controlled medications.[1] Such prescriptions are not required to be countersigned by a supervising physician, and a prescription is not required to be written on the physician's prescription forms as long as the physician's name is reflected.[1] Updating proposed Rule 290 to match these requirements would ensure that podiatry patients are able to receive the same level of patient care from PAs that patients with all other medical needs are able to receive.

Commented [KE7]: DS: Prescribing controlled substances is within the scope of practice for PAs, and should be changed.
RB: PAs should be able to work autonomously with podiatrists, seeing their own patients, and working within their full scope.

Commented [KE8]: 9/9 Board: Remove Par 1

Commented [KE9]: JD: Review/compare the CMB's rules regarding PAs prescriptive authority, and supervision.

Commented [KE10]: DS: Reporting, documenting, and supervising requirements are too restrictive and inefficient.

Commented [KE11]: KC from the United Food & Commercial Workers International Union on 5/20/22:

Additionally, Podiatry Rule 290 greatly and unnecessarily restricts the prescriptive authority of PAs. PAs have a long, safe history of prescribing medications. PAs can currently get DEA numbers, and they take dozens of hours of continuing medical education to maintain their licenses and assure safe practice. PAs prescribe controlled substances when it is medically recommended. This occurs throughout their clinical days to complete hospital discharges, address surgical wounds, and to assure patients get the therapies they need to get back on their feet in a myriad of other ways.

Each licensed supervising podiatrist shall file with the Board information required on the forms provided by the Board within thirty days of the employment of such PA, and shall notify the Board of the termination of employment of any such supervised persons previously registered within seven days of such termination. The filing of such information shall not be deemed as an approval by the Board of the job descriptions of such supervised persons or the adequacy of their direction and supervision by the licensed podiatrist. However, such information will be maintained by the Board for the purposes of (i) investigating complaints against licensed podiatrists supervising such PAs and (ii) maintaining a registry of the licensed podiatrists and PAs.

E. DISCIPLINE

Physician assistants are subject to the disciplinary procedures set forth in section 12-240-125, C.R.S., of the Medical Practice Act.

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1.18 RULES REGARDING THE USE OF BENZODIAZEPINE

This Rule is promulgated pursuant to sections 12-20-204, 12-290-106(1)(a), and 12-30-109(6), C.R.S.

A. Licensees must limit any prescription for a continuous benzodiazepine to a 30-day supply, for any patient who~~to whom the licensee~~ has not been prescribed a benzodiazepine in the last 12 months.

~~B.~~ Prior to prescribing the second fill of a benzodiazepine for a condition that is not exempt under section 12-280-404(4)(a.5) C.R.S., a licensee must comply with the requirements of section 12-280-404(4), C.R.S.

~~Failure to comply with section 12-280-404(4), C.R.S., constitutes unprofessional conduct or grounds for discipline under section 12-290-108(3), C.R.S.~~

B~~C~~. The limitation stated in Section (A) of this Rule does not apply to patients for whom licensees prescribe benzodiazepines for the following conditions:

1. Epilepsy;
2. A seizure, a seizure disorder, or a suspected seizure disorder;
3. Spasticity;
4. Alcohol withdrawal; or
5. A neurological condition, including a post-traumatic brain injury or catatonia.

C~~D~~. These rules do not require or encourage abrupt discontinuation, limitation, or withdrawal of benzodiazepines. Licensees are expected to follow generally accepted standards of podiatry practice, based on an individual patient's needs, in tapering benzodiazepine prescriptions.

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1.20 PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401, *et seq.*, 12-290-106(1)(a), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Regulator" means as defined in section 12-20-102(14), C.R.S.

8. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

B. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's license based solely on the applicant or licensee's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's license based solely on a civil or criminal judgment against the applicant or licensee arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's license based solely on a professional disciplinary action or any other sanction against the applicant's or licensee's professional licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant or licensee's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's ~~registration, certificate or~~ license based solely on the licensee's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's license based solely on a civil or criminal judgment against the applicant or licensee arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.21 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-290-106(1)(a) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

4. "Licensee" means as defined in section 12-20-102(10), C.R.S.

5. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's license based solely on a civil or criminal judgment against the applicant or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's license based solely on a professional disciplinary action against the applicant's or licensee's professional licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

1.22 CONCERNING HEALTH CARE PROVIDER DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER

This Rule is promulgated pursuant to sections 12-20-204, 12-30-112, and 12-290-106(1)(a), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health.

The purpose of this Rule is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider.

This Rule applies to health care providers as defined in section 10-16-102(56), C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Publicly available" means, for the purposes of this regulation, searchable on the health care provider's public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The health care provider's public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.

B. Disclosure requirements.

1. An out of network provider may balance bill a covered person for post-stabilization services in accordance with section 10-16-704, C.R.S., and covered nonemergency

Commented [MD12]: List of ancillary services?

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services in an in-network facility that are not ancillary services if the provider meets the requirements set forth in section 12-30-112(3.5), C.R.S. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix B in compliance with section 12-30-112(3.5), C.R.S.

2. The health care provider shall provide the disclosure contained in Appendix B as set forth in section 12-30-112(3.5), C.R.S.

C. Noncompliance with this Rule may result in the imposition of any of discipline made available by section 12-290-108(3)(g), C.R.S.

…

APPENDIX B

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes

Commented [MD15]: These are linked in the Federal Model Disclosure. Should these terms be defined in rule?

services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you believe you've been wrongly billed by a healthcare provider, please contact the Colorado Podiatry Board at dora_podiatryboard@state.co.us or at 303-894-7800. Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. Visit section 12-30-112, C.R.S., for more information about your rights under state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed by a healthcare provider, please contact the Colorado Podiatry Board at dora_podiatryboard@state.co.us or at 303-894-7800. Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. The federal phone number for information and complaints is: 1-800-985-3059.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Visit the Colorado Podiatry Board website (https://dpo.colorado.gov/Podiatry) for more information about your rights under section 12-30-112, C.R.S.

Notice of Proposed Rulemaking

Tracking number

2022-00713

Department

700 - Department of Regulatory Agencies

Agency

723 - Public Utilities Commission

CCR number

4 CCR 723-11

Rule title

RULES REGULATING PIPELINE OPERATORS AND GAS PIPELINE SAFETY

Rulemaking Hearing

Date

01/19/2023

Time

09:00 AM

Location

By video conference using Zoom at a link in the calendar of events on the Commissions website: https://puc.colorado.gov/

Subjects and issues involved

The Colorado Public Utilities Commission issues this Notice of Proposed Rulemaking (NOPR) to amend the Rules Regulating Pipeline Operators and Gas Pipeline Safety (Pipeline Safety Rules) to: (1) address the legislative declaration and rule changes outlined in Senate Bill 21-108 (SB21-108), which strengthen and streamline Colorados laws governing gas pipeline safety to meet emerging challenges in Colorado; (2) to update rules to incorporate the May 16, 2022 and October 5, 2022 effective changes in 49 C.F.R Parts 190-199; and (3) to incorporate the changes in § 9-1.5-105, C.R.S., the update of Utility Notification Center Of Colorado (UNCC/Colorado 811) membership requirements. In addition, the proposed rules revise typographic and inadvertent errors. This NOPR proposes changes to the Pipeline Safety Rules enacted in 2019, as described in this Decision and its attachments. Proposed rules intend on allowing innovations in technology, improving the rules in recognition of an aging infrastructure system, a growing population that increasingly encounters gas infrastructure, and climate change policy. We also recognize within these rules that we share the responsibility for pipeline safety oversight with other federal and state agencies, commissions, and regulatory bodies.

Statutory authority

The statutory authority for the rules proposed here is found at §§ 24-4-101 et seq., 40-1-103, 40-2-108, 40-2-112, 40-2-115, 40-3-110, 40-4-109, 40-6-108, and 40-7-117, C.R.S.

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COLORADO DEPARTMENT OF REGULATORY AGENCIES

Public Utilities Commission

4 *CODE OF COLORADO REGULATIONS* (CCR) 723-11

PART 11
RULES REGULATING GAS PIPELINE SAFETY

GENERAL PROVISIONS

11000. Scope and Applicability.

(a) Absent a specific statute, rules or Commission order that provides otherwise, all rules in this Part 11 (the 11000 series) shall apply to all public utilities and all municipal or quasi-municipal corporations transporting natural gas or providing natural gas service, all operators of master meter systems, and all operators or pipelines transporting gas in intrastate~~interstate~~ commerce, as defined in 49 C.F.R. § 191.3.

* * *

[indicates omission of unaffected rules]

11001. Definitions.

The following definitions apply throughout this Part 11, except where a specific rule or statute provides otherwise or where the context otherwise indicates. In the event of a conflict between these definitions and a statutory definition, the statutory definition shall apply.

(a) "Advanced Leak Detection Technology" is included in the definition of "New and novel technologies," which means any products, designs, materials, testing, construction, inspection, or operational procedures that are not addressed in 49 CFR parts 192, 193, or 195, due to technology or design advances and innovation for new construction. Technologies that are addressed in consensus standards that are incorporated by reference into parts 192, 193, and 195 are not "new or novel technologies."

(b~~a~~) "C.F.R." means the Code of Federal Regulations.

(c~~b~~) "Confirmed discovery" means a discovery defined, as of the effective date of these rules, in 49 C.F.R. § 191.3.

(d~~c~~) "Continuing violation" or "time-dependent violation" means any violation of these rules for which a timeframe of non-compliance can be established through physical evidence and/or records that include, but are not limited to: operator annual reports; operator compliance, operations, and maintenance records; and commission inspection, compliance and proceeding records.

(e~~d~~) "Delivered system pressure" means the system operating pressure measured at the outlie of the furthest downstream appurtenance maintained by the pipeline system operator, e.g., regulator, meter, valve, or the terminal connection of the service riser in low-pressure distribution systems.

(fe) "De minimis gas system" means a non-utility underground pipeline system used for transport and distribution of natural gas to less than ten customers within a definable private (i.e., non-municipal or public) area (e.g., a mobile home park or resort) and that does not cross a public right-of-way.

(gf) "Direct sales meter" means a meter that measures the transfer of gas to a direct sales customer purchasing gas for consumption.

(hg) "Direct sales pipeline" means a pipeline not under the jurisdiction of the Federal Energy Regulatory Commission and that runs from an intrastate or interstate transmission pipeline, a production facility, or a gathering pipeline to a direct sales meter, a pressure regulator, or an emergency valve, whichever is the furthest downstream.

(ih) "Excavation damage" means any impact that results in the need to repair or replace an underground facility due to a weakening or the partial or complete destruction of a facility, including, the protective coating; plastic pipe tracer wire; lateral support; cathodic protection; or the housing for the line device or facility

(ji) "Gas" means any material specified in these rules, including natural gas, flammable gas, toxic or corrosive gas, and petroleum gas.

(kj) "Gathering pipeline" means any pipeline determined through the use of 49 C.F.R. § 192.8.

(l) "Geographic Information Systems (GIS)" means a computer-based system for capturing, storing, checking, displaying, and analyzing data related to positions on Earth's surface.

(ml) "Hazardous facility" means a pipeline facility that, if allowed to go into operation or to remain in operation, would pose a severe or imminent risk to public safety.

(n) "Inactive/Idle" means a pipeline or pipeline segment that has ceased normal operations and will not resume service for a period of not less than 180 days; has been isolated from all sources of hazardous liquid, natural gas, or other gas; and has been purged of combustibles and hazardous materials and maintains a blanket of inert, non-flammable gas at low presser or has not been purged but the volume of gas is so small that there is no potential hazard, as defined in 49 U.S.C. § 60143.

(ol) "Incident" means an event defined as of the effective date of these rules, in 49 C.F.R. § 191.3, for a pipeline facility covered by 49 C.F.R. Part 192 or an emergency, as defined in § 193.2007 for an LNG facility.

(pm) "Liquefied natural gas" (LNG) means natural or synthetic gas that has methane (CH4) as its major constituent and that has been converted to liquid form for purposes of storage or transport.

(qn) "Liquid petroleum gas (LPG) system" means the liquid petroleum (LP) tanks and/or the pipeline system used to transport and distribute LP fuel gas to ten or more customers within a definable private (i.e. non-municipal or public) area (e.g., a mobile home park or resort), or less than ten customers if the system crosses a public right-of-way. LPG systems may have multiple operators if the supplying tank(s) is/are operated and maintained distinctly from the pipeline system by a different owner.

(ro) "Low-pressure distribution system" means a gas distribution system in which the gas pressure in the main is substantially the same as the pressure provided to the customer, i.e., the low-

pressure gas burning equipment of the customer may be safely and continually operated at the delivered system pressure.

(sp) "LPG Tank – CDLE OPS Inspected" means any LPG tank inspected by the Colorado Department of Labor and Employment, Division of Oil and Public Safety under the authority of the OPS rules.

(tq) "LNG facility" means a pipeline facility that is used for liquefying natural or synthetic gas and/or for transferring, storing, or vaporizing liquefied natural gas.

(ur) "Main" means a distribution line that serves, or is designed to serve, as a common source of supply for more than one service line.

(vs) "Major master meter operator (MMO)/LPG system" refers to any MMO or LPG pipeline system serving 100 or more customers.

(wt) "Mechanical excavation" means any operation in which earth is moved or removed by means of any tools, equipment, or explosives and includes auguring, backfilling, boring, ditching, drilling, grading, plowing-in, pulling-in, ripping, scraping, trenching, hydro-excavating, post/postholing, and tunneling.

(xu) "MMO gas system" means a non-utility pipeline system used for transport and distribution of natural gas to ten or more customers within a definable private (i.e., non-municipal or public) area (e.g., a mobile home park or resort), or less than ten customers if the system crosses a public right-of-way.

(yv) "Minor MMO/LPG system" means any MMO or LPG pipeline system serving between 20 and 99 customers.

(zw) "Municipality" means a city, town, or village in the state of Colorado.

(aax) "NRC" means the National Response Center of the United States Coast Guard.

(bby) "NTSB" means the National Transportation Safety Board, an independent federal agency.

(ccz) "Natural Gas Pipeline Act" means the federal statute found at 49 U.S.C. §§ 60101 et seq., as amended.

(ddaa) "No immediate safety impact" refers to action or inaction by operator/operator contractors on jurisdiction pipeline facilities that resulted in no immediate or imminent hazard to either the public, operator/operator contractor personnel, or pipeline system integrity.

(eebb) "Operator" means a person who is engaged in the transportation of gas, or who has the right to bury underground pipeline, or who is both engaged in the transportation of gas and has the right to bury underground pipeline, and may include an owner, such as a pipeline corporation.

(ffcc) "Operator contractor" means any person or entity empowered by an operator to perform any action covered by 49 C.F.R. Part 192 and these rules.

(ggdd) "Operator endangerment" refers to action or inaction by operator/operator contractors on pipeline facilities that resulted in an immediate or imminent hazard to operator/operator contractor personnel.

(hh~~ee~~) "OPS" means the Office of Pipeline Safety, a unit of the PHMSA.

(ii~~ff~~) "Part 192" means 49 C.F.R. Part 192 – Transportation of natural and other gas by pipeline: Minimum Federal safety standards.

(jj~~gg~~) "Person" means an individual, firm, joint venture, partnership, corporation, association, municipality, cooperative association, or joint stock association, and includes any trustee, receiver, assignee, or personal representative thereof.

(kk~~hh~~) "Petroleum gas" means propane, propylene, butane, (normal butane or isobutanes), and butylene (including isomers), or mixtures composed predominately of these gases having a vapor pressure not exceeding 208 psi (1434 kPa) gage at 100 °F (38 °C).

(ll~~ii~~) "PHMSA" means the Pipeline and Hazardous Materials Safety Administration, an agency of the United States Department of Transportation.

(mm~~jj~~) "Pipeline" or "pipeline system" means all parts of those physical intrastate facilities through which gas moves in transportation, including, but not limited to, pipes, valves, and other appurtenances attached to pipes, compressor units, metering stations, regulator stations, delivery stations, holders, and fabricated assemblies that start downstream beyond the farthest most point of oil and gas production. Flowlines that are regulated by the COGCC and used for oil and gas production are not included in this definition.

(nn~~kk~~) "Pipeline excavation damage prevention program" means an operator's written program and processes to prevent damage to a pipeline by excavation, as defined in 49 C.F.R. § 192.614.

(oo~~ll~~) "Pipeline facility" means new and existing intrastate pipelines, rights-of-way, and any equipment, facility, or building used in the transportation of gas, or in the treatment of gas during transportation.

(pp~~mm~~) "Pipeline integrity" means the ability of a pipeline system to operate as it was verifiably designed and constructed.

(qq~~nn~~) "Pipeline safety program" (PSP) means the Commission's 49 U.S.C. § 60105(a) certified pipeline safety program.

(rr~~oo~~) "Production facility" means flowline and associated equipment used at a wellsite in producing, extracting, recovering, lifting, stabilizing, initial separating, treating, initial dehydrating, disposing, and/or above ground storing, of liquid hydrocarbons, associated liquids, and associated natural hydrocarbon gases. A production facility may include flowlines up to a central delivery point directly associated with a specific producing field. To be a production facility under this rule, a flowline must be used in the process of extracting hydrocarbons and associated liquids from the ground or from facilities where hydrocarbons are produced or must be used for disposal or injection in reservoir maintenance or recovery operations.

(ss~~pp~~) "PSP Chief" means the program manager of the PHMSA certified PSP of the Colorado Public Utilities Commission.

(tt~~qq~~) "PSP Lead Engineer" means the senior technical staff member of the PHMSA certified PSP of the Colorado Public Utilities Commission.

(uu~~rr~~) "PSP s~~S~~taff" means a staff member of the PHMSA certified PSP of the Colorado Public Utilities Commission.

(vv~~ss~~) "Program certification obligations" means the pipeline safety program obligations required under 49 U.S.C. § 60105(a).

(ww~~tt~~) "Public endangerment" means an action or inaction by an operator/operator contractor on pipeline facilities that results in:

(I) interruption or delay of make safe actions designed to protect human life;

(II) unintended gas release requiring emergency (versus precautionary) evacuation of the public;

(III) an unsafe ignition of intended gas release in an area accessible to the public;

(IV) system overpressurization event/failure of system overpressure protection requiring emergency (versus precautionary) evacuation of the public; or

(V) any other hazardous situation that results in an immediate or imminent hazard to the public.

(xx) "Records" means all recorded information, regardless of form or characteristics, made or received by a federal agency under federal law or in connection with the transaction of public business and preserved or appropriate for preservation by that agency or its legitimate successor as evidence of the organization, functions, policies, decisions, procedures, operations, or other activities of the United States Government or because of the information value of data in them; and does not include library and museum material made or acquired and preserved solely for reference or exhibition purposes; or duplicate copies of records preserved only for convenience. For purposes of this rule, the term "recorded information" includes all traditional forms of records, regardless of physical form or characteristics, information created, manipulated, communicated, or stored in digital or electronic form. The Archivist's determination whether recorded information, regardless of whether it exists in physical, digital, or electronic form, is a record as defined in subsection (a) shall be binding on all federal agencies as defined in 44 U.S.C. Section 3301.

(yy~~uu~~) "Roadway" means a main public artery, highway, or interstate highway.

(zz~~vv~~) "Related violation" for purposes of informing the Commission authority pursuant to § 40-7-117, C.R.S., means a violation of these rules that has been proven to be directly linked with a PUC rule violation or violations by time, place, activity, and/or personnel.

(aaa~~ww~~) "Request for Information (RFI)" means any request from the PSP Chief or assignee to a jurisdictional operator for information associated with PSP inspection activities authorized by paragraph 11013(a).

~~(xx) "Rural gathering pipeline" means any gathering pipeline located in a Class 1 location and defined in 49 C.F.R. § 192.5 or a Type B gathering pipeline located in a Class 2 area that the operator determines does not meet the Area 2 dwelling density definition in 49 C.F.R. § 192.8.~~

(bbb~~yy~~) "Single structure, above-ground MMO/LPG system" or "SSAG System" means any MMO or LPG system that is:

(I) a low-pressure gas distribution system;

(II) is comprised wholly of above-ground piping/appurtenances; and

(III) is contained wholly within or on a single continuous structure such as an apartment building, hotel, mall, etc.

(ccczz) "Small operator" means any gas distribution system operator that operates less than 1000 natural gas distribution services in the state of Colorado.

(dddaaa) "Threshold MMO/LPG system" means any MMO or LPG pipeline system serving less than 20 customers.

(eeebbb) "Transportation of gas" means the gathering, transmission, or distribution of gas by pipeline, or the storage of gas in or affecting interstate or foreign commerce within the State of Colorado that is not subject to the jurisdiction of the Federal Energy Regulatory Commission under the Natural Gas Act.

(fffccc) "UNCC/Colorado 811" means the Utility Notification Center of Colorado.

(ggg) "U.S.C." means the United States Code.

11002. – 11007. [Reserved].

11008. Incorporation by Reference.

(a) The Commission incorporates by reference the federal standards for reporting safety-related conditions associated with the transportation of natural gas and other gas by pipeline published in 49 C.F.R. § 191.23 (reporting safety-related conditions) and § 191.25 (filing safety-related condition reports); effective May 16, 2022. ~~October 1, 2019.~~ This incorporation by reference does not include later amendments to, or editions of, 49 C.F.R. Part 191.

(b) The Commission incorporates by reference the federal safety standards for the transportation of natural gas and other gas by pipeline published in 49 C.F.R. Part 192 effective October 5, 2022. ~~1, 2019.~~ This incorporation by reference does not include later amendments to, or editions of, 49 C.F.R. Part 192.

(c) The Commission incorporates by reference the federal safety standards for liquefied natural gas facilities that are published in 49 C.F.R. Part 193 effective May 16, 2022. ~~October 1, 2019.~~ This incorporation by reference does not include later amendments to, or editions of, 49 C.F.R. Part 193.

(d) The Commission incorporates by reference the drug and alcohol testing regulations and procedures of PHMSA published in 49 C.F.R. Parts 40 and 199 effective May 16, 2022. ~~October 1, 2019.~~ This incorporation by reference does not include later amendments to, or editions of, 49 C.F.R. Parts 40 and 199.

(e) The Commission incorporates by reference the NPMS Operator Standards Manual, updated October 2017.

(fe) Any material incorporated by reference in this Part 11 may be examined at the offices of the Commission, 1560 Broadway, Suite 250, Denver, Colorado 80202, during normal business hours,

Monday through Friday, except for state holidays. Incorporated standards shall be available electronically and provided in certified copies, at cost, upon request. Restrictions on the provision of physical copies due to copyright protections may apply. The Director or the Director's designee will provide information regarding how the incorporated standards may be examined at any state public depository library. The standards and regulations are also available from the agency, organization or association originally issuing the code, standard, guideline or rule as follows: Code of Federal Regulations: www.govinfo.gov/help/cfr.

* * *

[indicates omission of unaffected rules]

11010. Interpretation.

* * *

[indicates omission of unaffected rules]

(c) If the petition requires interpretation of a federal regulation incorporated by reference into these rules and the Commission accepts the petition, PHMSA must review the Commission's interpretation of the federal regulation. The Commission's decision interpreting the federal regulation, and the reasons therefore, shall issue as an interim decision that shall be provided to the Office of Pipeline Safety for final review. Any response by the Office of Pipeline Safety shall be incorporated into the Commission's final decision.

* * *

[indicates omission of unaffected rules]

11011. Waiver – Non-emergency.

(d) PHMSA Review: If the Commission grants a petition filed by an owner/operator for a waiver of a federal rule that is incorporated into the Commission rules, PHMSA must review the Commission's decision, except for petitions for waiver covered by paragraph (c) above. The Commission's decision granting a waiver request that requires PHMSA review, and the reasons therefore, shall issue as an interim decision that shall be provided to the Office of Pipeline Safety for final review pursuant to 49 U.S.C. § 60118(d). Any response by the Office of Pipeline Safety shall be incorporated into the Commission's final decision.

* * *

[indicates omission of unaffected rules]

11012. Waiver – Emergency.

* * *

[indicates omission of unaffected rules]

(b) An emergency waiver request will be granted if it is in the public interest, is not inconsistent with pipeline safety, and is necessary to address an actual or impending emergency involving pipeline transportation, including emergencies caused by natural or manmade disasters.

* * *

[indicates omission of unaffected rules]

11013. Inspections and Investigations.

(a) Upon presenting appropriate credentials, a representative of the PSP may enter upon, inspect, and examine, at reasonable times, and in a reasonable manner, the records, facilities, and properties of pipeline operators to the extent such records, facilities, and properties are relevant to determining the compliance of such operators with the requirements of these rules or Commission orders.

(b) Qualifications and verifiable credentials for personnel engaged in pipeline construction, inspection, and repair activities are required to be provided on site.

(c~~b~~) Prior to an inspection or investigation, the PSP Chief or assignee shall notify an operator. Except in emergency situations, the operator shall have an opportunity to respond to the notification prior to the initiation of an inspection or investigation relating to any jurisdictional pipeline facility, including the operator's right of way or easement, new and existing piping, valves, and other above ground appurtenances attached to pipes, or, upon request of PHMSA, an interstate pipeline to determine compliance with 49 U.S.C. §§ 60101 et. seq., with these rules, and with applicable Commission orders.

(d) Inspections and investigations are necessitated by the existence of one or more of the following circumstances:

(I) routine scheduling by the PSP Chief, PSP Lead Engineer, or other designee;

(II) pipeline-related incidents and events reported to the PSP in accordance with rules 11101 through 11103;

(III) a complaint received from a member of the public and verified by the PSP Chief or Lead Engineer as related to a jurisdictional pipeline facility and involving a discrete and auditable matter potentially impacting public safety;

(IV) information obtained from a previous inspection; or

(V) when deemed appropriate by the Commission or PHMSA under their respective authorities.

(e) After an inspection, the PSP Chief will pursue one of the following:

(I) an inspection close-out indicating that no further action will be taken on final inspection findings;

(II) a RFI indicating that the inspection is ongoing without final inspection findings, to be answered within the timeframe requested in the RFI, typically 30 calendar days from the operator's receipt of the RFI unless otherwise indicated and agreed to by the PSP Chief and the operator; or

(III) a compliance action taken on final inspection findings as described in rules 11502 and 11503.

(f) If a representative of the PSP investigates an incident involving a pipeline facility, the PSP Chief of the Commission may request that the operator make available to the representative all records and information that directly or indirectly pertain to the incident, including integrity management plans and test results, and that the operator afford all reasonable assistance in the investigation.

(g) To the extent necessary to carry out the responsibilities of the Program Certification Obligations, the PSP may require testing of portions of pipeline facilities that have been involved in, or affected by, an incident. However, before exercising this authority and accepting responsibility, the PSP shall make every effort to negotiate a mutually acceptable plan with the owner of those facilities and, where appropriate, other local and state fire and safety authorities, PHMSA, the NTSB, and any known third parties for performing the testing.

* * *

[indicates omission of unaffected rules]

INFORMATION REQUIRED OF OPERATORS

11100. Submission of Reports and Notices - General.

(a) For all annual reporting, the PSP will access the PHMSA Pipeline Data Mart beginning on March 16 of every year to confirm operator submittals. Failure to meet ~~A~~annual ~~R~~report submittal deadlines will result in issuance in a ~~W~~warning ~~N~~notice; failure to meet submittal deadlines in two successive calendar years will result in the issuance of a NPV against the operator.

(b) For all specialized reporting, failure to meet submittal deadlines and requirements will result in issuance in a ~~W~~warning ~~N~~notice or a NPV against the operator.

(c) Geographic Information System (GIS) data shall be submitted to the PSP and shall include assets as defined in paragraph 11001(mm) as pipeline facilities and/or pipeline systems. GIS data shall be submitted in the North American Datum of 1983 (NAD 83) approved in writing by the PSP Chief. Data may be submitted in zipped geodatabase (GDB), zipped shapefile (SHP), or google keyhole markup language (KML), with preference for GDB and SHP.

(I) Data shall be submitted electronically and can be submitted through a form available on the Commission's website. Commission staff may update the form periodically. Whether annual filings are provided through the Commission-provided form or separately, operators shall ensure that all information required is included in any submitted report filings.

(II) Data specifications. In addition to the data requirements listed in the National Pipeline Mapping System (NPMS) Operator Standards Manual, the state of Colorado also has the following data requirements:

(A) the maximum allowable operating pressure;

(B) testing pressure;

(C) the pipe description (i.e., nominal diameter, coating, standard dimension ratio, and material);

(D) description of corrosion protection (i.e., Galvanic, Rectified/Impressed Current, or NA);

(E) identify as HCA/MCA on each segment for class location, as applicable; and

(F) abandoned as defined in 49 CFR 192.3 and inactive pipelines. Include abandonment and inactive dates as applicable, as defined in 49 CFR 192.727.

(III) Disclosure of GIS data.

(A) The PSP Chief will make GIS data for transmission and distribution pipeline systems available through a publicly accessible online map viewer. Line attributes available to the public through the online map viewer will include the spatial location, operator, fluid type, pipe material type, and pipe size. Online map viewer data only will be available at scales greater than or equal to 1:6,000. Any person may view spatial data at scales less than 1:6,000 for an individual parcel at the Commission's office.

(B) Upon request from a local governmental designee(s), and subject to executing a confidentiality agreement and the provisions of the Colorado Open Records Act, the Commission will provide to the local government all GIS data for all transmission, distribution or gathering systems. The local government may only reproduce or public data that the Commission makes publicly available through its website. A local government may share more specific data in person than that which the Commission makes publicly available, but the information must be treated as confidential and may not be reproduced or published.

(C) Except as provided in subparagraphs (III)(A) and (B) above, the Commission will keep all such GIS data confidential to the extent allowed by the Colorado Open Records Act.

(D) This data will not be used in lieu of Colorado 811 locates and is subject to civil penalties set forth in and fines assessed pursuant to §§ 9-1.5-104.4 or 9-1.5-104.5, C.R.S.

(d) All advanced leak detection technologies being used and their descriptions. If advanced leak detection technology is not being used, an explanation describing why should be provided.

(ee) For all electronic reporting to PHMSA, if this reporting method imposes an undue burden and hardship, an operator may submit a written request for an alternative reporting method to: Information Resources Manager, Office of Pipeline Safety, Pipeline and Hazardous Materials Safety Administration, PHP-20, 1200 New Jersey Avenue, SE, Washington, DC 20590. The request must describe the undue burden and hardship. PHMSA will review the request and may authorize, in writing, an alternative reporting method. An authorization will state the period for which it is valid, which may be indefinite. An operator must contact PHMSA at 202-366-8075; electronically to informationresourcesmanager@dot.gov; or make arrangements for submitting a report that is due after a request for alternative reporting is submitted but before an authorization or denial is received.

11101. Submission of Reports and Notices.

* * *

[indicates omission of unaffected rules]

(d) Pipeline damage and ~~of~~ locate information reporting. Each operator subject to the requirements of these rules and Colorado Revised Statutes Title 9, Article 1.5 (the "Colorado One-call Law") shall submit the PSP Damage and Locate Report (PSP DLR) to the Commission through its E-Filings System in accordance with ~~sub~~paragraph 1204(a~~)(III~~) of the Commission's Rules of Practice and Procedure in the repository proceeding opened for such reporting purposes.

* * *

[indicates omission of unaffected rules]

11103. Submission of Annual Reports.

(a) On or before March 15 of each year:

(I~~a~~) ~~On or before March 15 of each year, e~~Each operator shall file with the Commission an annual report for the preceding calendar year. The reports shall be filed in accordance with ~~sub~~paragraph 1204(a)~~(III)~~ of the Commission's Rules of Practice and Procedure.

(II~~b~~) Each operator of a distribution pipeline system, excepting MMO/LPG systems, shall submit the Annual Report (PHMSA F 7100.1-1) to PHMSA using its electronic portal at https://portal.phmsa.dot.gov.

(III~~c~~) Each operator of an MMO/LPG system shall submit the MMO/LPG~~Small Operator~~ Annual Report ~~(PSP SOAR)~~ to the Commission through its E-Filings System in the repository proceeding opened for annual reports.

(~~d~~IV) Each operator of a transmission or Type A or Type B or Type C gathering system (i.e., excepting Type R as defined in 49 CFR 191.3~~rural gathering~~), shall submit the Annual Report (PHMSA F 7100.2-1) to PHMSA using its electronic portal at https://portal.phmsa.dot.gov.

(V~~e~~) Each operator of a LNG facility shall submit the Annual Report (PHMSA F 7100.3-1) to PHMSA using its electronic portal at https://portal.phmsa.dot.gov.

(VI) Each operator shall submit GIS data according to paragraph 11100(c).

(VII) Each operator shall submit a list of advanced leak detection technology and their descriptions according to paragraph 11100(d).

* * *

[indicates omission of unaffected rules]

11201. Pipeline Excavation Damage Prevention.

(a) All~~An operator, including~~ operators ~~of MMO/LPG and rural gathering pipeline systems,~~ must be ~~a~~ members~~Tier 1 Member~~ at the UNCC/Colorado 811 if any part of the pipeline system is located in any public or railroad right-of-way.

(b) An operator, excluding operators of MMO/LPG pipeline systems but including operators of rural gathering pipeline systems, must report underground facility damages to the UNCC/Colorado 811 in accordance with § 9-1.5-103(7), C.R.S.

(c) Operators of MMO/LPG and rural gathering pipeline systems must install and maintain pipeline markers, labeled according to § 192.707(d), at each crossing of a public road or railroad right-of-way.

(d) An operator, excluding operators of MMO/LPG and ~~rural~~ gathering pipeline systems, must have written guidelines regarding when and how civil penalties are pursued under § 9-1.5-104.5, C.R.S. against persons damaging their pipeline facilities, and when and how penalty alternatives are implemented. At a minimum, the collection of data on and subsequent analysis of the causes of excavation damages to comply with 49 C.F.R. § 192.614 (a). These guidelines must provide for:

(I) recording information about pipeline damages that includes identification of the responsible party and the probable cause of each excavation damage in the following categories:

(A) inadequate excavation practices;

(B) no locate requested;

(C) inaccurate/missing locate – Operator located; and

(D) inaccurate/missing located – Contractor located.

(II) Analysis of the information in (a) above that allows for the identification of acute risk parties that have caused multiple pipeline damages in the preceding 18 months; and

(III) analysis of the information in (a) above that allows for the identification of chronic risk parties that have caused multiple pipeline damages over (a) time period(s) greater than 18 months.

(e) Each operator must provide documentation of the deactivation and abandonment of pipelines to the PSP consistent with rule 11100.

(fe) The PSP will pursue compliance action against an operator under § 192.614(c)(5) whose excavation damages due to inaccurate or missing locates:

(I) were found through investigation to be contributory to a pipeline incident;

(II) were found through investigation to be contributory to a pipeline event that, in the opinion of the PSP, represented a major threat to public safety; or

(III) were found to represent an excessive risk to the operator's pipeline by the analyses required by subparagraphs 11201(d)(II) and (III).

* * *

[indicates omission of unaffected rules]

11203. Small Operator Systems.

(a) General requirements.

(I) Unless otherwise specified in this rule, a small operator system is subject to these rules and all applicable 49 C.F.R. Part 192 rules, as incorporated.

(II) Unless otherwise specified in this rule, any operator of a small operator system may opt into the prescriptive distribution integrity management provisions of paragraph (h) of this rule via written request to the PSP Chief or PSP Lead Engineer.

(b) Standards applied to de minimis gas systems.

(I) Unless otherwise specified in this rule, de minimis gas systems are exempt from these rules and 49 C.F.R. Part 192 rules, as incorporated.

(II) System expansion.

(A) Operators of de minimis gas systems must apply for Commission approval prior to any system expansion.

(B) Operators of de minimis gas systems are prohibited from expanding the system unless proper permits are issued by the appropriate plumbing inspection authority.

(III) Leak surveys.

(A) De minimis gas systems must be leak surveyed with equipment using instruments and techniques suitable for detecting fugitive natural gas, or LPG in gaseous/vapor form, as applicable, once every two years.

(B) Records and results of all leak surveys will be kept for the life of the system.

(IV) System repairs.

(A) An operator of a de minimis gas system must repair all hazardous pipeline leaks immediately upon discovery.

(B) An operator of a de minimis gas system must repair all other pipeline system leaks within 45 days of discovery.

(C) All system repairs must be completed by a plumber, gas utility technician, or utility contractor qualified to install and repair underground gas systems.

(D) Prior to any leak repair, the operator of a de minimis gas system must acquire a plumbing permit issued by the appropriate plumbing inspection authority. If a leak has been repaired immediately due to a public safety hazard, the repair must be permitted after the fact and will be left exposed for inspection by the appropriate plumbing inspection authority or a PSP Inspector.

(c) Standards applied to SSAG systems.

(I) Any SSAG system is compliant with these rules if the system has been inspected and passed a system safety inspection within the last five years by one of the following means:

(A) inspection by the PSP;

(B) inspection by the Fire Department or Fire Marshall using NFPA 54 (National Fuel Gas Code), NFPA 101 (Life Safety Code), or a written equivalent standard; or

(C) inspection by the plumbing entity using the International Fuel Gas Code or a written equivalent standard.

(II) Record of the final, approved inspection of the gas system installation shall be kept for the life of the system.

(III) Records of all subsequent inspections shall be maintained and available for PSP inspection for a minimum of ten years from the date of inspection.

(d) Standards applied to LPG systems.

(I) The PSP will deem any LPG tank – CDLE OPS Inspected to be compliant with these rules, subject to the following restrictions:

(A) the tank has passed the CDLE OPS inspection; and

(B) the tank has been inspected within the last five calendar years.

(II) Leak surveys and leak pinpointing must use instruments and techniques suitable for detecting fugitive LPG in gaseous/vapor form.

(e) Standards applied to Major MMO/LPG systems.

(I) Major MMO/LPG systems must acquire a PHMSA Operator Identification Number.

(II) Major MMO/LPG systems are subject to the P-DIMP of paragraph 11203(h).

(f) Standards applied to Minor MMO/LPG systems.

(I) ~~Except as provided in subparagraph 11203(h)(VII),~~ Minor MMO/LPG systems are subject to the P-DIMP of paragraph 11203(h).

(g) Standards applied to threshold MMO/LPG systems.

(I) ~~Except as provided in subparagraph 11203(h)(VII),~~ Threshold MMO/LPG systems are subject to the P-DIMP of paragraph 11203(h).

(h) Prescriptive distribution integrity management program (P-DIMP).

(I) Operators subject to this rule shall be subject to a P-DIMP consisting of an evaluation and a plan.

(II) Operators subject to this rule shall have a P-DIMP evaluation performed by the PSP at least once every five years; sooner when system history or PSP inspection indicates a change in any operating condition that necessitates a new P-DIMP evaluation.

(III) The P-DIMP shall explicitly consider, prioritize, and rank system risks based on the following:

(A) number of affected persons;

(B) physical system parameters including but not limited to:

(i) materials;

(ii) delivered system pressure, including whether the system is a low-pressure distribution system; and

(iii) leak and leak repair history.

(C) Operational system parameters including, but not limited to:

(i) compliance history of the current legal operator;

(ii) system records;

(iii) availability of appropriate tools and equipment to operate gas pipeline system;

(iv) availability of trained and/or qualified personnel to operate and maintain the system during normal operations; and

(v) availability of trained and/or qualified personnel to operate the system during emergencies.

(IV) All physical and operational parameters that are unknown at the time of the P-DIMP evaluation shall be considered by the PSP to pose the maximum public safety risk that is reasonably associated with the unknown parameter.

(V) Following a completed P-DIMP evaluation, all operators of a Threshold MMO/LPG system or Minor MMO/LPG system shall be subject to P-DIMP unless the operator opts out of a P-DIMP as allowed in subparagraph 11203(h)(VII).

(VI) The P-DIMP shall prescribe operations and maintenance activities appropriate to maximize system integrity and minimize the public safety risk posed by the operation of the system.

* * *

[indicates omission of unaffected rules]

RULE VIOLATIONS, CIVIL PENALTIES, AND COMPLIANCE ACTIONS

11500. Violations - General.

* * *

[indicates omission of unaffected rules]

(b) Violations will be examined by the PSP Chief to determine the impact category resulting from the violation: no immediate safety impact, incident, public endangerment, operator endangerment, or a loss/reduction of pipeline integrity.

11501. Violations – Civil Penalties.

(a) This rule shall apply to violation(s) that would have otherwise been discovered by a prudent operator in the normal course of business. This is the lowest degree of culpability for which operators may be penalized and does not limit the Commission from penalizing operators for higher degrees of culpability.

(b) An operator who violates these rules or an order of the Commission issued under these rules may be subject to civil penalties as follows:

(I) civil penalties shall not exceed $200~~100~~,000 per instance of violation;

(II) each day of a continuing violation constitutes a separate instance of violation; and

(III) in the case of a group or series of related violations, the aggregate amount of such penalties shall not exceed $2,000,000.

(c) Civil penalties – general. The PSP Chief may propose that the Commission assess civil penalties against an operator following a PSP inspection and/or investigation that has established specific pipeline safety rule violation(s) and a time-dependent or time-independent nature of the violations(s).

(d) Civil penalties – calculation. To provide consistency and specificity, civil penalties shall be calculated through the formulaic method as follows.

(I) Time-dependent/history based activity violations.

(A) Violations determined by an action or activity not performed or failure to be performed in accordance with rule or procedure:

(i) the penalty is assessed by individual action or activity required by rule or procedure;

(ii) the penalty amount is calculated by the equation:

$$B \times t \times F_{ph} \times F_{hh} \times F_i ,$$

where:

B = Base penalty of $1 per day for the activity associated with the violation

t = Timeframe of non-compliance, in days

F_{ph} = Pertinent/related system history factor, as determined in the Time-Dependent Violation Impact Factor Table

F_{hh} = Hazardous history factor, as determined in the Time-Dependent Violation Impact Factor Table

F_i = Incident history factor, as determined in the Time-Dependent Violation Impact Factor Table

(B) Time-dependent violation impact factor table:

Time-Dependent Violation Impact Factor Table

FACTOR	THRESHOLD	Factor multiplier if threshold *NOT* met	Factor multiplier if threshold met
F_{ph}	The violation was associated with other inspection findings that indicated related effects on pipeline system integrity (e.g., leaks, corrosion, PHMSA Advisory Bulletin, missing records, etc.)	1	5
F_{hh}	The violation was associated with other inspection findings that indicated related effects on public safety (e.g., hazardous leaks, safety-critical activity, safety-related condition, etc.)	1	10
F_i	The violation was associated with other inspection findings that indicated the violation contributed to an Incident	1	20

(II) Time-independent/outcome-based violations.

(A) Violations determined by a failure to follow or inadequate/missing operator procedures:

(i) the penalty is assessed by individual or group actions or activities required by rule or procedure;

(ii) the penalty amount is calculated by the equation:

$B \times F_{impact}$, where

B = $5,000 base penalty per instance of violation

F_{impact} = Time-independent Impact Factor as determined in the Time-Independent Violation Impact Factor Table

(B) Violations determined by an unqualified worker performing operations, maintenance, or construction tasks:

(i) the penalty is assessed per worker and specific individual qualification required by rule or procedure; and

(ii) the penalty amount is calculated by the equation:

$B \times F_{impact}$, where

B = $5,000 base penalty per instance of violation

F_{impact} = Time-independent Impact Factor as determined in the Time-Independent Violation Impact Factor Table

(C) Rule 11201 violations:

(i) the penalty is assessed per applicable paragraph of rule 11201;

(ii) the penalty amount is calculated by the equation:

$B \times F_{impact}$, where:

B = $5,000 base penalty per instance of violation

F_{impact} = Time-independent Impact Factor as determined in the Time-Independent Violation Impact Factor Table

(D) Missing or incomplete records:

(i) the penalty is assessed by grouped action or activity required by rule or procedure;

(ii) the penalty is assessed by applicable inspection focus, i.e., district operating area, operating unit, or total operator system;

(iii) the penalty is calculated based on the estimated volume of missing or incomplete records:

(a) Gross Incompletion (Record incompletion/absence ≥ 10 percent for complete record absence for a required code segment) = $10,000/code/segment/calendar year;

(b) Major Incompletion (Record incompletion/absence ≥ 5 percent and < 10 percent for a required code segment) = $5,000/code/segment/calendar year; and

(c) Significant Incompletion (Record incompletion/absence ≥ 2 percent and < 5 percent for a required code segment) = $2,500/code/segment/calendar year.

(E) Time-independent violation impact factor table:

Time-Independent Violation Impact Factor Table	
THRESHOLD	Factor multiplier if threshold met
The violation resulted in no immediate safety impact	1
The violation resulted in operator endangerment; operator property loss > $10,000; or emergency (versus precautionary) actions by the operator necessary to protect system integrity	5
The violation resulted in public endangerment; non-operator property loss > $10,000; or a loss of pipeline integrity	10
The violation resulted in an Incident	20

(e) Multiple calculated penalties will be summed to compute a final civil penalty.

(f) The PSP Chief may propose to the Commission the assessment of a revised final civil penalty lower than the summed calculated penalties based on the operator's documented and verifiable efforts to mitigate the violations(s) and improve overall system safety and integrity.

(g) The calculated and final civil penalty amounts shall be illustrated in the NPV to the operator.

(h) Nothing in this rule shall prohibit the Commission from the calculation and/or assessment of a new final civil penalty during a formal hearing process.

(i) The Commission may assess doubled or tripled civil penalties against any public utility, as provided by § 40-7-113.5(3), C.R.S., § 40-7-113.5(4), C.R.S., and this rule.

(I) The Commission may assess any public utility a civil penalty containing doubled penalties only if:

(A) the public utility has admitted liability by paying the proposed final civil penalty for, or has been adjudicated by the Commission in an administratively final written decision to be liable for, engaging in prior conduct that constituted an intentional violation of a statute in Articles 1 to 7 and 15 of Title 40, C.R.S., a Commission rule, or a Commission order;

(B) the conduct for which doubled civil penalties are sought violates the same statute, rule, or order as conduct for which the public utility has either admitted liability by paying the civil penalty assessment, or been adjudicated by the Commission in an administratively final written decision to be liable; and

(C) the conduct for which doubled civil penalties are sought occurred within one year after conduct for which the public utility has either admitted liability by paying the

civil penalty assessment, or been adjudicated by the Commission in an administratively final written decision to be liable.

(II) The Commission may assess any public utility a civil penalty containing tripled penalties only if:

(A) the public utility has admitted liability by paying the proposed final civil penalty for, or has been adjudicated by the Commission in an administratively final written decision to be liable for, engaging in prior conduct that constituted two or more intentional violations of a statute in Articles 1 to 7 and 15 of Title 40, C.R.S., a Commission rule, or a Commission order;

(B) the conduct for which tripled civil penalties are sought violates the same statute, rule, or order as conduct for which the public utility has either admitted liability by paying the civil penalty assessment, or conduct for which the public utility has been adjudicated by the Commission in an administratively final written decision to be liable, in at least two prior instances; and

(C) the conduct for which tripled civil penalties are sought occurred within one year after the two most recent instances of conduct for which the public utility has either admitted liability by paying the civil penalty assessment, or been adjudicated by the Commission in an administratively final written decision to be liable.

* * *

[indicates omission of unaffected rules]

11503. Compliance Action – Warning Notice.

In the instance of a probable violation of these rules that has no previous enforcement history and poses a low risk to public safety and/or pipeline/LNG facility integrity, as determined by current regulation, industry standard, or other relevant objective technical standard, or if the operator provides advance notice, the PSP Chief will issue a Warning Notice to an operator. The Warning Notice will advise the operator of the probable violation, require the operator to correct the probable violation or be subject to further enforcement action under these rules, and may require a formal written response from the operator on their corrective action plan so that a follow-up inspection can be scheduled.

11504. Notice of Probable Violation (NPV).

(a) In the instance of a probable violation of these rules that has a previous enforcement history or poses a moderate to severe risk to public safety or pipeline or LNG facility integrity, as determined by current regulation, industry standard, or other relevant objective technical standard, the PSP Chief may issue a NPV to an operator. The NPV will advise the operator of the probable violation and include the following sections:

(I) a statement of inspection findings that incorporates the requirements of rule 11502, above;

(II) a statement of the regulatory interpretation upon which the determination of probable violation is based;

(III) a civil penalty calculation using rule 11501 stating separately for each probable violation the maximum penalty amount provided and a total penalty;

(IV) the PSP Chief's civil penalty assessment evaluation consistent with § 40-7-117, C.R.S. that includes a conclusion for or against assessment of the civil penalty in whole or in part;

(V) a final recommended civil penalty assessment;

(VI) as appropriate, the NPV will offer the operator a proposed alternative enforcement in lieu of the civil penalties, in whole or in part. The proposed alternative enforcement will describe the process in sufficient detail to explain how it will provide for the improvement of public safety;

(VII) as appropriate, the NPV will include a compliance directive that prescribes specific actions to be taken by the operator within a specific timeframe to correct the violation; and

(VIII) a description of the operator's response options.

(b) The NPV shall be filed in a new proceeding and shall serve as notice of the alleged probable violation and potential actions to be taken by the Commission.

(c) Within 30 days after receipt of a NPV issued pursuant to the rule, an operator shall file in the proceeding its response with one of the following options.

(I) The operator may admit the NPV through the following filings and actions:

(A) the operator shall pay any proposed final civil penalty in full; and

(B) the operator shall agree to any proposed compliance directive.

(II) The operator may request the Commission consider an offer in compromise to the NPV through the following filings and actions:

(A) the operator may request reconsideration, reissuance, or dismissal of the initial NPV through submittal of a written explanation, information, or other material in response to the allegations contained in the NPV; in objection to the proposed compliance directive; or in mitigation of the proposed final civil penalty; or

(B) the operator and the PSP Chief may jointly file a stipulation and settlement agreement pursuant to rule 1150811507, resolving the allegations in the NPV for the Commission's consideration.

(C) Any civil penalty authorized by this rule may be reduced by the Commission based on consideration of factors and metrics, as follows:

(i) an evaluation of the severity of the violation, in terms of it actual or potential effects on the public safety or pipeline system integrity;

(ii) the extent to which the violation and any underlying conditions that may have contributed to the likelihood or severity of the violation have been remedied; and

(iii) the extent to which the violator agrees to spend, in lieu of the payment of part of the civil penalty, a specified amount on commission-approved measures to reduce the overall risk to the pipeline system safety or integrity; except that the amount of the penalty payable to the Commission shall be no less than $5,000.

(III) The operator may oppose the NPV, or any part thereof. The operator shall file its response opposing the allegations in the NPV in the proceeding and provide all relevant information it finds addresses the issues raised. If an operator opposes any alleged violation in the NPV, the matter shall be set for hearing. When applicable and appropriate, such appeal will stay the duration of the noncompliance for purposes of any penalty calculation contingent upon interim operator actions to cure the alleged violation(s).

(d) If the operator fails to respond as provided in this rule within 30 days of the NPV, the NPV shall be deemed opposed by the operator and shall be set for hearing as prescribed by subparagraph (c) (III) above.

(e) If a violator does not remit the assessed penalty or the lesser amount agreed upon pursuant to this rule, the Commission may recover the amount due plus court costs in a civil action in any court of competent jurisdiction.

(f) The remedy provided in this rule is an addition to any other remedies available to the Commission under the constitution or laws of the state or of the United States.

* * *

[indicates omission of unaffected rules]

11507. Compliance Action – Hazardous Facilities Order (HFO).

(a) If an inspection, audit, investigation, or test reveals that the continued operation of a pipeline or LNG facility may pose a severe and imminent risk to public safety, as determined by current regulation, industry standard, or other relevant objective technical standard, the PSP Chief may consider the pipeline or LNG facility to be a hazardous facility and file a formal complaint with the Commission against the operator of the facility. The complaint shall allege facts sufficient to establish the existence of a hazardous facility and to support an HFO issued upon conclusion of a Commission proceeding, or, if justified, a summary HFO pursuant to paragraph (i) of this rule.

(b) A formal complaint by PSP sStaff shall be issued, and a hearing shall be conducted in accordance with the Commission's Rules of Practice and Procedure and Article 6 of Title 40, C.R.S.

(c) Except as provided in paragraph (i) of this rule, if the Commission finds, after hearing, that a pipeline facility or a LNG facility is hazardous to life or property, the Commission shall issue an order directing the operator to take corrective action. Corrective action may include, without limitation, suspension or restriction of the use of the pipeline facility or LNG facility, physical inspection, testing, repair, or replacement.

Decision No. C22-0701

BEFORE THE PUBLIC UTILITIES COMMISSION OF THE STATE OF COLORADO

PROCEEDING NO. 22R-0491GPS

IN THE MATTER OF THE PROPOSED RULES REGULATING PIPELINE OPERATORS AND GAS PIPELINE SAFETY, 4 CODE OF COLORADO REGULATIONS 723-11.

COMMISSION NOTICE OF PROPOSED RULEMAKING

Mailed Date: November 9, 2022
Adopted Date: November 2, 2022

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I. BY THE COMMISSION

A. Statement

1. The Colorado Public Utilities Commission issues this Notice of Proposed Rulemaking (NOPR) to amend the Rules Regulating Pipeline Operators and Gas Pipeline Safety (Pipeline Safety Rules) to: (1) address the legislative declaration and rule changes outlined in Senate Bill 21-108 (SB21-108), which strengthen and streamline Colorado's laws governing gas pipeline safety to meet emerging challenges in Colorado; (2) to update rules to incorporate the May 16, 2022 and October 5, 2022 effective changes in 49 C.F.R Parts 190-199; and (3) to incorporate the changes in § 9-1.5-105, C.R.S., the update of Utility Notification Center Of Colorado (UNCC/Colorado 811) membership requirements. In addition, the proposed rules revise typographic and inadvertent errors.

2. This NOPR proposes changes to the Pipeline Safety Rules enacted in 2019,[1] as described in this Decision and its attachments. Proposed rules intend on allowing innovations in technology, improving the rules in recognition of an aging infrastructure system, a growing population that increasingly encounters gas infrastructure, and climate change policy. We also recognize within these rules that we share the responsibility for pipeline safety oversight with other federal and state agencies, commissions, and regulatory bodies.

[1] *See* Proceeding No. 19R-0703GPS.

3. We welcome the submission of alternative proposed rules, including both individual proposals and consensus proposals joined by multiple stakeholders. Participants are encouraged to provide redlines of specific proposed rule changes for comment and consideration.

4. The Commission refers this matter to an Administrative Law Judge (ALJ), who will hold a hearing on the proposed rules at the below-stated time and place. In addition to submitting written comments, participants will be able to present comments orally at hearing unless the ALJ deems oral presentations unnecessary. The Commission will consider all comments, whether oral or written.

B. Background

5. The statutory authority for the rules proposed here is found at §§ 24-4-101 *et seq.,* 40-1-103, 40-2-108, 40-2-112, 40-2-115, 40-3-110, 40-4-109, 40-6-108, and 40-7-117, C.R.S.

6. This Commission conducts its Pipeline Safety Program (PSP) activities primarily under §§ 40-1-103, 40-2-115, and 40-7-117, C.R.S. In particular, § 40-2-115, C.R.S., provides authority permitting the Commission to enter into cooperative agreements with federal agencies, directs the Commission to coordinate with state and federal agencies, and authorizes the Commission to adopt and create rules to administer and enforce the Natural Gas Pipeline Act found at 49 U.S.C. §§ 60101, *et seq.*

7. SB21-108 makes changes to §§ 40-2-115 and 40-7-117, C.R.S. The statutes allow the Commission to submit certification to or enter into an agreement with the United States Secretary of Transportation under 49 U.S.C. Sec. 60105 or 60106 that allows the Commission to enforce rules of the United States Department of Transportation Pipeline Hazardous Materials Safety Administration (PHMSA) and to adopt such rules as are necessary and proper to comply with federal requirements. The rules adopted under SB21-108 apply to all persons and entities

constituting the intrastate pipeline system to the maximum extend permissible under Federal Law and the Colorado Constitution. § 40-2-115(1)(c), C.R.S. Updates provided under SB21-108 further defines the specific types of hazardous materials and pipeline systems to be regulated by the Commission, and require that the Commission rules address mapping, reduction of risks posed by abandoned gas pipelines, mapping of all pipelines within the Commission's jurisdiction, and increased frequency of inspections, use of advanced lead detection technology, and expansion of annual reporting requirements, among other requirements. *See* § 40-2-115(1)(d)(II)(A) through (G), C.R.S.

8. Changes made to statute through SB21-108 also increase the maximum of penalties issued from one million dollars to two million dollars. § 40-7-117, C.R.S.

9. Current Pipeline Safety Rules were last updated in 2019, moving the Pipeline Safety Rules from their previous location within the Gas Utilities and Pipeline Operator Rules at 4 CCR, 723-4, to a new, standalone Part 11, 4 CCR, 723-11.[2] The technical updates and rule revisions were made for clarity and consistency, which provided for a more public, clear, and transparent processes concerning the Commission's Pipeline Safety Program.

10. As part of the Commission's review process to implement the requirements of SB21-108, in 2022 Staff of the Colorado Public Utilities Commission (Staff), including the Commission's Pipeline Safety Program Chief, conducted outreach to stakeholders regarding the Commission's Pipeline Safety Program processes and rules. Considerations were aimed at improvements to reinforce pipeline safety throughout Colorado, and specifically, statutory revisions required by SB21-108. We continue to invite stakeholders to raise both rule and statutory considerations within their comments.

[2] *See* Proceeding No. 19R-0703GPS.

11. Overall, we propose rule revisions that significantly alter and aim to improve upon pipeline safety oversight at the Commission. The proposed rules also continue our commitment to added transparency, while maintaining regulatory efficiencies and continued improvement of the pipeline safety practices of the Commission's Pipeline Safety Program. The proposed rule changes also maintain compliance with recent changes to 49 C.F.R. 190-199.

12. We find that referral to an Administrative Law Judge (ALJ) for issuance of a recommended decision is appropriate and that an ALJ is well suited to address complex technical, procedural and policy goals of this Commission related to pipeline safety such that the ALJ can provide recommended rules to this Commission. As discussed below, we describe our objectives in issuing the attached proposed rules for ALJ and stakeholder consideration.

C. Proposed Pipeline Safety Rules

1. Typographical Errors

13. Typographical errors are found throughout the Part 11 Rule, which includes misspellings, grammatical errors, and reference updates.[3] The rules this affects include: 11000(a), 11010(c), 11011(d), 11012(b), 11101(d), 11500(b), and 11507(a) and (c).

14. We do not seek comment on the typographical changes included in these sections because the content, intent, and function will not change.

2. Section 11001 Definitions

15. We propose the addition of four new definitions to Part 11, updates to two definitions, and the removal of one definition. Each definition is added to support a specific

[3] Through previously adopted rules, Rule 11000 inadvertently stated scope and applicability to "interstate" commerce, which has been updated to "intrastate" in correlation with state law and authority.

section as required in SB21-108 and the changes defined in Amendment 192-129, effective May 16, 2022.

16. "Advanced Leak Detection Technology" is included in the definition of "New and novel technologies,"[4] which means any products, designs, materials, testing, construction, inspection, or operational procedures that are not addressed in 49 CFR parts 192, 193, or 195, due to technology or design advances and innovation for new construction. Technologies that are addressed in consensus standards that are incorporated by reference into Parts 192, 193, and 195 are not "new or novel technologies."

17. "Geographic Information Systems (GIS)" and "Inactive/Idle" are added in support of changes to § 40-2-115 (1)(d)(II)(C), C.R.S. These proposed rules are needed to support the proposed GIS mapping changes required by SB21-108.

18. "Rural gathering pipeline" definition was removed in lieu of the Type R definition in 49 CFR 191.3, which is incorporated by reference.

19. "Records" is added as defined in 44 U.S.C. §3301 in support of the requirement for § 40-2-115(1)(d)(II)(A), C.R.S. This requirement requires increased availability of records for Pipeline Safety Program inspectors in the field for all field activities.

20. We add the definition for "Inactive/Idle" as found in 49 U.S.C. §60143 for ease of reference.

21. We add a definition for "U.S.C." for clarification.

[4] The definition intends to include, as a baseline, "new and novel technologies" but also allow for additional technologies to be included in the state-defined "advanced leak detection technologies." Commenters are invited to consider revisions that make clear the advanced technologies included in the definition, but at the same time, allow for ongoing improvements that can be identified through reporting that explains the specific technologies used.

22. Finally, we make updates to the definitions of "Petroleum gas" and "Transportation of gas."

3. Section 11008 Incorporation by Reference

23. The rules are also updated to reflect recent changes in federal law and for general clarity. The most recent change in 49 CFR 191 and 192 occurred on May 16, 2022, which clarified the regulation of gathering lines. 49 CFR 192 will be changed and effective on October 5, 2022, which updated the regulation of valves for gas pipelines. Proposed rules include incorporations by reference of the most recent effective federal updates, and commenters are encouraged through the process of this rulemaking to include whether any updates regarding the regulation of valves for gas pipelines should be included in these rules.

24. We have also added an incorporation by reference of the NPMS Operator Standards Manual, updated October 2017 to outline standards that will apply to the mapping efforts required by SB21-108.

4. Section 11013 Inspections and Investigations

25. Proposed Rule 11013(b) is updated to include the requirement in SB21-108 giving the Pipeline Safety Program the authority to require personnel engaged in pipeline construction, inspection, and repair activities to provide verifiable credentials, on site, when requested by a Pipeline Safety Program Inspector.

5. Section 11100 Submission of Report and Notices – General

26. Proposed Rule 11100(c) provides for the development of GIS data within the context of the Pipeline Safety Program. Data type is listed, along with submission requirements. The use of this data will be used to develop a risk-based inspection program, so that Pipeline Safety Program can perform more targeted and efficient inspections throughout Colorado.

27. Through the proposed rules, we propose annual reporting can be provided through completion of a form that is provided on the Commission's website. While use of the form would not be required, it will allow each operator to submit data consistently and in a standard format. Whether annual filings are provided through the Commission-provided form or separately in an appropriate filing, operators shall ensure that all information required is included in any submitted report filings.

28. The data proposed to be collected includes: maximum allowable operating pressure, testing pressure, pipe description, description of corrosion protection, pipeline class identification (High/Moderate Consequence Areas) as applicable, and abandoned, inactive, or idle pipeline status. Pipeline status, specifically abandoned, inactive, or idle, are being tracked to ensure compliant abandonment procedures and to track if a gas pipeline is abandoned in place or removed. This data will be used in the Pipeline Safety Program's risk model assessment for inspections.

29. The proposed rule includes language consistent with the GIS rules within the current Colorado Oil and Gas Conservation Commission (COGCC) rule 2 CCR 404-1, Rule 1101.e. For efficiencies between agencies, PSP hopes to merge its data with that of the COGCC. Specifically, § 40-2-115(1)(d)(II)(C), C.R.S., includes that the commission "may incorporate information from any existing flowline maps or other maps prepared by [COGCC] and showing pipelines subject to the jurisdiction of that agency." The security rules included in this section have been adjusted to apply to the jurisdictional pipelines the Pipeline Safety Program regulates and to the data this Commission collects. We ask stakeholders to comment that the similar language, based on COGCC's rules, is an efficient and effective way to create efficiencies and consistencies between agencies and protect sensitive information.

30. We propose an explicit statement indicating that the GIS data is not to be used in lieu of Colorado 811 locates.

31. Proposed Rule 11100(d) requires that a list and description of all advanced leak detection technologies being used by gas pipeline operators be provided to the Pipeline Safety Program. Under § 40-2-115(1)(d)(II)(E), C.R.S., the Commission's rules must address the use of advanced leak detection technology to meet the need for pipeline safety and protection of the environment. By requiring a list and description of all advanced leak detection technology, the Commission can better assess whether and how such detection technology is being applied and enable PSP staff to take appropriate action if improvements can be made.

32. Commenters are encouraged to include any additional rule revisions or suggestions regarding the use of advanced leak technology that can meet Colorado's needs for pipeline safety and protection of the environment, including if Commission fining or other authority could best enable these needs are met through Commission processes and rule updates. For example, commenters should consider if operators should identify in annual reporting minimum advanced leak technologies used and, if advanced leak technologies are not identified and used, if the operator should be subject to violation of Commission rules and penalties as noted in Rules 11501 and 11503.

33. The proposed rule's inclusion of annual filing forms as either required or optional formats are intended to better ensure consistency and assist operators in completeness of reporting. Commenters are requested to provide input on how best the Commission, or its Staff can update the Commission-provided form periodically for clarity to assist in better ensuring completed annual filings.

34. Through Rule 11100 the Commission provides useful information on processes currently before PHMSA. Commenters are encouraged to address whether this information is best provided through rule or in the Commission-provided form or website. Particularly as this rule implicates processes before PHMSA, directing operators and the public to the process through informational documents on the Commission's website or otherwise may avoid inconsistencies should PHMSA revise its processes.

6. Section 11103 Submission of Annual Reports

35. We propose a wording change to the list of annual reporting requirements for each type of operator for brevity and clarity.

36. We propose renaming the Small Operator Annual report to clarify applicability to master meter and liquid petroleum gas operators.

37. Through the proposed rules, we further propose including a state supplemental report, through the proposed form provided on the Commission's website in proposed Rule 11100, to submit GIS data during the annual reporting period.

38. Given updates proposed in these rules, including for submission of GIS data in accordance with proposed Rule 11100(c), commenters should include whether annual filing deadlines for 2023 should be set for a date certain other than March 15 once rules are effective, and for March 15 for the following years.[5]

39. We propose including a state supplemental report, through the proposed state provided form in Section 11100, to submit the list and descriptions of the advanced leak detection technologies utilized during the annual reporting period.

[5] Rules may be effective sufficiently in advance of March 15, 2023, to ensure operators can gather and provide the necessary information, consistent with any final adopted rules. However, through the course of this proceeding we encourage the assigned ALJ and commenters to consider if that date should be slightly later than March 15 for the first year the updated rules and annual reporting requirements are effective.

7. Section 11201 Pipeline Excavation Damage Prevention

40. We propose the update of UNCC/Colorado 811 membership, based on the change in statute from § 9-1.5-105, C.R.S.

41. We propose the requirement of documentation of all abandoned pipelines, as defined in 49 CFR 192.3, be submitted through the annual mapping data report state form. This proposed rule is aimed at the requirements in § 40-2-115(1)(d)(II)(B), C.R.S. to reduce the risks posed by abandoned gas pipelines. Operator's provision of abandoned pipeline information will on one hand better inform the Commission of areas with abandoned pipelines, and on the other hand further the development of the risk-based inspection program within PSP.[6] Commenters are encouraged to include rule revisions and suggestions that address abandoned gas pipeline safety considerations and implementation in Commission rule.

8. Section 11203 Small Operator Systems

42. We propose the removal of distribution integrity management plans (DIMP) exemptions because there was no guidance for major MMO/LPG systems that have 100 to 999 customers. Master Meter Operator (MMO) systems are exempt from DIMP requirements as per 49 CFR 192.1003 and Liquid Petroleum Gas (LPG) systems are subject to DIMP requirements as per 49 CFR 192.1015.

9. Section 11501 Violations – Civil Penalties

43. We propose an increase in civil penalty not to exceed amounts, both for individual instance of violation and group or series of related violations, from $100,000 per instance of violation not to exceed $1,000,000 in aggregate, to $200,000 per instance of violation, not to

[6] Knowing these details could inform future actions, including construction over an abandoned line that was not fully sealed.

exceed $2,000,000 in aggregate, consistent with updates in § 40-7-117, C.R.S., made through SB21-108, and in compliance with 49 CFR 190.223.

44. Notably, 49 CFR 190.223 is adjusted annually to meet requirements of the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015. Commenters are encouraged to address whether changes to this increase given the rising annual federal amounts warrant any further revisions, including if commenters suggest further statutory changes to mirror rising federal penalty limits.

10. Sections 11503 Compliance Action – Warning Notice and 11504 Notice of Probable Violation (NPV)

45. We propose the availability of a penalty reduction based on the listed factors and metrics, as part of a requirement for §§ 40-7-117(2)(a) through (c), C.R.S. An operator receiving a NPV should never be caught off guard, except in exceptional circumstances (*e.g.*, flagrant violations, deaths, or other negligent actions), because the operator will have already received a Warning Notice Compliance Action from the Pipeline Safety Program.

46. We propose a clarification to the NPV process through a court of law as required in § 40-7-117(3) and (4), C.R.S.

D. Conclusion

47. The Commission invites comments from interested persons on these proposed revisions to the Pipeline Safety Rules. The Commission prefers and encourages that comments be filed in this Proceeding through the Commission's Electronic Filings (E-Filings) System at:

https://www.dora.state.co.us/pls/efi/EFI.homepage.

48. We have included the Gas Utilities and Pipeline Operator Rules at 4 CCR 723-11 in legislative (*i.e.,* strikeout/underline) format to remove pertinent rules (Attachment A). A full

final format version of the newly proposed Pipeline Safety Rules is attached (Attachment B). The attachments are available through the Commission's E-Filings System at:

https://www.dora.state.co.us/pls/efi/EFI.Show_Docket?p_session_id=&p_docket_id=22R-0491GPS

49. Written comments, including redlines to the proposed rules, are requested by December 12, 2022, with responsive comments requested on or before January 3, 2023.

50. This Commission refers this Proceeding to an ALJ, who will hold a hearing on the proposed rules at the stated time and place. Interested persons may provide oral comments at the public hearing unless the ALJ deems oral presentations unnecessary.

II. ORDER

A. The Commission Orders That:

1. This Notice of Proposed Rulemaking shall be filed with the Colorado Secretary of State for publication in the November 25, 2022, edition of *The Colorado Register*.

2. Comments from interested persons on the proposed amendments to the Rules are requested by December 12, 2022 and reply comments are requested no later than January 3, 2023.

3. The hearing on the proposed rules and related matters shall be held before an Administrative Law Judge (ALJ) as follows:

DATE:	January 19, 2023
TIME:	9:00 a.m.
LOCATION	By video conference using Zoom at a link in the calendar of events on the Commission's website, available at: https://puc.colorado.gov/

The ALJ may set additional hearings, if necessary.

4. At the time set for hearing, interested persons may submit written comments and may present these orally unless the ALJ deems oral comments unnecessary.

5. This Decision is effective upon its Mailed Date.

B. ADOPTED IN COMMISSIONERS' WEEKLY MEETING November 2, 2022.

(S E A L)

ATTEST: A TRUE COPY

Doug Dean,
Director

THE PUBLIC UTILITIES COMMISSION
OF THE STATE OF COLORADO

ERIC BLANK

JOHN GAVAN

MEGAN M. GILMAN

Commissioners

Permanent Rules Adopted

Department

Department of Revenue

Agency

Division of Motor Vehicles

CCR number

1 CCR 204-30

Rule title

1 CCR 204-30 DRIVER'S LICENSE-DRIVER CONTROL 1 - eff 01/31/2023

Effective date

01/31/2023

RULE 1 RULES FOR APPLICATION FOR A COLORADO ROAD AND COMMUNITY SAFETY ACT IDENTIFICATION DOCUMENTS § 42-2-501, C.R.S.

Purpose

The purpose of this rule is to set forth regulations for application and issuance of driver's licenses, minor driver's licenses, instruction permits and Identification Cards for individuals who cannot demonstrate lawful presence in the United States and for individuals who can demonstrate Temporary Lawful Presence in the United States. These regulations establish the source documents that are acceptable to establish Identity, date of birth, Colorado residency, and, as applicable, Temporary Lawful Presence.

Statutory Authority

The statutory bases for this regulation are sections 24-4-103, 24-72.1-103, 42-1-204, C.R.S. and Title 42, Article 2, Parts 1, 2, 3, and 5.

Incorporation By Reference Of Federal Law

The Department incorporates by reference as part of Rule 1 of the Department of Revenue Regulations, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. 104-208, section 384, 110 Stat. 3009 (Sept. 30, 1996), referred to in this Rule 1. Such Act is published by the Department of Homeland Security in full in the United States Statutes at Large, Volume 110, page 3009. Rule 1 does not include any later amendments or editions of such Act.

A copy of such Act is available for a reasonable charge from the Colorado Department of Revenue, 1881 Pierce Street, Lakewood, Colorado 80214. A copy of such Act is maintained by the Colorado Department of Revenue and may be inspected by contacting the Driver License Office Manager at the Colorado Department of Revenue, 1881 Pierce Street, Lakewood, Colorado 80214 during normal business hours. The incorporated material may also be examined at any state publications depository library. A copy, including a certified copy, of such Act is also available from the United States Citizenship and Immigration Services ("USCIS") Historical Reference Library at 111 Massachusetts Avenue NW, First Floor (MS2180), Washington, DC 20529-2180.

(100) Definitions

a) Applicant – Any natural person applying to the Department for a Colorado Identification Document who can demonstrate Temporary Lawful Presence in the U.S., or who cannot demonstrate lawful presence in the U.S.
b) CO-RCSA – The Colorado Road and Community Safety Act, part 5 of Title 42 C.R.S.
c) Department – The Colorado Department of Revenue.

d) Document – An original document certified by the issuing agency, an amended original document certified by the issuing agency, or a true copy certified by the issuing agency, excluding miniature, wallet sized, or photocopies of documents.
e) Exceptions Processing – The procedure the Department has established for persons who are unable, for reasons beyond their control, to present all necessary Documents and must rely on alternative Documents to establish Identity or date of birth.
f) Full Legal Name – The Applicant's first name, middle name(s), and last name or surname, without use of initials or nicknames.
g) Hearing – Hearing before a Department Administrative Hearing Officer.
h) Identification Card – A Document issued by a Department of Motor Vehicles or its equivalent that contains the Applicant's Full Legal Name, full facial digital photograph, date of birth, and sex, but does not confer upon the bearer the right to operate a motor vehicle.
i) Identification Document – Has the same meaning as defined in C.R.S. 42-2-503(1).
j) Identity –The verifiable characteristics that when taken together make a person unique and identifiable. Evidence of Identity includes proof of Full Legal Name, date of birth, and physical characteristics, including a verifiable photograph.
k) Incomplete Application – An application for a CO-RCSA Identification Document that does not satisfy state requirements for the issuance of a CO-RCSA Identification Document.
l) Individual Taxpayer Identification Number (ITIN) – A tax processing number issued by the Internal Revenue Service (IRS) as shown on an ITIN card issued by the IRS, on a letter from the IRS, or on a certified state tax return.
m) Temporary Lawful Presence – The status of a person whose authority to lawfully remain in the United States is temporary and who qualifies for a CO-RCSA Identification Document.
n) SSA – The U.S. Social Security Administration.
o) SSN – The Social Security Number issued by SSA.
p) SSOLV – The Social Security Online Verification system managed by SSA.

(200) Qualifications for CO-RCSA Identification Documents

a) Pursuant to section 42-2-506, C.R.S., individuals claiming Temporary Lawful Presence in the United States who apply for an Identification Document, must:
    1. Provide Documents that demonstrate the Applicant's Identity:
        i. A foreign passport bearing a photograph of the Applicant, valid or expired less than 10 years;
        ii. An Employment Authorization Document (EAD, Form I-766), valid or expired less than 10 years;
        iii. A Colorado Identification Document, valid or expired less than 10 years;
        iv. A driver license, instruction permit, or identification card issued by a state or territory of the United States, valid or expired less than 10 years; or
        v. A consular identification card, valid or expired less than 10 years.
    2. Provide valid documentary evidence of Temporary Lawful Presence:

i. Unexpired foreign passport with unexpired I-94 showing class of admission;
ii. Unexpired Employment Authorization Document (EAD, Form I-766);
A. Expired Employment Authorization Document (EAD, Form I-766) automatically extended due to a Temporary Protected Stay;
iii. Expired Employment Authorization Document (EAD, Form I-766) with I-797C Notice of Action demonstrating receipt of an Application for Employment Authorization, evidencing an applicable unexpired automatic extension issued within 5 years of the date of application;
iv. I-797C Notice of Action demonstrating receipt of an Application to Register Permanent Residence or Adjust Status issued within 5 years of the date of application;
v. I-797C Notice of Action demonstrating receipt of an Application for Asylum issued within 5 years of the date of application;
vi. I-797C Notice of Action demonstrating receipt of an Application for or Grant of Temporary Protected Status issued within 5 years of the date of application;
vii. I-797C Notice of Action demonstrating receipt of an application for change or extension of status issued within 2 years of the date of application; or
viii. An I-797C listed above, dated outside of the specified timeframe, with written evidence from the U.S. Citizenship and Immigration Services that the application is still pending.

3. Present proof of current residential address in Colorado.
i. To document the address of principal residence in Colorado, an Applicant must present at least one article of documentation that includes the Applicant's name and address of principal residence. Examples include, but are not limited to: utility bill, credit card statements, pay stub or earnings statement, rent receipt, telephone bill, or bank statement.

b) Pursuant to section 42-2-505, C.R.S., Applicants who apply for an Identification Document, who cannot demonstrate lawful presence in the United States, must:

1. Demonstrate Colorado residency in either of the following two ways:
i. Sign a DR 2212 CO-RCSA Affidavit that states that the Applicant is currently a resident of Colorado, and present a certified proof of Colorado income tax return filing (from the Department) for the immediately preceding year; or
ii. Sign a DR 2212 CO-RCSA Affidavit that the Applicant has continuously been a resident in Colorado for the immediately preceding 24 months, and present evidence of such residence in Colorado by providing:
A. In order to prove that the Applicant has continuously resided in Colorado for the immediately preceding 24 months, the Applicant must present three articles of documentation demonstrating: one for current residency (date on the documentation must not be older than 12 months from date of application), one for residency from one year prior (date on the documentation must be later than

12 months, but not later than 23 months prior to the date of application), and one for residency from two years prior (date on the documentation must be later than 23 months, but not later than 30 months prior to the date of application).

2. Present proof of current residential address in Colorado.
    i. To document the address of principal residence in Colorado, an Applicant must present at least one article of documentation that includes the Applicant's name and address of principal residence. Examples include, but are not limited to: utility bill, credit card statements, pay stub or earnings statement, rent receipt, telephone bill, or bank statement.
3. Provide the Applicant's SSN or provide documentation of the Applicant's ITIN as specified in Section 100(l).
    i. An SSN may be added to an Applicant's record only by appearing in person.
    ii. An Applicant's SSN shall be verified with the SSOLV.
4. Sign a DR 2212 CO-RCSA Affidavit affirming that the Applicant has applied to be lawfully present within the U.S., or will apply to be lawfully present as soon as the Applicant is eligible.
5. Provide documentation of the Applicant's Identity and date of birth by presenting one of the following Documents, translated into English, from the Applicant's country of origin:
    i. A passport;
    ii. A consular identification card; or
    iii. A military identification document.
6. The Documents in Section 200(b)(5) must contain: the Applicant's full legal name; the Applicant's date of birth; the date the Document was issued; the name of the country that issued the Document; and a full facial photograph of the Applicant.
7. The Documents listed in Section 200(b)(5) above will be accepted for 10 years after the expiration date listed on the Document. Documents without an expiration date will be accepted for 10 years from their issuance date.
8. Applicants shall sign their name, under penalty of perjury, on all required affidavits and Documents in the presence of a Department employee.

c) Applicants may use an interpreter during their application process. The use of an interpreter will be arranged for by the Applicant and any costs associated with the use of an interpreter will be the responsibility of the Applicant.

d) Applicants may use an interpreter for the written test for a driver's license, minor's driver's license, or instruction permit.
    1. All interpreters for Applicants applying for a CO-RCSA driver's license, minor driver's license, or instruction permit must be at least 16 years old and show an unexpired driver's license or Identification Card from any state in the United States or any Document provided in Section 200 (b)(5).

e) A Colorado street address must be displayed on the Identification Document except as provided below:

1. An alternative address may be displayed for individuals for whom a State law, regulation, or DMV procedure permits display of an alternative address.
2. An alternative address may be displayed for individuals who satisfy any of the following:
    i. If the individual is enrolled in the Colorado Address Confidentiality Program, which allows victims of domestic violence, dating violence, sexual assault, stalking, or a severe form of trafficking, to keep, obtain and use alternative addresses, and provides that the address of such person must be kept confidential; or
    ii. If the individual is entitled to have their address suppressed under state or federal law or suppressed by a court order including an administrative order issued by a State or Federal court; or
    iii. If the individual is protected from disclosure of information pursuant to section 384 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996.
3. In areas where a number and street name has not been assigned for U.S. mail delivery, an address convention used by the U.S. Postal Service is acceptable.

(300) Process for Translation

a) All Documents provided to the Department by the Applicant shall be in English or have been translated into English.
b) The original and corresponding translated Documents shall be presented together at the time of application.
c) All translated Documents must have the following included at the end (must be typed or electronically printed on the same page as the translation, not on separate pieces of paper or the translation will not be accepted by the Department):
    1. An attestation that states: “I, [insert translator’s full name], affirm that the foregoing is a complete and accurate translation from [insert foreign language] to the English language to the best of my ability. I further affirm that I am fully competent to translate from [insert foreign language] to the English language and that I am proficient in both languages;” and
    2. The number and state of issuance of the translator’s unexpired driver’s license, instruction permit, or Identification Card.
d) All translated Documents and information required by Section 300(c) shall be included in the Applicant’s permanent motor vehicle record.
e) Applicants are responsible for all costs of translation.

(400) Fee Structure

a) For those who cannot demonstrate lawful presence, the fee for a CO-RCSA driver’s license or a minor driver’s license is $33.00, which includes an additional fee to cover direct and indirect costs. The cost for a CO-RCSA instruction permit is $21.00, which includes an additional fee to cover direct and indirect costs. The cost for a CO-RCSA

Identification Card is $13.00, which includes an additional fee to cover direct and indirect costs.

b) As of July 1, 2020, the following fee increases were effective for those that can demonstrate Temporary Lawful Presence:
   1. For those who can demonstrate Temporary Lawful Presence, the cost for a CO-RCSA driver's license or minor driver's license under section 42-2-506, C.R.S. is $30.87.
   2. For those who can demonstrate Temporary Lawful Presence, the cost for a CO-RCSA instruction permit is $18.52. The cost for a CO-RCSA Identification Card is $12.67.

(500) Qualifications for Renewal

a) CO-RCSA Identification Documents will expire three years after the date of issuance except as provided below:
   1. A driver's license issued to an Applicant under 21 will expire three years after the date of issuance or 20 days after the 21st birthday of the Applicant (whichever comes first).
   2. An Identification Card or instruction permit issued to an Applicant under 21 will expire three years after the date of issuance or on the 21st birthday of the Applicant (whichever comes first).

b) Applicants may apply in person, by mail, or electronically in accordance with C.R.S. 42-2-118 or 42-2-304 to renew a CO-RCSA Identification Documents.
   1. Applicants over the age of 21 can renew Identification Documents electronically.
   2. Renewals by mail and electronic renewals will not be processed with an out of state mailing address.

c) An Applicant seeking to renew an Identification Document is required to present the same documentation as required under Section 200 of this rule, except that an applicant who cannot demonstrate lawful presence may present a Colorado Identification Document expired less than one year instead of the Identity documentation required by Section 200(b)(5) and is not required to present proof of ITIN or SSN if proof was provided at time of issuance of a previous Identification Document.

(600) Qualifications for Issuance of a Duplicate Credential

a) Applicants may apply for a duplicate of an existing CO-RCSA Instruction Permit or Driver's License as provided below:
   1. Applicants must appear in person and certify, under penalty of perjury, that the previous credential was lost, stolen, or destroyed by completing the "Request for Duplicate Instruction Permit/Driver License" (DR2989) form provided by the Department.
   2. Eligible Applicants may submit an electronic application, on which the Applicant must certify, under penalty of perjury, that the previous credential was lost, stolen, or destroyed.

3. Applicants must present proof Documents as required in Section 200 above except that proof of ITIN is not required if proof of ITIN was provided for issuance of a previous Identification Document.
4. A duplicate will not be issued to an Applicant with a lawful presence status that has changed since issuance of the previous credential. A change of lawful presence status requires renewal.

(700) Electronic Applications

a) The Department may accept electronic applications for services provided electronically.
b) The Department may accept an application electronically if the Applicant's fingerprint was captured as part of a previous application.
c) The Department may accept an application electronically if a signature was captured as part of a previous application and if the Applicant verifies the information on the application.

(800) Process for Complete Application

a) When an Applicant has completed the required application and established the standards set forth in this rule, the Applicant will be required to review and verify the information on the application by signing a "signature capture device," a fingerprint will be captured, and a photograph of the Applicant will be taken. A temporary CO-RCSA Identification Document will be issued. The permanent CO-RCSA Identification Document will be mailed to the Applicant at the address provided on the Applicant's application.

(900) Process for Incomplete Application

a) If an application is incomplete or the Applicant has failed to provide Documents verifiable by the Department for Identity, date of birth, residency, and, as applicable, Temporary Lawful Presence, the Department shall provide a Notice of Incomplete Application unless the Department provides a Notice of Denial per Section 1000 below.
b) The Notice of Incomplete Application shall include a notation of the information that is incomplete, or of the documentation that is unverifiable. If the authenticity of a Document cannot be verified, then an application may be considered incomplete and additional documentation may be required, or the Applicant may be referred to Exceptions Processing. An Applicant may return to the Department with the required additional documentation prior to being denied an Identification Document.

(1000) Denial of Application

a) If an application is incomplete or the Applicant has failed to provide Documents verifiable by the Department for Identity, date of birth, residency, and, as applicable, Temporary Lawful Presence, the Department shall provide a Notice of Denial.

b) Nothing in this regulation shall be construed to prevent the Department from denying an application on the basis that an Applicant has presented Documents that are fraudulent or that are not verifiable.

c) Nothing in this regulation restricts or prohibits the Department from verifying any Document presented by an Applicant.

d) An application shall be denied if the Applicant presents fraudulent or altered Documents or commits any other fraud in the application process.

(1100) Hearing and Final Agency Action

a) An Applicant who has received a Notice of Denial may, within 60 days of the date of the Notice of Denial, request a hearing on the denial by filing a written request for hearing with the Hearings Section of the Department at 1881 Pierce St. Entrance B, #112, Lakewood, CO 80214.

b) Hearings shall be held in accordance with the provisions of the State Administrative Procedure Act, and the provisions of Title 42 of the Colorado Revised Statutes.

c) The only issue at a hearing shall be whether the Applicant has satisfied federal and state requirements for the issuance of an Identification Document.

d) The hearing officer shall issue a written decision. If the hearing officer finds that the Applicant has not satisfied federal and state requirements for the issuance of an Identification Document, then the denial shall be sustained. If the hearing officer finds that the Applicant has satisfied requirements for the issuance of an Identification Document, then the denial shall be rescinded and the Department shall issue an Identification Document.

e) The decision by the hearing officer shall constitute final agency action, and is subject to judicial review as provided by section 24-4-106, C.R.S.

PHILIP J. WEISER
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Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2022-00447

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Motor Vehicles

on 10/21/2022

1 CCR 204-30

DRIVER'S LICENSE-DRIVER CONTROL

The above-referenced rules were submitted to this office on 11/03/2022 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.

November 09, 2022 08:39:00

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Revenue

Agency

Division of Motor Vehicles

CCR number

1 CCR 204-30

Rule title

1 CCR 204-30 DRIVER'S LICENSE-DRIVER CONTROL 1 - eff 01/31/2023

Effective date

01/31/2023

RULE 6 RULES FOR THE APPLICATION FOR A DRIVER'S LICENSE OR IDENTIFICATION CARD FOR U.S. CITIZENS AND INDIVIDUALS WHO CAN DEMONSTRATE PERMANENT LAWFUL PRESENCE AND COLORADO RESIDENCY

Purpose

The purpose of this rule is to set forth regulations for the types of documents the Department will accept as proof of the Applicant's Identity, date of birth, residency, and U.S. citizenship or Permanent Lawful Presence when applying for a Driver's License or Identification Card. Additionally, this rule describes the process the Applicant will be required to follow for completing the application and what will occur if an application is incomplete or denied, including the process the Applicant may use to request a Hearing if their application is denied.

Statutory Authority

The statutory bases for this regulation are sections 24-4-103, 24-72.1-102(5), 24-72.1-103, 42-1-204, 42-2-107, 42-2-108, and 42-2-302, C.R.S.

Incorporation by Reference of Federal Law

The Department incorporates, as part of Rule 6 of the Department of Revenue Regulations, the Illegal Immigration Reform and Immigrant Responsibility Act of 1996, Pub. L. 104-208, section 384, 110 Stat. 3009 (Sept. 30, 1996), referred to in this Rule 6. Such Act is published by the Department of Homeland Security in full in the United States Statutes at Large, Volume 110, page 3009. Rule 6 does not include any later amendments or editions of such Act.

A copy of such Act is available for a reasonable charge from the Colorado Department of Revenue, 1881 Pierce Street, Lakewood, Colorado 80214. A copy of such Act is maintained by the Colorado Department of Revenue and may be inspected by contacting the Records Custodian at the Colorado Department of Revenue, 1881 Pierce Street, Lakewood, Colorado 80214 during normal business hours. The incorporated material may also be examined at any state publications depository library. A copy, including a certified copy, of such Act is also available from the United States Citizenship and Immigration Services ("USCIS") Historical Reference Library at 111 Massachusetts Avenue NW, First Floor (MS2180), Washington, DC 20529-2180.

1.0 Definitions

1.1 Applicant–Any natural person applying to the Department for a Colorado Driver's License or Identification Card who is a U.S. citizen or who can demonstrate Permanent Lawful Presence in the U.S. and residency in Colorado.

1.2 Department–The Colorado Department of Revenue.

1.3 Document–An original document certified by the issuing agency, an amended original document certified by the issuing agency, or a true copy certified by the issuing agency, excluding miniature, wallet sized, or photocopies of documents.

1.4 Driver's License–A driver's license, minor driver's license, or instruction permit.

1.5 Exceptions Processing–The procedure the Department has established for persons who are unable, for reasons beyond their control, to present all necessary Documents and must rely on alternative Documents to establish Identity, date of birth, or U.S. citizenship

1.6 Full Legal Name –The Applicant's first name, middle name(s), and last name or surname, without use of initials or nicknames.

1.7 Hearing–Hearing before a Department Administrative Hearing Officer.

1.8 Identification Card– A Document issued by a Department of Motor Vehicles or its equivalent that contains the Applicant's Full Legal Name, full facial digital photograph, date of birth, and sex, but does not confer upon the bearer the right to operate a motor vehicle.

1.9 Identity–The verifiable characteristics that when taken together make a person unique and identifiable. Evidence of Identity includes proof of Full Legal Name, date of birth, and physical characteristics and must include a verifiable photograph unless approved through Exceptions Processing.

1.10 Incomplete Application–An application for a Colorado Driver's License or Identification Card that does not satisfy federal and state requirements for the issuance of a Colorado Driver's License or Identification Card.

1.11 SAVE– The Department of Homeland Security Systematic Alien Verification for Entitlements system, managed by the U.S. Citizenship and Immigration Services of the Department of Homeland Security.

1.12 Permanent Lawful Presence - The status of a person who is a citizen or national of the United States, a lawful permanent resident, a conditional lawful permanent resident, an asylee, or a refugee.

1.13 SSA – The U.S. Social Security Administration.

1.14 SSN – The Social Security Number issued by SSA.

1.15 SSOLV–The Social Security Online Verification system managed by SSA.

1.16 Travel Document - The Refugee Travel Document issued to a person with refugee or asylum status who wishes to travel outside the United States in order to return to the United States. Similar in appearance to a U.S. passport.

1.17 USCIS – United States Citizenship and Immigration Services.

2.0 Proof of Identity, Date of Birth, and Permanent Lawful Presence

2.1 Every application for a Colorado Driver's License or Identification Card shall include the Applicant's full legal name, date of birth, sex, SSN, and address of principal residence.

2.2 An Applicant must provide source Documents that are secure and verifiable as defined in section 24-72.1-102(5), C.R.S.

2.3 The following Documents or combination of Documents are acceptable to establish Identity, date of birth, and Permanent Lawful Presence:

2.3.1 A valid, unexpired Colorado Driver's License or Identification Card except that a Colorado Driver's License or Identification Card issued under the Colorado Road and Community Safety Act, section 42-2-501 et seq., C.R.S. is not acceptable.

2.3.2 A valid, unexpired U.S. passport verified using U.S. Passport Verification Services.

2.3.3 A certified copy of a birth certificate filed with a State Office of Vital Statistics or equivalent agency in the Applicant's state of birth.

2.3.4 A Consular Report of Birth Abroad (CRBA) issued by the U.S. Department of State (Form FS-240, DS-1350, or FS-545).

2.3.5 A valid, unexpired Permanent Resident Card (Form I-551) issued by the Department of Homeland Security (DHS) or USCIS, a valid or less than 10 years expired foreign passport with an I-551 ADIT (Alien Documentation, Identification and Telecommunication) stamp, a valid foreign passport with DHS stamped US visa showing admittance as a permanent resident for 1 year, or an expired I-551 card with an I-797 notice showing an unexpired extension, verified by SAVE.

2.3.6 A Certificate of Naturalization issued by DHS or USCIS (Form N-550 or N-570), verified by SAVE.

2.3.7 A Certificate of Citizenship issued by DHS or USCIS (Form N-560 or N-561), verified by SAVE.

2.3.8 A valid unexpired Driver's License or Identification Card verified with the state of issuance.

2.3.9 An unexpired foreign passport accompanied by a valid I-94 demonstrating approved refugee or asylee status, a valid I-94 demonstrating approved refugee or asylee status with DHS-attached photo less than 20 years old, or a valid I-94 demonstrating approved refugee or asylee status with a Travel Document, verified by SAVE.

2.3.10 Such other Documents as determined by the Department consistent with the REAL ID Act.

2.4 To establish a name other than the name that appears on a source Document (for example through marriage, adoption, court order or other mechanism permitted by state law or regulation), the Department shall require evidence of the name change through the presentation of Documents issued by a court, governmental body, or other entity as determined by the Department.

3.0 Social Security Requirements

3.1 An Applicant must provide his or her SSN.

3.2 An Applicant's SSN shall be verified using SSOLV.

4.0 Address of Principal Residence in Colorado

4.1 To document the address of principal residence in Colorado, an Applicant must present at least two articles of documentation that include the Applicant's name and address of principal residence. Examples include, but are not limited to: utility bill, credit card

statements, pay stub or earnings statement, rent receipt, telephone bill, or bank statement.

4.2 A Colorado street address must be displayed on the Driver's License or Identification Card except as provided below:

4.2.1 An alternative address may be displayed for individuals for whom a State law, regulation, or the procedures of the Department permit display of an alternative address.

4.2.2 An alternative address may be displayed for individuals who satisfy any of the following:

4.2.2.1 If the individual is enrolled in a State address confidentiality program, which allows victims of domestic violence, dating violence, sexual assault, stalking, or a severe form of trafficking, to keep, obtain and use alternative addresses, and provides that the address of such person must be kept confidential, or other similar program; or

4.2.2.2 If the individual is entitled to have their address suppressed under state or federal law or suppressed by a court order including an administrative order issued by a State or Federal court; or

4.2.2.3 If the individual is protected from disclosure of information pursuant to section 384 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996.

4.2.3 In areas where a number and street name has not been assigned for U.S. mail delivery, an address convention used by the U.S. Postal Service is acceptable.

5.0 Qualifications for Issuance of a Duplicate Driver's License

5.1 Applicants may apply for a duplicate of an existing Driver's License as provided below:

5.1.1 Applicants may appear in person and certify, under penalty of perjury, that the previous credential was lost, stolen, or destroyed by completing the "Request for Duplicate Instruction Permit/Driver's License" (DR2989) form provided by the Department.

5.1.2 Applicants may submit, by mail, the "Request for Duplicate Instruction Permit/Driver's License" (DR2989) form provided by the Department on which the Applicant must certify, under penalty of perjury, that the previous credential was lost, stolen, or destroyed.

5.1.3 Eligible Applicants may submit an electronic application, on which the Applicant must certify, under penalty of perjury, that the previous credential was lost, stolen, or destroyed.

6.0 Electronic Applications

6.1 The Department may accept electronic applications for services provided electronically.

6.2 The Department may accept an application electronically if the Applicant's fingerprint was captured as part of a previous application.

6.3 The Department may accept an application electronically if a signature was captured as part of a previous application and if the Applicant verifies the information on the application.

7.0 Process for Complete Application

7.1 When an Applicant has completed the required application and met the standards established in this rule, the Applicant will be required to review and verify the information on the application by signing a “signature capture device”; a fingerprint will be captured; and a photograph of the Applicant will be taken. A temporary Colorado Driver’s License or Identification Card will be issued. The permanent Colorado Driver’s License or Identification Card will be mailed to the Applicant at the address provided on the Applicant’s application.

8.0 Process for Incomplete Application

8.1 If an application is incomplete or the Applicant has failed to provide Documents verifiable by the Department for Identity, date of birth, Permanent Lawful Presence, and residency in Colorado, the Department shall provide a Notice of Incomplete Application unless the Department provides a Notice of Denial per section 9.0 below.

8.2 The Notice of Incomplete Application shall include a notation of the information that is incomplete or of the documentation that is unverifiable. If the authenticity of a Document cannot be verified, then an application may be considered incomplete and additional documentation may be required, or the Applicant may be referred to Exceptions Processing. An Applicant may return to the Department with additional documentation prior to being denied a Colorado Driver’s License or Identification Card.

8.3 Any Applicant who has received a Notice of Incomplete Application and believes he or she has provided sufficient documentation to establish Identity, date of birth, and Permanent Lawful Presence, may proceed with Exceptions Processing.

8.4 Any Applicant who has received a Notice of Incomplete Application and believes he or she has provided sufficient documentation to establish Identity, date of birth, Permanent Lawful Presence, and residency may request a Notice of Denial and contest the decision through the process described in section 9.0 below.

9.0 Denial of Applications

9.1 If an application is incomplete or the Applicant has failed to provide Documents verifiable by the Department for Identity, date of birth, Permanent Lawful Presence, and residency, the Department may provide a Notice of Denial.

9.2 Nothing in this regulation shall be construed to prevent the Department from denying an application on the basis that an Applicant has presented Documents that are fraudulent or that are not secure and verifiable pursuant to section 24-72.1-102(5), C.R.S.

9.3 Nothing in this regulation restricts or prohibits the Department from verifying any Document presented by an Applicant.

9.4 An application shall be denied if the Applicant presents fraudulent or altered Documents or commits any other fraud in the application process.

10.0 Hearing and Final Agency Action

10.1 An Applicant who has received a Notice of Denial may, within 60 days of the date of the Notice of Denial, request a hearing on the denial by filing a written request for hearing with the Hearings Section of the Department at the address specified on the Notice of Denial.

10.2 Hearings shall be held in accordance with the provisions of the State Administrative Procedure Act and the provisions of Title 42 of the Colorado Revised Statutes.

10.3 The only issue at the hearing shall be whether the Applicant has satisfied federal and state requirements for the issuance of a Colorado Driver's License or Identification Card.

10.4 The hearing officer shall issue a written decision. If the hearing officer finds that the Applicant has not satisfied federal and state requirements for the issuance of a Colorado Driver's License or Identification Card, then the denial shall be sustained. If the hearing officer finds that the Applicant has satisfied federal and state requirements for the issuance of a Colorado Driver's License or Identification Card, then the denial shall be rescinded and the Department shall issue the Colorado Driver's License or Identification Card.

PHILIP J. WEISER
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Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2022-00448

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Motor Vehicles

on 10/21/2022

1 CCR 204-30

DRIVER'S LICENSE-DRIVER CONTROL

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 09, 2022 08:43:26

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Revenue

Agency

Division of Motor Vehicles

CCR number

1 CCR 204-30

Rule title

1 CCR 204-30 DRIVER'S LICENSE-DRIVER CONTROL 1 - eff 01/31/2023

Effective date

01/31/2023

RULE 16 RULES FOR EXCEPTIONS PROCESSING

Purpose

The purpose of this rule is to set forth regulations for an Exceptions Process and identify the alternative documents the Department will accept. Exceptions Processing is the procedure the Department has established for persons who are unable, for reasons beyond their control, to present all the necessary documents required for a Colorado or Colorado Road and Community Safety Act Driver's License or Identification Card, and must rely on alternative documents. For Applicants who are U.S. citizens, Exceptions Processing allows for alternative documents to be presented that establish Identity, date of birth and U.S. citizenship. For Applicants who cannot demonstrate lawful presence or for Applicants who can demonstrate temporary or permanent lawful presence, Exceptions Processing allows for alternative documents to be presented that establish Identity and date of birth. For Applicants who do not have an established residence, Exceptions Processing allows for an alternative to establish residency.

Statutory Authority

The statutory bases for this regulation are sections 13-15-101(5) (a), 24-4-103, 24-72.1102(5), 42-1-204, 42- 1-230, 42-2-107, 42-2-136, 42-2-302, and 42-2-501, et seq., C.R.S. This regulation applies to documents issued under Title 42, Article 2, Parts 1, 2, 3, and 5.

1.0 Definitions

1.1 Applicant – Any natural person applying to the Department for a Colorado Driver's License, Identification Card or a Colorado Road and Community Safety Act Identification Document.

1.2 CO-RCSA – The Colorado Road and Community Safety Act, part 5 of Title 42 C.R.S.

1.3 Department – The Colorado Department of Revenue.

1.4 Document – An original document certified by the issuing agency, an amended original document certified by the issuing agency, or a true copy certified by the issuing agency, excluding miniature, wallet sized, or photocopies of documents.

1.5 Driver's License – A driver's license, minor driver's license, or instruction permit.

1.6 Exceptions Processing – The procedure the Department has established for persons who are unable, for reasons beyond their control, to present all necessary Documents and must rely on alternative Documents to establish Identity, date of birth or U.S. citizenship.

1.7 Full Legal Name – The Applicant's first name, middle name(s), last name or surname, without use of initials or nicknames.

1.8 Hearing – Hearing before a Department Administrative Hearing Officer.

1.9 Identification Card – A Document issued by a Department of Motor Vehicles or its equivalent that contains the Applicant's Full Legal Name, full facial digital photograph, date of birth, and sex, but does not confer upon the bearer the right to operate a motor vehicle.

1.10 Identity – The verifiable characteristics that when taken together make a person unique and identifiable. Evidence of Identity includes proof of Full Legal Name, date of birth, and physical characteristics, and must include a verifiable photograph unless approved through Exceptions Processing.

1.11 Incomplete Application – An application that does not satisfy all the federal and state requirements for issuance of a Colorado Driver's License, Identification Card or a CO-RCSA Identification Document resulting in a Notice of Incomplete Application.

1.12 Minor Spelling Inconsistencies – Slight variations in the spelling of a full legal name such that the variations are similar in appearance or produce a phonetically similar or identical sound as pronounced.

1.13 Permanent Lawful Presence - The status of a person who is a citizen or national of the United States, a lawful permanent resident, a conditional lawful permanent resident, an asylee, or a refugee.

1.14 SSA – The United States Social Security Administration

1.15 SSN – The Social Security Number issued by SSA.

1.16 SSOLV – The Social Security Online Verification system managed by SSA.

1.17 Temporary Lawful Presence –The status of a person whose authority to lawfully remain in the United States is temporary and who qualifies for a CO-RCSA Identification Document.

2.0 Exceptions Processing Procedures

2.1 An Applicant who has applied for a Driver's License, Identification Card or CO-RCSA Identification Document and was unable to provide the required Documents may request Exceptions Processing after being issued a Notice of Incomplete Application.

2.2 For Applicants who are U.S. citizens, Exceptions Processing shall only be used to establish Identity, date of birth and U.S. citizenship.

2.3 For Applicants who are not a citizen or national of the United States and Applicants who are applying for an Identification Document pursuant to CO-RCSA, Exceptions Processing shall only be used to establish Identity and date of birth.

2.4 If an Applicant submits any source Document that reflects a name differing from the Applicant's Full Legal Name (for example through marriage, adoption, court order or other mechanism permitted by state law or regulation), the Department shall require evidence of the name change through the presentation of Documents issued by a court, governmental body, or other entity as determined by the Department.

2.5 The Department may resolve Minor Spelling Inconsistencies in, or slight misspellings of, a full legal name through Exceptions Processing if the totality of the evidence gathered demonstrates the Applicant's Identity and the resolution is not contrary to the public interest.

2.6 If the totality of evidence gathered through Exceptions Processing establishes the Applicant's Identity, date of birth, and U.S. citizenship (where applicable), the Applicant may be issued a Colorado Driver's License, Identification Card, or CO-RCSA Identification Document.

2.7 If the totality of evidence gathered through Exceptions Processing does not establish the Applicant's Identity, date of birth, and U.S. citizenship (where applicable), the Applicant shall be issued a Notice of Denial and thereafter may request a Hearing with the Hearings Section of the Department.

2.8 For Applicants who do not have an established residence, proof of residency Documents are waived if an Applicant provides a letter on letterhead, signed by an authorized staff member of a homeless shelter, certifying that the individual is homeless and is registered at the shelter.

3.0 Exceptions Processing to Establish Identity and Date of Birth for U.S. citizens.

3.1 The following Documents or combination of Documents may be used to establish an Applicant's Identity and date of birth:

- 3.1.1 A U.S. Passport expired no more than 10 years.
- 3.1.2 A Driver's License or Identification Card issued by any state, including a state that does not require proof of lawful presence to obtain such Document, that either has not expired or that expired within the last 10 years.
- 3.1.3 A military identification card or common access card expired no more than 10 years issued by the U.S. Department of Defense that bears a photograph of the Applicant. Such identification cards include active duty, retiree, National Guard, and dependent identification cards.
- 3.1.4 A life, health, or other insurance record that bears the Applicant's full legal name, date of birth, and place of birth.
- 3.1.5 An identification card issued within the last 20 years by the Bureau of Indian Affairs or by a federally recognized Native American Tribe, and verified by the issuing authority, that bears a photograph of the Applicant, provided the first and last name and date of birth match the first and last name and date of birth on the Document presented by the Applicant.
- 3.1.6 A Veteran's Administration card that bears a photograph of the Applicant and was issued within the last 20 years.
- 3.1.7 An identity card issued by the Federal Bureau of Prisons or any State Department of Corrections, verified by the issuing authority, provided the first and last name and date of birth match the first and last name and date of birth on the Document presented by the Applicant.
- 3.1.8 A valid individual Colorado or federal U.S. income tax return, with an Applicant's copy of an Internal Revenue Service form W-2 or 1099. Validity shall be determined using the SSOLV system. If the SSN on the Document provided is not validated by the SSOLV system, then the Document shall be deemed invalid.
- 3.1.9 An Affidavit of Identity that includes the name or names by which the Applicant is known.
  - 3.1.9.1 The affiant must present the affidavit in person, provide identification, and sign the affidavit in the presence of a Department employee.
  - 3.1.9.2 The affiant must be an employee of a government or non-profit agency registered by the Department with proof of agency affiliation.

3.1.9.3 The Affidavit of Identity shall be used only for Applicants who can demonstrate U.S. Citizenship.

3.1.10 Any Document that is secure and verifiable pursuant to section 24-72.1- 102(5), C.R.S., as determined by the Department, and which establishes evidence of the Applicant's Identity or date of birth.

4.0 Exceptions Processing for U.S. Citizens Using Alternative Documents to Establish U.S. Citizenship.

4.1 An Applicant may use alternative Documents to establish U.S. citizenship.

4.2 The following Documents or combination of Documents may be accepted in support of an Applicant seeking to establish U.S. citizenship:

4.2.1 A certified Order of Adoption of the Applicant bearing the seal or certification of the court of any state, political subdivision, or territory of the United States, or a certified Order of Adoption of that Applicant bearing the seal or certification of the court where a valid adoption took place abroad, so long as the same adoption was the basis of the Applicant's admission into the United States as a legal permanent resident. Any adoption decree must include the date and location of the adoptee's birth.

4.2.2 A U.S. passport expired no more than 10 years.

4.2.3 A city issued birth certificate or hospital birth record that includes the name and date of birth.

4.2.4 Any secure and verifiable Document, that serves to provide evidence of the Applicant's U.S. citizenship.

5.0 Exceptions Processing to Establish Identity and Date of Birth for Non-Citizens with Permanent Lawful Presence.

5.1 The following Documents or combination of Documents may be used to establish an Applicant's Identity and/or date of birth:

5.1.1 A Driver's License or Identification Card issued by any state, including a state that does not require proof of lawful presence to obtain such Document, that either has not expired or that expired within the last 10 years.

5.1.2 A military identification card or common access card expired no more than 10 years issued by the U.S. Department of Defense that bears a photograph of the Applicant. Such identification cards include active duty, retiree, National Guard, and dependent identification cards.

5.1.3 A life, health, or other insurance record that bears the Applicant's full legal name, date of birth, and place of birth.

5.1.4 A Veteran's Administration card that bears a photograph of the Applicant and was issued within the last 20 years.

5.1.5 An identity card issued by the Federal Bureau of Prisons or any State Department of Corrections, provided the first and last name and date of birth

match the first and last name and date of birth on the Document presented by the Applicant.

5.1.6 A valid individual Colorado or federal income tax return, with an Applicant's copy of an Internal Revenue Service form W-2 or 1099. Validity shall be determined using the SSOLV system. If the SSN on the Document provided is not validated by the SSOLV system, then the Document shall be deemed invalid.

5.1.7 A DHS certified photocopy of a foreign passport.

5.1.8 A U.S. Department of State or Department of Homeland Security travel authorization document with photograph.

5.1.9 Any Document that is secure and verifiable pursuant to section 24-72-1-102(5), C.R.S., as determined by the Department, which establishes evidence of the Applicant's Identity or date of birth.

6.0 Exceptions Processing to Establish Identity and Date of Birth for Non-Citizens Who Cannot Demonstrate Lawful Presence or Non-Citizens Who Can Demonstrate Temporary Lawful Presence.

6.1 The following Documents or combination of Documents may be used by an Applicant to establish Identity and/or date of birth

6.1.1 A Driver's License or Identification Card issued by any state, including a state that does not require proof of lawful presence to obtain such Document, that has not expired or that has expired within the last ten years.

6.1.2 A military identification card or common access card issued by the U.S. Department of Defense that contains a photograph of the Applicant that has expired within the previous 10 years. Such identification cards include active duty, retiree, National Guard, and dependent identification cards.

6.1.3 A Veteran's Administration card issued within the last 20 years that bears a photograph of the Applicant.

6.1.4 An identification card issued by the Federal Bureau of Prisons or any State Department of Corrections provided that the first and last name and date of birth match the first and last name and date of birth on the Document presented by the Applicant.

6.1.5 A life, health, or other insurance record that bears the Applicant's name, date of birth, and place of birth.

6.1.6 A DHS certified photocopy of a foreign passport.

6.1.7 A U.S. Department of State or Department of Homeland Security travel authorization document with photograph.

6.1.8 Any other Document that is secure and verifiable pursuant to section 24-72.1-102(5), C.R.S., which serves to provide evidence of the Applicant's identity or date of birth as determined by the Department.

7.0 Process for Translation

7.1 All Documents provided to the Department by the Applicant shall be in English or have been translated into English.

7.2 The original and corresponding translated Documents shall be presented together at the time of application.

7.3 All documents translated must have the following included at the end (must be typed or electronically printed on the same page as the translation, not on separate pieces of paper or the translation will not be accepted by the Department):

7.3.1 An attestation that states: “I, [insert translator’s full name], affirm that the foregoing is a complete and accurate translation from [insert foreign language] to the English language to the best of my ability. I further affirm that I am fully competent to translate from [insert foreign language] to the English language and that I am proficient in both languages” and

7.3.2 The number and state of issuance of the translator’s unexpired Driver’s License, Identification Card or CO-RCSA Identification Document.

7.4 All translated Documents and information required by rule 8.3 shall be included in the Applicant’s permanent motor vehicle record.

7.5 Applicants are responsible for all costs of translation.

8.0 Denial of Application

8.1 If an application is incomplete or the Applicant has failed to provide Documents verifiable by the Department for Identity, date of birth or U.S. citizenship, the Department may provide a Notice of Denial.

8.2 Nothing in this regulation shall be construed to prevent the Department from denying an application on the basis that an Applicant has presented Documents that are fraudulent or that are not secure and verifiable.

8.3 Nothing in this regulation restricts or prohibits the Department from verifying any Documents presented by an Applicant.

8.4 An application may be denied or canceled if the Applicant presents fraudulent or altered Documents or commits any other fraud in the application process. If the authenticity of a Document cannot be verified, then the application may be considered incomplete and additional documentation may be required.

9.0 Hearing and Final Agency Action

9.1 An Applicant who has received a Notice of Denial may, within 60 days of the date of the Notice of Denial, request a Hearing on the denial by filing a written request for Hearing with the Hearings Section of the Department at 1881 Pierce St. Entrance B, #112, Lakewood, CO 80214.

9.2 Hearings shall be held in accordance with the provisions of the State Administrative Procedure Act and the provisions of Title 42 of Colorado Revised Statutes.

9.3 The only issue at Hearing shall be whether the Applicant has satisfied federal and state requirements for the issuance of a Colorado Driver’s License, Identification Card, or CO-RCSA Identification Document.

9.4 The hearing officer shall issue a written decision. If the hearing officer finds that the Applicant has not satisfied state and federal requirements for the issuance of a Colorado Driver's License, Identification Card, or CO-RCSA Identification Document, then the denial shall be sustained. If the hearing officer finds that Applicant has satisfied state and federal requirements for the issuance of a Colorado Driver's License, Identification Card, or CO-RCSA Identification Document, then the denial shall be rescinded and the Department shall issue a Colorado Driver's License, Identification Card, or CO-RCSA Identification Document.

9.5 The decision by the hearing officer shall constitute final agency action, and is subject to judicial review as provided by section 24-4-106, C.R.S.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00449

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Motor Vehicles

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1 CCR 204-30

DRIVER'S LICENSE-DRIVER CONTROL

The above-referenced rules were submitted to this office on 11/03/2022 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.

November 09, 2022 08:47:06

Philip J. Weiser
Attorney General
by Eric R. Olson
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 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF REGULATORY AGENCIES

Division of Insurance

3 CCR 702-5

PROPERTY AND CASUALTY

Regulation 5-1-21

CONCERNING LAW AND ORDINANCE COVERAGE

Section 1 Authority

This regulation is being promulgated and adopted by the Commissioner of Insurance under the authority of §§ 10-1-108(7), 10-1-109(1), 10-3-1103, 10-3-1104(1)(h), and 10-3-1110, C.R.S.

Section 2 Scope and Purpose

On December 30, 2021, the Marshall Fire - the most devastating fire in Colorado history - damaged or destroyed more than 1,000 residential and commercial structures. In the aftermath of the fire, the towns of Louisville and Superior are allowing victims of the Marshall Fire to opt-out of certain portions of their building codes. The purpose of this regulation is to protect homeowner policyholders who have suffered a loss and have law and ordinance coverage. This regulation identifies specific acts or practices regarding law and ordinance coverage that may constitute unfair claim settlement practices.

Section 3 Applicability

This regulation shall apply to all companies issuing homeowner insurance policies that have loss claims and have law and ordinance coverage.

Section 4 Rules

A. Companies shall pay benefits to policyholders based on the terms of their policies and for amounts incurred by policyholders to rebuild their homes. These payments shall include all

payments owed under the primary structure limit and any optional coverages that are applicable, including law and ordinance coverage.

B. Companies shall pay benefits to policyholders for law and ordinance coverage based on the policyholders' costs incurred to rebuild to the applicable building codes in effect on the date of the policyholders' loss. If there is no policy language specifying that the law and ordinance coverage is for codes in place at the time of loss then the company shall consider paying for codes in place at the time of rebuild, subject to applicable coverage limits.

C. If a policyholder chooses to utilize prior building codes, as allowed by the local government, companies shall provide coverage for rebuilding costs for those portions of the building codes in effect on the date of loss that the policyholder chooses to apply, subject to applicable coverage limits.

D. If the policyholder requests that the Dwelling Unit Fire Sprinkler Systems be included in the rebuild, and such a system is required under the building code in effect on the date of loss, the company shall cover the cost of indoor fire sprinklers subject to applicable coverage limits and law and ordinance coverage in the policy.

E. Companies shall not interfere with the policyholder's decision to rebuild in whole or in part pursuant to a prior building code, including but not limited to use of coverage determinations or limitations to influence this decision.

F. A violation of this section may constitute an unfair claims settlement practice under sections 10-3-1103 and 10-3-1104(1)(h), C.R.S.

Section 5 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 6 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 7 Effective Date

This regulation shall become effective December 15, 2022.

Section 8 History

New regulation effective December 15, 2022.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2022-00549

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Insurance

on 10/24/2022

3 CCR 702-5

PROPERTY AND CASUALTY

The above-referenced rules were submitted to this office on 10/24/2022 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.

November 09, 2022 09:16:27

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Board of Nursing

CCR number

3 CCR 716-1

Rule title

3 CCR 716-1 NURSING RULES AND REGULATIONS 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF REGULATORY AGENCIES

Division of Professions and Occupations - State Board of Nursing

NURSING RULES AND REGULATIONS

3 CCR 716-1

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

1.1 RULES AND REGULATIONS FOR THE LICENSURE OF PRACTICAL AND PROFESSIONAL NURSES

A. BASIS: The authority for the promulgation of these rules and regulations by the State Board of Nursing is set forth in sections 12-20-202(3), 12-20-204(1), 12-255-107(1)(b),(d) and (j), 12-255-109, 12-255-110, 12-255-114, 12-255-115, and 12-255-121, C.R.S.

…

F. LICENSURE BY ENDORSEMENT

1. Pursuant to the Occupational Credential Portability Program under section 12-20-202(3), C.R.S., an applicant is entitled to licensure as a professional or practical nurse by endorsement in Colorado if the applicant has met the requirements of Sections (D)(1), (2) and (5) of Rule 1.1 is currently licensed in good standing in another state or U.S. territory, or through the federal government, or holds a military occupational specialty, as defined in section 24-4-201, C.R.S., and has submitted satisfactory proof under penalty of perjury that:

    a. The applicant:

        (1) Has substantially equivalent experience or credentials that are required by Article 255 of Title 12, C.R.S.; or

        (2) Has held for at least one year a current and valid license as a professional or practical nurse in a jurisdiction with a scope of practice that is substantially similar to the scope of practice for professional and practical nurses specified in Article 255 of Title 12, C.R.S.

…

2. The Board may deny such license if:

    a. The Board demonstrates by a preponderance of evidence, after notice and opportunity for a hearing, that the applicant:

        (1) Lacks the requisite substantially equivalent education, experience, or credentials for a license; or

…

3. An applicant who is not currently licensed in good standing in another state or U.S. territory or through the federal government is eligible for licensure as a professional or practical nurse by endorsement in Colorado if the applicant has met the requirements of Section (D) of Rule 1.1 (D) and:

   a. Has been previously licensed in another state or territory of the United States or through the federal government, graduated from an Approved Nursing Education Program or a recognized military education program approved by a board of nursing of a state or territory of the United States, passed the NCLEX exam, and has demonstrated competency as defined in section 12-20-202(3), C.R.S.; or

   b. Has been previously licensed as a professional nurse in another state or territory of the United States or through the federal government, graduated from a Nontraditional Nursing Education Program, and has worked a minimum of 2,000 hours as a professional nurse and has provided evidence of demonstrated continued competency requirements as defined in section 12-20-202(3), C.R.S.; or

   c. Has an encumbered license in another state or territory of the United States or through the federal government, only after review and approval by the Board.

…

1.10 RULES AND REGULATIONS FOR CERTIFICATION AS A NURSE AIDE

A. BASIS: The authority for the promulgation of these rules and regulations by the State Board of Nursing ("Board") specifically in relation to sections 12-255-107, 12-255-202, 12-255-203, 12-255-204, 12-255-205, and 12-255-206, C.R.S.; and as set forth in sections 12-20-202(3), 12-20-204(1), 12-255-107(1)(j), 12-255-206, C.R.S.

…

E. CERTIFICATION BY ENDORSEMENT

1. Pursuant to the Occupational Credential Portability Program under section 12-20-202(3), C.R.S., an applicant is entitled to certification as a nurse aide by endorsement in Colorado if the applicant is currently certified in good standing in another state or US territory or through the federal government, or holds a military occupational specialty, as defined in section 24-4-201, C.R.S., and has submitted satisfactory proof under penalty of perjury that:

   a. The applicant:

      (1) Has substantially equivalent education, experience, or credentials that are required by Article 255 of Title 12, C.R.S.; or

      (2) Has held for at least one year a current and valid certificate as a nurse aide in a jurisdiction with a scope of practice that is substantially similar to the scope of practice for nurse aides as specified in Article 255 of Title 12, C.R.S., and these rules.

   …

   d. The Board may deny such registration if:

(1) …

(a) Lacks the requisite substantially equivalent education, experience, or credentials for certification; or

…

1.14 RULES AND REGULATIONS TO REGISTER PROFESSIONAL NURSES QUALIFIED TO ENGAGE IN ADVANCED PRACTICE REGISTERED NURSING

A. BASIS: The authority for the promulgation of these rules and regulations by the State Board of Nursing ("Board") is set forth in sections 12-20-202(3), 12-20-204(1), 12-255-107(1)(e) and (j), 12-255-111, and 12-255-113, C.R.S.

…

D. REQUIREMENTS FOR INCLUSION ON THE ADVANCED PRACTICE REGISTRY

…

5. Registration by Endorsement

a. …

(1) The professional is currently in the advanced practice registry or is recognized as an advanced practice nurse in good standing in another state or US territory or through the federal government, or holds a military occupational specialty, as defined in section 24-4-201, C.R.S., and has submitted satisfactory proof under penalty of perjury that:

(a) The professional nurse

(i) Has substantially equivalent experience or credentials that are required by Article 255 of Title 12 C.R.S.; or

(ii) Has held for at least one year a current and valid registration or recognition as an advanced practice nurse in another jurisdiction with a scope of practice that is substantially similar to the scope of practice for advanced practice nurses as specified in Article 255 of Title 12, C.R.S., and these Rules

…

(2) The Board may deny inclusion in the registry if:

(b) The Board demonstrates by a preponderance of evidence, after notice and opportunity for a hearing that the professional nurse:

(i) Lacks the requisite substantially equivalent education, experience, or credentials for a inclusion in the registry; or

(ii) Has committed an act that would be grounds for disciplinary action under Article 255 of Title 12, C.R.S.;

b. A professional nurse may be included on the advanced practice registry by endorsement if:

(1) The professional nurse holds active national certification, as described in Section (D)(4)(d) above, in the Role and, where applicable, the Population Focus for which the Applicant seeks inclusion on the APR and possesses an appropriate graduate degree as determined by the board. Verification of current certification or recertification, as may be appropriate, shall be submitted by the applicant as part of the application process or in another manner approved by the Board.

…

1.31 RULES REGARDING THE USE OF BENZODIAZEPINES

The basis for the Board's promulgation of these rules and regulations by the State Board of Nursing is set forth in sections 12-20-204(1), 12-255-107, and 12-30-109(6), C.R.S.

The purpose for the Board's promulgation of these rules and regulations is to implement rules required by section 12-30-109(6), C.R.S., related to requirements for prescribing benzodiazepines to patients who have not previously prescribed benzodiazepines within the last twelve months.

A. Licensees must limit any prescription for a continuous benzodiazepine to a 30-day supply, for any patient who has not been prescribed a benzodiazepine in the last 12 months.

Prior to prescribing the second fill of a benzodiazepine for a condition that is not exempt under section 12-280-404(4)(a.5), C.R.S.,, a licensee must comply with the requirements of section 12-280-404(4), C.R.S.

B. The limitation stated in section (A) of this Rule does not apply to patients for whom licensees prescribe benzodiazepines for the following conditions:

1. Epilepsy;

2. A seizure, a seizure disorder, or a suspected seizure disorder;

3. Spasticity;

4. Alcohol withdrawal; or

5. A neurological condition, including a post-traumatic brain injury or catatonia.

C. These rules do not require or encourage abrupt discontinuation, limitation, or withdrawal of benzodiazepines. Licensees are expected to follow generally accepted standards of advanced practice nursing with prescriptive authority, based on an individual patient's needs, in tapering benzodiazepine prescriptions.

1.32 CONCERNING HEALTH CARE PROVIDER DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER

This Rule is promulgated pursuant to sections 12-20-204, 12-30-112, and 12-255-107(1), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health.

The purpose of this Rule is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider.

This Rule applies to health care providers as defined in section 10-16-102(56), C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Publicly available" means, for the purposes of this regulation, searchable on the health care provider's public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The health care provider's public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.

B. Disclosure requirements.

1. An out of network provider may balance bill a covered person for post-stabilization services in accordance with section 10-16-704, C.R.S., and covered nonemergency services in an in-network facility that are not ancillary services if the provider meets the requirements set forth in section 12-30-112(3.5), C.R.S. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix B in compliance with section 12-30-112(3.5), C.R.S.

2. The health care provider shall provide the disclosure contained in Appendix B as set forth in section 12-30-112(3.5), C.R.S.

C. Noncompliance with this Rule may result in the imposition of any of discipline made available by section 12-255-120(1)(e) or 12-255-209(1)(d), C.R.S.

1.33 PROTECTIONS FOR PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401 *et seq.*, 12-255-107(1), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding and abetting, complicity, and conspiracy in the provision of reproductive health care.

2. "Certificate holder" or "certificant" means as defined in section 12-20-102(3), C.R.S.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services,

funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options counseling, and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Registrant" means as defined in section 12-20-102(12), C.R.S.

8. "Regulator" means as defined in section 12-20-102(14), C.R.S.

9. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

B. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on the applicant or registrant's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on a civil or criminal judgment against the applicant or registrant arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on a professional disciplinary action or any other sanction against the applicant's or registrant's professional registration, certification or licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's or registrant's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on the applicant/licensee/registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate, or license based solely on a civil or criminal judgment against the applicant or registrant arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.34 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-255-107(1) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Certificate holder" or "certificant" means as defined in section 12-20-102(3), C.R.S.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

7. "Registrant" means as defined in section 12-20-102(12), C.R.S.

8. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on a civil or criminal judgment against the applicant or registrant regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on a professional disciplinary action against the applicant's or registrant's professional registration, certification or licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's or registrant's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

…

APPENDIX B

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but

are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you believe you've been wrongly billed by a healthcare provider, please contact the State Board of Nursing at dora_nursingboard@state.co.us or at 303-894-7800.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Visit section 12-30-112, C.R.S., for more information about your rights under state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed by a healthcare provider, please contact the State Board of Nursing at dora_nursingboard@state.co.us or at 303-894-7800. Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. Visit section 12-30-112, C.R.S., for more information about your rights under state law. The federal phone number for information and complaints is: 1-800-985-3059.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Visit the State Board of Nursing (https://dpo.colorado.gov/Nursing) website for more information about your rights under section 12-30-112, C.R.S.

Editor's Notes

History

Chapter 1 eff. 07/02/2007.
Chapters XIII; XX eff 10/01/2007. Chapter XVIII repealed eff. 10/01/2007.
Chapters I, IX, XI eff. 12/31/2007.
Chapter XII repealed eff. 06/01/2008.
Chapters I, VII, XVI eff. 10/01/2008.
Chapters I, XIV, XV eff. 12/30/2008.
Chapter X eff. 03/30/2009.
Chapters IX, XX eff. 06/30/2009.
Chapter XXI emergency rule eff. 07/14/2009
Chapter XXI eff. 10/14/2009.
Chapter II eff. 10/30/2009.
Chapter I eff. 12/30/2009.
Chapter XIX repealed eff. 12/30/2009.
Chapters II, III eff. 03/31/2010.
Chapter XIII eff. 06/30/2010. Chapter XXI repealed eff. 06/30/2010.
Chapters XIV, XV eff. 07/01/2010.
Chapters XII, XIX eff. 01/01/2010.
Chapter VII repealed eff. 03/17/2011.
Chapter I eff. 09/14/2011.
Chapters I, IX eff. 07/01/2012.
Chapter XV eff. 09/14/2012.
Chapters 1, 5, 10, 16, 19 eff. 12/15/2012.
Chapters 1, 2, 5, 10, 19 eff. 03/18/2013.
Chapters 20, 22, 23 eff. 06/14/2013.
Chapters 2, 11, 13 eff. 06/14/2014.
Chapters 10, 13 emer. rules eff. 08/05/2015.
Chapter 15 emer. rule eff. 09/01/2015.
Chapters 10, 13 eff. 09/14/2015.
Chapter 15 eff. 11/14/2015.
Chapter 24 eff. 12/30/2015.
Chapter 2 eff. 06/30/2016.

Chapter 13 eff. 06/14/2017
Chapters 5, 6, 14, 15 eff. 09/14/2017.
Chapter 2 eff. 06/14/2018.
Chapters 1, 20 eff. 03/17/2019.
Rules 1.15 K.4, 1.15 L.2, 1.25 eff. 12/15/2019.
Rule 1.26 emer. rule eff. 05/01/2020; expired 08/29/2020.
Rule 1.27 emer. rule eff. 05/11/2020; expired 09/08/2020.
Rule 1.26 emer. rule eff. 08/30/2020.
Rule 1.27 emer. rule eff. 09/09/2020.
Rules 1.1-1.6, 1.10-1.17, 1.19-1.24 emer. rules eff. 10/28/2020.
Rule 1.26 emer. rule eff. 12/07/2020.
Rule 1.27 emer. rule eff. 12/28/2020.
Rules 1.1-1.6, 1.9 F.4, 1.10-1.17, 1.19-1.24, 1.28, Appendix A eff. 12/30/2020.
Rule 1.28 emer. rule eff. 01/11/2021.
Rule 1.26 emer. rule eff. 04/06/2021.
Rule 1.27 emer. rule eff. 04/27/2021.
Rule 1.28 emer. rule eff. 05/11/2021.
Rules 1.29, 1.30, Appendix A eff. 06/14/2021.
Rules 1.26, 1.27, 1.28 emer. rules eff. 07/12/2021.
Rule 1.31 emer. rule eff. 11/01/2021.
Rules 1.26, 1.27, 1.28 emer. rules eff. 11/02/2021.
Rules 1.1 F, G, 1.2 F, G, H, 1.5 A, 1.10 E, 1.13 H.7, 1.14 D, 1.15 B, F, G, 1.16 B, 1.31 eff. 12/15/2021.
Rules 1.26, 1.27, 1.28 emer. rules eff. 03/02/2022.

Annotations

Rule 1.28 E.4 (adopted 10/28/2020) was not extended by Senate Bill 21-152 and therefore expired 05/15/2021.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00557

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Board of Nursing

on 10/19/2022

3 CCR 716-1

NURSING RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 11/08/2022 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.

November 08, 2022 10:40:37

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Plumbing Board

CCR number

3 CCR 720-1

Rule title

3 CCR 720-1 PLUMBING RULES AND REGULATIONS 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF REGULATORY AGENCIES

State Plumbing Board

PLUMBING RULES AND REGULATIONS

3 CCR 720-1

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

…

1.10 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-155-105(1)(e) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

4. "Licensee" means as defined in section 12-20-102(10), C.R.S.

5. "Registrant" means as defined in section 12-20-102(12), C.R.S.

6. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a civil or criminal judgment against the registrant or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a professional disciplinary action against the applicant's, registrant's, or licensee's professional registration or license in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

Editor's Notes

History

Entire rule eff. 01/01/2008.

Entire rule eff. 04/01/2010.

Rules 2.3.A, 2.4.1-2.4.2, 6.4 eff. 09/01/2011.

Entire rule eff. 03/15/2014.

Rules 2.3, 3.1 eff. 12/15/2014.

Entire rule eff. 02/14/2016.

Rules 2.5.1.27, 4.1, 4.2, 4.5.4, 4.5.5, 4.6-4.13, 6.1, 7.4 eff. 04/01/2016.

Rules 1.2 A-C, 1.2 D.4, 1.2 D.7-10, 1.2 E, 1.3, 1.4 A, 1.4 E, 1.6 B.8 eff. 06/14/2020. Rule 1.4.D repealed eff. 06/14/2020.

Rule 1.3 C eff. 08/30/2021.

Rule 1.4 L.2 eff. 12/15/2021.

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Office of the Attorney General

Tracking number: 2022-00554

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Plumbing Board

on 10/26/2022

3 CCR 720-1

PLUMBING RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 14, 2022 16:31:28

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Veterinary Medicine

CCR number

4 CCR 727-1

Rule title

4 CCR 727-1 VETERINARY MEDICINE RULES AND REGULATIONS 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF REGULATORY AGENCIES

State Board of Veterinary Medicine

VETERINARIAN AND VETERINARY TECHNICIAN RULES AND REGULATIONS

4 CCR 727-1

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

…

1.2 SCOPE AND PURPOSE

These regulations shall govern the process to become a Colorado licensed veterinarian, or a Colorado registered veterinary technician and the practice of veterinary medicine in Colorado.

1.3 APPLICABILITY

The provisions of this section shall be applicable to the practice of veterinary medicine in Colorado that includes veterinarians and veterinary technicians.

1.4 DEFINITIONS

This Rule is promulgated pursuant to sections 12-20-204, 12-315-106(5)(g), and 12-315-104, C.R.S., and any defined terms therein are applicable here. In addition to the definitions found in section 12-315-104, C.R.S., the following apply:

A. "Dentistry" means the diagnosing, treating, correcting, changing, relieving, or preventing abnormalities of the oral cavity or associated structures, including surgical, non-surgical, or related procedures.

B. A "veterinarian-client-patient relationship," as defined in section 12-315-104(19), C.R.S., means a relationship established when:

1. The veterinarian has assumed the responsibility for making medical judgments regarding the health of an animal and the need for medical treatment, and the owner or other caretaker has agreed to follow the instruction of the veterinarian;

2. There is sufficient knowledge of an animal by the veterinarian to initiate at least a general or preliminary diagnosis of the medical condition of the animal, which means that the veterinarian has recently seen and is personally acquainted with the keeping and care of the animal by virtue of an examination of the animal or by medically appropriate and timely visits to the premises where the animal is kept; and

3. The practicing veterinarian is readily available, or has arranged for emergency coverage, for follow-up evaluation in the event of adverse reactions or failure of the treatment regimen.

C. "Practice of Veterinary Medicine" as defined in section 12-315-104(14), C.R.S.

1.5 DENTISTRY

…

B. The practice of dentistry requires:

1. Establishing and maintaining a veterinarian-client-patient relationship (VCPR), as defined in section 12-315-104(19), C.R.S.;

…

C. The practice of dentistry, excluding making a diagnosis and performing surgical procedures, may be delegated to veterinary personnel under the direct supervision of a licensed veterinarian pursuant to section 12-315-105(1)(j), C.R.S., and as described in Rule 1.6(B)(1)

…

1.6 SUPERVISION

A. Supervised Practice pursuant to sections 12-315-104(6), (10), and (10.5), and 12-315-116, C.R.S., means the supervising licensed veterinarian directs or supervises the authorized delegated treatment or collection of diagnostic information of a patient.

1. Only a licensed veterinarian in Colorado may diagnose, prescribe, perform surgery, or initiate treatment.

a. These duties, with the exception of rabies vaccination administration pursuant to section 12-315-105(1)(q), C.R.S., cannot be delegated to veterinary personnel other than a veterinary student or veterinary student preceptor.

b. These duties may be delegated to a veterinary student or veterinary student preceptor in compliance with section 12-315-116, C.R.S.

B. "Direction and supervision" as applied in section 12-315-105(1)(j), C.R.S., is "direct supervision" as defined in section 12-315-104(6), C.R.S. Indirect supervision and immediate supervision are applicable under limited circumstances.

1. Direct supervision means the supervising licensed veterinarian is readily available on the premises where the patient is being treated.

2. Immediate Supervision means the supervising licensed veterinarian and any person being supervised are in direct contact with the patient as defined in 12-315-104(10) C.R.S.

3. Indirect supervision ….

4. In a life-threatening emergency…

C. …

1.7 VETERINARIAN LICENSURE REQUIREMENTS

This Rule is promulgated pursuant to sections 12-20-202, 12-20-203, 12-20-204, 12-20-404, 12-315-106(5)(g), 12-315-107, 12-315-108, 12-315-109, 12-315-110, 12-315-111, and 12-315-114, C.R.S.

A. Licensure by Examination

1. All documents required as part of a licensure application, except for license renewal, must be received by the Board within one year of the date of receipt of application. An application is incomplete until the Board receives all additional information requested or required in order to determine whether to grant or deny the application. If all required information is not submitted within the one year period, then the original application materials will be destroyed and the applicant will be required to submit a new application, fee, and all required documentation. The only exception to this are examination results; they will be maintained for an additional one year if the application is not completed within one year of receipt of the application before they are also destroyed if a new application is not filed before that time.

2. Each applicant shall submit a completed Board approved application along with the required fee in order to be considered for licensure approval and must also verify that the applicant:

    a. Graduated from a school or college of veterinary medicine accredited by the American Veterinary Medical Association (AVMA). The applicant must submit official documentation bearing the seal of the institution in the form of one of the following:

        (1) A final official transcript showing proof of degree or

        (2) A letter from the Dean of the School/College of Veterinary Medicine or the College/University Registrar stating that the applicant has been awarded the degree Doctor of Veterinary Medicine.

    b. Graduated from a non-approved school or college of veterinary medicine. The applicant must submit official certificate of completion from one of the following programs in lieu of school transcripts:

        (1) Educational Commission for Foreign Veterinary Graduates (ECFVG) or

        (2) Program for the Assessment of Veterinary Educational Equivalence (PAVE).

    c. Successfully completed the North American Veterinary Licensing Examination (NAVLE) administered by the International Council for Veterinary Assessment (ICVA) after November of 2000.

3. Each applicant will also be required to verify that the applicant:

    a. …

    b. …

    c. Demonstrates current clinical competency and professional ability through at least one of the following:

        (1) …

        (2) …

        (3) …

        (4) …

(5) …

(6) …

(7). Successfully completed a Board approved evaluation by an AVMA accredited institution within one year of the date the application is received, which certifies the applicant's proficiency as equivalent to the current school graduate. An applicant must submit a proposed evaluation for pre-approval by the Board before it is begun. The Board may reject an evaluation for which a proposal has not been pre-approved or for other good cause.

d. The Board may also consider applying one or more of the following towards demonstration of current clinical competency:

(1) …

(2) …

(3) …

B. Licensure by Endorsement

1. In order to be eligible for licensure by endorsement, an applicant must certify that the applicant does not currently possess a revoked, suspended, restricted, or conditional license to practice veterinary medicine, or is currently not pending disciplinary action against such license, in another state or territory of the United States, or through the federal government.

2. Each eligible applicant shall submit a completed Board approved application along with the required fee in order to be considered for licensure approval and must also verify through the state in which, or federal agency through which, he or she is seeking endorsement from that the applicant meets the requirements listed under Rule 1.7(A)(2).

3. The requirements in Rule 1.7(A)(3) apply for purposes of this Rule.

C. Academic License

1. A veterinarian who is employed …

a. …

b. …

c. The requirements in Rule 1.7(A)(2)) apply.

2. …

D. Education, Training, or Service Gained During Military Service and Military Spouses

1. Education, training, or service gained in military …

2. …

b. For the purposes of this Rule

…

c. A temporary license issued to a military spouse is valid for three years after the date of issuance and may not be renewed.

d. The Board hereby waives the application fee for temporary licenses issued.

E. Inactive Status and Reactivation of a License

1. …

a. …

b. …

c. …

d. …

2. …

3. Each applicant for reactivation shall certify the following:

a. …

b. …

c. …

d. …

4. …

5. If the license has been inactive for less than two years, then the applicant is required to submit proof of fulfilling the requirements of Rule 1.7(I) for the two-year period in which his or her license was last active as well as the two-year period in which the license was expired or inactive.

6. If the license has been inactive for two or more years, then the requirements in Rule 1.7(A)(3)(c) apply.

7. All applicants for reactivation are required to fulfill the substance use prevention training requirements..

F. Reinstatement Requirements for Expired Licenses

1. …

a. …

b. …

2. If the license has been expired for less than two years, then the applicant is required to submit proof of fulfilling the continuing education requirements for the two-year period in

which the applicant's license was last active as well as the two-year period in which the license was expired or inactive.

3. If the license has been expired for more than two years, then the requirements in Rule 1.7(A)(3)(c) apply.

4. All applicants for reinstatement are required to fulfill the substance use prevention training requirements.

G. Revocation

…

H. Renewal

A licensed veterinarian is required to renew their license biennially and submit the applicable fee.

I. Continuing Education

1. Each licensed veterinarian or academic veterinarian with an active license in Colorado is required to attend thirty-two hours of educational study per renewal period as set forth in section 12-315-110(3), C.R.S. Continuing education hours may only be applied to one renewal period. This requirement is not applicable to a licensed veterinarian renewing an inactive license. Continuing education hours must include:

a. Two hours of jurisprudence on the Colorado Veterinary Practice Act.

b. At least one hour in Substance Use Prevention Training covering specific topics. (see Rule 1.7(J))2. …

3. …

4. The Board may accept up to sixteen hours of continuing education credit per licensing period for non-biomedical topics including, but not limited to, leadership training, personnel management, client relations, communication training, and practice and personal wellness.

a. No presentation that is primarily promotional in nature regardless of subject material will be acceptable.

5. All licensed veterinarians are required to fulfill the substance use prevention training requirements of Rule 1.7(J). Subject to the approval of the Board, completed substance use prevention training hours that also meet the requirements for continuing education in this Rule may be applied towards the minimum continuing education hours required.

J. Substance Use Prevention Training for License Renewal, Reactivation, or Reinstatement

1. …

2. Training for the purpose of this section includes, but is not limited to, relevant and verifiable continuing education courses, conferences, or presentations, and distance learning. All such training must cover or be related to the topics specified in section 12-30-114(1)(a), C.R.S., and be in accordance with Rule 1.7(I).

3. …

4. This section shall apply to any applicant for reinstatement or reactivation of an expired or inactive license..

5. Applicants for license renewal, reactivation, or reinstatement shall attest during the application process to either their compliance with this substance use training requirement or their qualifying for an exemption.

6. …

7. Subject to the approval of the Board, completed substance use prevention training hours that also meet the requirements for continuing education may be applied towards the minimum continuing education hours required.

8. …

1.8 VETERINARY TECHNICIAN REGISTRATION REQUIREMENTS

This Rule is promulgated pursuant to sections 12-20-202, 12-20-203, 12-20-204, 12-20-404, 12-315-201, 12-315-202, 12-315-203(4), and 12-315-207, C.R.S.

A. Registration by Examination

1. All documents required as part of a registration application, except for registration renewal, must be received by the Board within one year of the date of receipt of application. An application is incomplete until the Board receives all additional information requested or required in order to determine whether to grant or deny the application. If all required information is not submitted within the one year period, then the original application materials will be destroyed and the applicant will be required to submit a new application, fee, and all required documentation.

2. Each applicant shall submit a completed Board approved application along with the required fee in order to be considered for registration approval and must also verify that the applicant:

   a. Holds a current credential from the Board-approved credentialing organization.

3. Each applicant will also be required to verify that the applicant:

   a. Accurately and completely list any acts that would be grounds for disciplinary action under the Veterinary Practice Act and provide a written explanation of the circumstances of such act, including supporting documentation if required.

   b. Accurately and completely provide any and all information pertaining to any final or pending disciplinary action by any state or jurisdiction in which the applicant is or has been previously credentialed.

B. Provisional Registration

1. Between January 1, 2023, and January 1, 2024, Colorado applicants who do not meet the examination registration requirements may apply for a provisional registration.

2. Each applicant shall submit a completed Board approved application along with the required fee in order to be considered for provisional registration approval and must also verify that the applicant completed the following:

a. Proof of current employment in the role or performing the duties of a veterinary technician;

b. Intent or desire to practice as a veterinary technician in Colorado.

3. Provisional registration is repealed as of October 1, 2028, as specified in section 12-315-203(4)(f), C.R.S.

C. Registration by Completion of Provisional Requirements

1. If an applicant meets the requirements pursuant to section 12-315-203(4)(c), C.R.S., on or before December 31, 2027, the applicant may apply for credentialing directly with the Board-approved credentialing organization. Once credentialed, the applicant may submit a completed Board-approved application, the required fee for registration approval, and verification that the applicant holds a current credential from the Board-approved credentialing organization.

2. Between January 1, 2023, and January 1, 2028, individuals holding a provisional registration may pursue registration as a veterinary technician as described below:

a. Each applicant with a provisional registration shall submit a completed Board-approved application along with the required fee in order to be considered for registration approval and shall verify that the applicant holds a current credential from the Board-approved credentialing organization.

3. An applicant may submit a request to the Board for a hardship extension to extend the provisional registration expiration date to a date no later than June 30, 2028.

4. Registration by Completion of Provisional Requirements is repealed as of October 1, 2028, as specified in section 12-315-203(4)(f), C.R.S.

D. Registration by Endorsement

1. In order to be eligible for registration by endorsement, an applicant must certify that the applicant does not currently possess a revoked, suspended, restricted, or conditional credential to practice as a veterinary technician, or is not currently pending disciplinary action against such credential, in another state or territory of the United States or through the federal government.

2. Each eligible applicant shall submit a completed Board approved application along with the required fee in order to be considered for registration approval and verify through the state in which, or federal agency through which, the applicant is seeking endorsement that the applicant satisfies the requirements of the occupational credential portability program.

E. Inactive Status and Reactivation of a Registration

1. A veterinary technician may apply to the Board to inactivate their registration.

a. If a veterinary technician registration is inactive, the veterinary technician shall not perform acts restricted to active registered veterinary technicians in Colorado pursuant to section 12-20-203(3), C.R.S., or use the title “veterinary technician”, or “registered veterinary technician” or the initials “RVT” or “VT” as restricted in section 12-315-204, C.R.S. The Board shall retain jurisdiction over inactive

veterinary technicians for the purposes of disciplinary action pursuant to section 12-315-207, C.R.S.

b. Practicing as a veterinary technician with an inactive registration shall constitute unregistered practice and, therefore, may be grounds for disciplinary or injunctive action, up to and including revocation.

c. Registered veterinary technicians with inactive registrations are required to renew their registration every two years and submit the applicable fee.

d. To be considered for registration reactivation, an applicant must submit a completed reactivation application form and the reactivation fee. Each applicant for reactivation shall certify the following:

(1) Every credential or registration to practice as a veterinary technician held by applicant is in good standing;

(2) Applicant has reported to the Board any injunction or disciplinary action completed or pending against the applicant's credential or registration to practice as a veterinary technician in any state;

(3) Applicant has reported to the Board any malpractice judgment, any settlement of a malpractice action or claim, and any malpractice action or claim pending against the applicant in which the malpractice allegedly relates to the applicant's practice as a veterinary technician;

(4) Applicant has reported to the Board any inquiry/complaint pending, investigation being conducted by, or disciplinary proceeding pending before the licensing, grievance, or disciplinary board of any jurisdiction in which the applicant is registered or credentialed to practice as a veterinary technician in which the complaint, investigation, or proceeding concerns the applicant's practice.

e. The Board may decline to reactivate a registration if disciplinary action is pending or if there is an unresolved complaint.

f. If the registration or credential has been inactive for less than two years, then the applicant is required to submit proof of fulfilling the requirements for the two-year period in which the individual's registration was last active as well as the two-year period in which the registration or credential was expired or inactive.

g. If the registration or credential has been inactive for two or more years, then the requirements in Rule 1.8(A)(2) apply.

F. Reinstatement Requirements for Expired Registration

1. In order to reinstate or reactivate a registration back into active status, each applicant shall submit a completed Board approved application along with the required fee in order to be considered for registration approval and must also verify that the applicant:

a. Accurately and completely lists any acts that would be grounds for disciplinary action under the Veterinary Practice Act and provides a written explanation of the circumstances of such act, including supporting documentation, if required, since last renewing their registration to an active status in this state.

b. Accurately and completely provides any and all information pertaining to any final or pending disciplinary action by any state or jurisdiction in which the applicant is or has been previously credentialed since last renewing the individual's registration to an active registration in this state.

c. Holds a current credential from the Board-approved credentialing entity.

G. Revocation

1. Any person whose registration to practice is revoked will be ineligible to apply for any registration under the Veterinary Practice Act for at least two years after the date of revocation or surrender of the registration. Any subsequent application for registration shall be treated as an application for an original registration.

H. Renewal

1. A registered veterinary technician is required to renew their registration every two years, submit the applicable fee, and provide proof of current credential from the Board-approved credentialing organization.

2. A veterinary technician's renewal fee will be waived while on active duty with any branch of the Armed Services of the United States pursuant to section 12-315-206(2), C.R.S. **1.9 VETERINARY PROFESSIONAL REPORTING CHANGE OF ADDRESS, TELEPHONE NUMBER, OR NAME**

This Rule is promulgated pursuant to sections 12-20-204 and 12-315-106(5)(g), C.R.S.

A. A veterinary professional shall inform the Board in a clear, explicit, and unambiguous written statement of any name, address, or electronic mail address, change within thirty days of the change. The Board will not change the veterinary professional's information without explicit written notification from the veterinary professional. Notification by fax or email is acceptable.

B. The Division of Professions and Occupations maintains one mailing address and electronic mailing address for each veterinary professional, regardless of the number of different professional licenses or registrations the veterinary professional may hold.

C. All communication from the Board to a veterinary professional will be to the mailing address or the electronic mail address maintained with the Division of Professions and Occupations.

1. The Board requires one of the following forms of documentation to change a veterinary professional's name or correct a social security number or individual taxpayer identification number:

…

D. Any notification by the Board to a veterinary professional or applicant, required or permitted, under section 12-315-101 *et seq.*, C.R.S. or the State Administrative Procedure Act, found at section 24-4-101 *et seq.*, C.R.S., shall be served personally or by first class mail to the last address of record provided in writing to the Board. Service by mail or electronic mail shall be deemed sufficient and proper upon a veterinary professional or applicant.

1.10 VETERINARY MEDICAL ETHICS AND CODE OF CONDUCT

This Rule is promulgated pursuant to sections 12-20-204 and 12-315-106(5)(g), C.R.S.

A. …

1. Primary Consideration

Veterinary professionals should place the needs of the patient first in their practice of veterinary medicine. This includes the needs to relieve disease, diminish suffering, minimize pain and fear, provide palliative care where appropriate and ensure patient care to the best of their abilities.

2. Care

Once a veterinarian has accepted a patient for care and established a veterinarian-client-patient relationship (VCPR), care must be provided as best as possible within the constraints of the agreed upon parameters of the VCPR. Veterinarians may decline a VCPR in individual cases, and are advised to do so in cases where they lack the appropriate expertise, environment, or experience to practice safely. In cases where the client limits payment, veterinarians are encouraged to clearly inform the client of the prognosis with and without treatment. Veterinary professionals should provide care only within their ability and competence.

3. Twenty-Four Hour Care

Veterinarians who advertise and offer twenty-four hour care to clients must ensure that such care is provided on a twenty-four hour basis. Staff must be available on site throughout the twenty-four hour period, and care given must be documented. If the veterinarian lacks the resources to treat such patients, then the client should be referred to a facility with the necessary resources. The veterinarian should also provide necessary supportive care prior to the transfer, and expedite transfer unless the referral is declined.

4. Emergency Care

In emergency situations, veterinary professionals should provide essential services to patients when necessary to relieve suffering or to save life. If the veterinarian is unable to treat an emergency patient, then the veterinarian should offer to refer the client to a facility with the necessary resources to treat the patient, provide necessary supportive care in the interim prior to transfer, and expedite the transfer unless the referral is declined. Veterinary professionals are encouraged to clearly inform the client of the prognosis with and without treatment.

5. Representations

Veterinary professionals should be honest, fair, and considerate in their dealings with clients and other colleagues. It is unethical for veterinarians to misrepresent their credentials, experience, expertise or academic degrees. Veterinary professionals must not engage in fraud, deceit or misrepresentation, nor become involved in situations where a conflict of interest may occur.

6. …

7. VCPR

The veterinary-client-patient relationship is the basis for veterinary care. To establish such a relationship, the veterinarian should have sufficient knowledge of the patient to understand its current health and render at least a preliminary diagnosis. This would require that the veterinarian is personally acquainted with the patient either through office

or home visits. This section shall not be construed to allow the establishment of a veterinary-client-patient relationship (VCPR) solely by telephonic or other electronic means.

8. Prescription Drugs

Veterinarians may only prescribe medication when they have a VCPR with the patient. Under federal and state law, veterinarians may not sell, distribute, dispense or participate in or arrange for the sale of prescription medicines in any fashion except through a VCPR or in compliance with Rule 1.13. Veterinarians are charged with knowledge of the pharmacy practice act provisions that apply to their practice, as well as the laws and regulations of the federal food and drug administration. When a client requests a copy of a prescription for their animal under current treatment, the veterinarian must provide it to the client.

9. …

10. Communication

The veterinary professional must communicate to the client the procedures, diagnoses, proposed treatments, estimated cost and prognosis for the patient. Such communication should be sufficient to enable the client to understand clearly the problem and the choices that must be made. If other staff is involved in the communication process, it is the responsibility of the veterinary professional to ensure that such communications are appropriate.

11. Advertising

No veterinary professional may advertise Specialty Board Certification without certification by the American Veterinary Medical Association or the National Association of Veterinary Technicians in America in that specialty area. It is unethical to allow one's credentials to be used by any organization that engages in, or has members that engage in, the unauthorized practice of veterinary medicine. A veterinary professional should only advertise information about their practice that is accurate and services that are actually provided.

12. Aiding and Abetting

No veterinary professional may engage in acts that aid and abet the unlicensed practice of veterinary medicine. This includes situations where duties delegated to office staff include duties reserved for veterinarians. This also includes, but is not limited to, employment where non-veterinarians influence or engage in the practice of veterinary medicine.

13. Environment

All veterinary professionals must maintain a sanitary environment in which they care for patients. This includes, but is not limited to, sanitization, disinfection, disposal of water and any other activity required to address the cleanliness in which patients are treated. If veterinary professionals work in clinics they do not own, they are responsible for ensuring that their work is done in a clean environment and within the standards of care.

1.11 RECORD KEEPING REQUIREMENTS

…

1.12 TRANSRECTAL PROCEDURES, OVA TRANSPLANT, EMBRYO TRANSFER, UTERINE LAVAGES, AND REPRODUCTIVE PROCEDURES

…

1.13 WAIVER OF VETERINARIAN-CLIENT-PATIENT RELATIONSHIP FOR ADMINISTERING, DISTRIBUTING, DISPENSING, OR PRESCRIBING IN AN URGENT SITUATION ONLY

…

1.14 FINING SCHEDULE FOR VIOLATIONS OF THE VETERINARY PRACTICE ACT AND BOARD RULES

…

1.15 DECLARATORY ORDERS

…

1.16 REPORTING CONVICTIONS, JUDGMENTS, AND ADMINISTRATIVE PROCEEDINGS

This Rule is promulgated pursuant to sections 12-20-204, 12-315-106(5)(g), and 12-315-112(1)(n), (o), (p), and (q), C.R.S.

A licensee or registrant, as defined in section 12-20-102(10) and (12), C.R.S., means any veterinary professional who is licensed or registered by the Board. Each veterinary professional shall inform the Board in writing within thirty days of any of the following:

A. Reporting Convictions

1. A veterinary professional must report in writing within thirty days the following criminal convictions:

…

B. Reporting Judgments and Administrative Proceedings

1. A veterinary professional must report in writing within thirty days any of the following:

a. A disciplinary action imposed upon the veterinary professional by another jurisdiction that would be a violation of section 12-315-112, C.R.S., including but not limited to, a citation, sanction, probation, civil penalty, or a denial, suspension, revocation, or modification of a license whether it is imposed by consent decree, order, or other decision, for any cause other than failure to pay a license fee by the due date or failure to meet continuing education requirements.

b. Any judgment, award, or settlement of a civil action or arbitration in which there was a final judgment or settlement against the veterinary professional for malpractice of veterinary medicine.

…

1.17 CONFIDENTIAL AGREEMENTS TO LIMIT PRACTICE FOR PHYSICAL ILLNESS, PHYSICAL CONDITION, OR BEHAVIORAL OR MENTAL HEALTH DISORDER

This Rule is promulgated pursuant to sections 12-20-204, 12-30-108, 12-315-124, 12-315-125, and 12-315-208, C.R.S.

A. These requirements apply to a veterinarian or veterinary technician who holds an active license or registration issued by the Board, including a veterinarian issued an academic license.

B. No later than thirty days from the date a physical illness, physical condition, or behavioral or mental health disorder impacts a licensee's ability to practice with reasonable skill and safety, the licensee shall provide the Board, in writing, the following information:

1. The diagnosis and a description of the illness, condition, or disorder;

2. The date the illness, condition, or disorder was first diagnosed;

3. The name of the current treatment provider and documentation from the current treatment provider confirming the diagnosis, date of onset, and treatment plan;

4. A description of the licensee's or registrant's practice and any modifications, limitations or restrictions to that practice that have been made as a result of the illness, condition, or disorder;

5. Whether the licensee or registrant has been evaluated by, or is currently receiving services from the Board's authorized Peer Health Assistance Program related to the illness, condition, or disorder, and, if so, the date of initial contact and whether services are ongoing.

C. Compliance with this Rule is a prerequisite for eligibility to enter into a Confidential Agreement with the Board pursuant to sections 12-315-125 and 12-30-108, C.R.S. However, mere compliance with this Rule does not require the Board to negotiate regarding, or enter into, a Confidential Agreement. Rather, the Board will evaluate all facts and circumstances to determine if a Confidential Agreement is appropriate.

D. If the Board discovers that a licensee has a physical illness, physical condition, or behavioral or mental health disorder that impacts the licensee's or registrant's ability to practice with reasonable skill and safety and the licensee has not notified the Board as required under these Rules of such illness, condition, or disorder, the licensee shall not be eligible for a Confidential Agreement and may be subject to disciplinary action for failure to notify under section 12-315-112, 12-315-207, C.R.S.

1.18 EXPANDED SCOPE OF PRACTICE FOR VETERINARIANS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 028

…

1.19 EXPANDED SCOPE OF PRACTICE FOR VETERINARIANS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 028

…

1.20 RULES REGARDING THE USE OF BENZODIAZEPINE

The basis for the Board's promulgation of these rules and regulations is sections 12-20-204(1), 12-315-106(5)(g) and 12-315-126, C.R.S. The specific statutory authority for the promulgation of this Rule is section 12-30-109(6), C.R.S.

The purpose for the Board's promulgation of these rules and regulations are to implement rules required by section 12-30-109(6), C.R.S., related to requirements for prescribing benzodiazepines to patients that have not been prescribed benzodiazepines within the last twelve months.

A. Licensees must limit any prescription for a benzodiazepine to no more than 30 continuous days, for a patient who has not received a benzodiazepine prescription within the last 12 months.

Prior to prescribing a benzodiazepine for a condition that is not exempt under section 12-280-404(4)(a.5), C.R.S.,, a licensee must comply with the requirements of section 12-280-404(4), C.R.S.

B. The limitation stated in section (A) of this Rule does not apply to patients for whom licensees prescribe benzodiazepines for the following conditions:

1) Epilepsy;

2) A seizure or seizure disorder, or suspected seizure disorder;

3) Spasticity; or

4) A neurological condition, including a posttraumatic brain injury or catatonia.

C. These rules do not require or encourage abrupt discontinuation, limitation, or withdrawal of benzodiazepines. Licensees are expected to follow generally accepted standards of veterinary medicine practice, based on an individual patient's needs, in tapering benzodiazepine prescriptions.

1.21 PROTECTIONS FOR PROVISION OF HUMAN REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, sections 25-6-401 *et seq.*, 12-315-105(6)(g), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Registrant" means as defined in section 12-20-102(12), C.R.S.

8. "Regulator" means as defined in section 12-20-102(14), C.R.S.

9. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

B. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on the applicant's or registrant's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a professional disciplinary action or any other sanction against the applicant's, registrant's, or licensee's professional registration or licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on the applicant/licensee/registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.22 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, sections 12-315-105(6)(g) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

7. "Registrant" means as defined in section 12-20-102(12), C.R.S.

8. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a civil or criminal judgment against the applicant, registrant, or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a professional disciplinary action against the applicant's, registrant's, or licensee's professional registration or licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

Editor's Notes

History

Rules 1.00, 4.00 eff. 09/30/2007.
Rule 4.00 eff. 01/30/2008.
Entire rule eff. 12/30/2011.
Rule I.B eff. 08/30/2012.
Rule I.B emer. rule eff. 02/08/2013.
Rules I.A, 1.B, 1.E eff. 05/30/2013.
Rule I.A eff. 06/14/2013.
Rules I.B, II.A.17 eff. 09/30/2013.
Rule I eff. 08/14/2014.
Rules 1.2 A.8-18, 1.2 E.4, 1.2 G eff. 11/30/2019.
Rule 1.23 emer. rule eff. 05/01/2020; expired 08/29/2020.
Rule 1.24 emer. rule eff. 05/11/2020; expired 09/08/2020.
Rule 1.23 emer. rule eff. 08/30/2020; expired 12/28/2020.
Rule 1.24 emer. rule eff. 09/09/2020.
Entire rule eff. 10/15/2020.
Rule 1.10 B eff. 12/15/2020.
Rules 1.24, 1.25 emer. rules eff. 12/28/2020.
Rule 1.25 emer. rule eff. 01/11/2021.
Rules 1.4 E-F, 1.12 C eff. 04/14/2021.
Rules 1.24, 1.25 emer. rules eff. 04/27/2021.
Rule 1.25 emer. rule eff. 05/11/2021.
Rules 1.24, 1.25 emer. rules eff. 07/12/2021.
Rule 1.26 emer. rule eff. 11/01/2021.
Rules 1.24, 1.25 emer. rules eff. 11/02/2021.
Rules 1.17 C.1, 1.26 eff. 11/30/2021.
Rules 1.24, 1.25 emer. rules eff. 03/02/2022.
Rules 1.24, 1.25 emer. rules eff. 06/28/2022.

PHILIP J. WEISER
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Office of the Attorney General

Tracking number: 2022-00532

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Veterinary Medicine

on 10/13/2022

4 CCR 727-1

VETERINARIAN AND VETERINARY TECHNICIAN RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/27/2022 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.

November 02, 2022 16:00:47

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

4 CCR 732-1 PHYSICAL THERAPY RULES AND REGULATIONS 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF REGULATORY AGENCIES

State Physical Therapy Board

PHYSICAL THERAPY RULES AND REGULATIONS

4 CCR 732-1

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

…

1.7 REQUIRED DISCLOSURE TO PATIENTS – CONVICTION OF OR DISCIPLINE BASED ON SEXUAL MISCONDUCT (Section 12-30-115, C.R.S.)

…

1.8 PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401 *et seq.*, 12-285-106(2)(b), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Regulator" means as defined in section 12-20-102(14), C.R.S.

8. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

9. "Certificate holder" or "certificant" means as defined in section 12-20-102(3), C.R.S.

B. The regulator shall not deny licensure or certification to an applicant or impose disciplinary action against an individual's license or certification based solely on the applicant's, certificant's, or licensee's provision of or assistance in the provision of reproductive health care in this state or

any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure or certification to an applicant or impose disciplinary action against an individual's license or certification based solely on a civil or criminal judgment against the applicant, certificant, or licensee arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny licensure or certification to an applicant or impose disciplinary action against an individual's license or certification based solely on a professional disciplinary action or any other sanction against the applicant's, certificant's, or licensee's professional licensure or certification in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant, certificant, or licensee's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny licensure or certification to an applicant or impose disciplinary action against an individual's certificate or license based solely on the certificant's or licensee's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny licensure or certification to an applicant or impose disciplinary action against an individual's license or certification based solely on a civil or criminal judgment against the applicant, certificant, or licensee arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.9 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-285-106(2)(b) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

4. "Licensee" means as defined in section 12-20-102(10), C.R.S.

5. "Regulator" means as defined in section 12-20-102(14), C.R.S.

6. "Certificate holder" or "certificant" means as defined in section 12-20-102(3), C.R.S.

B. The regulator shall not deny licensure or certification to an applicant or impose disciplinary action against an individual's license or certification based solely on a civil or criminal judgment against the applicant, certificant, or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure or certification to an applicant or impose disciplinary action against an individual's license or certification based solely on a professional disciplinary action against the applicant's, certificant's, or licensee's professional licensure or certification in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, certificant's, or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

1.10 CONCERNING HEALTH CARE PROVIDER DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER

This Rule is promulgated pursuant to the rulemaking authority in sections 12-20-204, 12-30-112, and 12-285-106(2)(b), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health.

The purpose of this Rule is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider.

This Rule applies to health care providers as defined in section 10-16-102(56), C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Publicly available" means, for the purposes of this regulation, searchable on the health care provider's public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The health care provider's public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.

B. Disclosure requirements.

1. An out of network provider may balance bill a covered person for post-stabilization services in accordance with section 10-16-704, C.R.S., and covered nonemergency services in an in-network facility that are not ancillary services if the provider meets the requirements set forth in section 12-30-112(3.5), C.R.S. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix B. The health care provider shall provide the disclosure contained in Appendix B in compliance with section 12-30-112(3.5), C.R.S.

C. Noncompliance with this Rule may result in the imposition of any of discipline made available by sections 12-285-120(1)(p) or 12-285-211(1)(l), C.R.S.

…

1.11 EXPANDED SCOPE OF PRACTICE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 028

…

1.12 EXPANDED SCOPE OF PRACTICE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 028

…

APPENDIX B

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you believe you've been wrongly billed by a healthcare provider, please contact the Colorado State Physical Therapy Board at 303-894-7800 or dora_physicaltherapyboard@state.co.us.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Review section 12-30-112, C.R.S., for more information about your rights under Colorado state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory,

neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed by a healthcare provider, please contact the Colorado State Physical Therapy Board at 303-894-7800 or dora_physicaltherapyboard@state.co.us. The federal phone number for information and complaints is: 1-800-985-3059.

Visit www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

Visit https://dpo.colorado.gov/PhysicalTherapy for more information about your rights under Colorado state law, pursuant to section 12-30-112, C.R.S.

Editor's Notes

History

Rules 7, 10, 11 eff. 11/30/2007.

Rule 6 eff. 03/30/2011.

Rules 1-11 emer. rules repealed eff. 03/09/2012.

Rules 1-11 emer. rules eff. 03/09/2012.

Rules 1-11, 303, 304 emer. rules eff. 04/02/2012.

Rules 301, 302, 305, 306 emer. rules eff. 06/01/2012.

Rules 201-211, 301-305 eff. 06/30/2012. Rules 1-11 repealed eff. 06/30/2012.

Rules 101-102, 212, 214 eff. 01/30/2013.

Rule 215 emer. rule eff. 06/02/2014.

Rules 202-203, 205, 215, 303 eff. 09/14/2014.

Rules 207, 213 eff. 11/01/2014.

Rules 102, 103, 201-206, 208, 212, 302-306 eff. 05/15/2015.

Rules 101-107, 201-202, 204-207, 210, 212-213, 215, 301-306 eff. 11/14/2016. Rules 209, 214 repealed eff. 11/14/2016.

Rules 106, 107, 201, 204, 213, 303, 305 eff. 03/02/2017.

Rule 211 emer. rule eff. 01/11/2019.

Rules 204, 205, 206, 211, 213, 303, 304, 305, 307 eff. 04/30/2019.

Rule 1.4 emer. rule eff. 05/01/2020; expired 08/29/2020.

Rule 1.5 emer. rule eff. 05/11/2020; expired 09/08/2020.

Rule 1.4 emer. rule eff. 08/30/2020.

Rule 1.5 emer. rule eff. 09/09/2020.

Rules 1.2 F, 1.3 E, 1.6, Appendix A eff. 12/15/2020.

Rules 1.4, 1.5 emer. rules eff. 12/28/2020.

Rule 1.7 emer. rule eff. 01/11/2021.

Rules 1.4, 1.5 emer. rules eff. 04/27/2021.

Rule 1.7 emer. rule eff. 05/11/2021.

Rules 1.6, Appendix A eff. 06/14/2021.

Rules 1.4, 1.7 emer. rules eff. 07/12/2021.

Entire rule eff. 10/15/2021.

Rules 1.4, 1.7 emer. rules eff. 11/02/2021.

Rules 1.4, 1.7 emer. rules eff. 03/02/2022.

Rules 1.4, 1.7 emer. rules eff. 06/28/2022.

Annotations

Rule 1.6 E.4 (adopted 10/15/2020) was not extended by Senate Bill 21-152 and therefore expired 05/15/2021.

PHILIP J. WEISER
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Office of the Attorney General

Tracking number: 2022-00533

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Physical Therapy Board

on 10/13/2022

4 CCR 732-1

PHYSICAL THERAPY RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/13/2022 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.

November 02, 2022 08:54:18

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Board of Unlicensed Psychotherapists

CCR number

4 CCR 734-1

Rule title

4 CCR 734-1 UNLICENSED PSYCHOTHERAPISTS RULES AND REGULATIONS 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF REGULATORY AGENCIES

State Board of Unlicensed Psychotherapists

UNLICENSED PSYCHOTHERAPISTS RULES AND REGULATIONS

4 CCR 734-1

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

AUTHORITY

1.17 CONCERNING HEALTH CARE PROVIDER DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER

This Rule is promulgated pursuant to the rulemaking authority in sections 12-20-204, 12-30-112, and 12-245-204(4)(a), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health.

The purpose of this Rule is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider.

This Rule applies to health care providers as defined in section 10-16-102(56), C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Publicly available" means, for the purposes of this regulation, searchable on the health care provider's public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The health care provider's public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.

B. Disclosure requirements.

1. An out of network provider may balance bill a covered person for post-stabilization services in accordance with section 10-16-704, C.R.S., and covered nonemergency services in an in-network facility that are not ancillary services if the provider meets the requirements set forth in section 12-30-112(3.5), C.R.S. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix B. The health care provider shall provide the disclosure contained in Appendix B in compliance with section 12-30-112(3.5), C.R.S.

C. Noncompliance with this Rule may result in the imposition of any of discipline made available by section 12-245-224(1)(b), C.R.S.

1.18 PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401 *et seq.*, 12-245-204(4)(a), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

5. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

6. "Registrant" means as defined in section 12-20-102(12), C.R.S.

7. "Regulator" means as defined in section 12-20-102(14), C.R.S.

8. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

B. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on the applicant or registrant's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a civil or criminal judgment against the applicant or registration arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a professional disciplinary action or any other sanction against the applicant's or registrant's professional registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant or registrant's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on the registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a civil or criminal judgment against the applicant or registration arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.19 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-245-204(4)(a) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

4. "Registrant" means as defined in section 12-20-102(12), C.R.S.

5. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a civil or criminal judgment against the applicant or registrant regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a professional disciplinary action against the applicant's or registrant's professional registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's or registrant's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

…

APPENDIX B

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you believe you've been wrongly billed by a healthcare provider, please contact the State Board of Unlicensed Psychotherapists at dora_mentalhealthboard@state.co.us or at 303-894-7800.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. Visit section 12-30-112, C.R.S., for more information about your rights under state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
    - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed by a healthcare provider, please contact the State Board of Unlicensed Psychotherapists at dora_mentalhealthboard@state.co.us or at 303-894-7800.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. Visit section 12-30-112, C.R.S., for more information about your rights under state law. The federal phone number for information and complaints is: 1-800-985-3059.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Visit the State Board of Unlicensed Psychotherapists website (https://dpo.colorado.gov/UnlicensedPsychotherapy) for more information about your rights under section 12-30-112, C.R.S.

Editor's Notes

History

Entire rule emer. rule eff. 12/16/2011.

Entire rule eff. 02/15/2012.

Authority, Purpose and Scope, rules 1.1 A, 1.1 E, 1.4 B.1, 1.6, 1.7 B.3, 1.8 - 1.10, 1.12, 1.14 emer. rules eff. 10/16/2020.

Authority, Purpose and Scope, rules 1.1 A, 1.1 E, 1.4 B.1, 1.6, 1.7 B.3, 1.8 - 1.10, 1.12 - 1.16, Appendix A eff. 12/15/2020.

Rules 1.6 A, 1.16, Appendix A eff. 06/14/2021.

Rule 1.8 B eff. 12/15/2021.

Annotations

Rule 1.16 E.4. (adopted 10/16/2020) was not extended by Senate Bill 21-152 and therefore expired 05/15/2021.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2022-00553

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Board of Unlicensed Psychotherapists

on 10/21/2022

4 CCR 734-1

UNLICENSED PSYCHOTHERAPISTS RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/24/2022 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.

November 08, 2022 16:01:12

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Marriage and Family Therapist Examiners

CCR number

4 CCR 736-1

Rule title

4 CCR 736-1 MARRIAGE AND FAMILY THERAPIST EXAMINERS RULES AND REGULATIONS 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF REGULATORY AGENCIES

Board of Marriage and Family Therapist Examiners

MARRIAGE AND FAMILY THERAPIST EXAMINERS RULES AND REGULATIONS

4 CCR 736-1

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

…

1.12 OCCUPATIONAL CREDENTIAL PORTABILITY PROGRAM (C.R.S. §§ 12-245-207, 12-20-202(3))

A. General. To be considered for licensure by endorsement pursuant to the Occupational Credential Portability Program under sections 12-20-202(3) and 12-245-207, C.R.S., an applicant must submit a completed application form, all supporting documentation, and the appropriate fee.

B. Complaints/inquiries, investigations, disciplinary actions. The Board may decline to issue a license to an applicant for licensure by endorsement pursuant to the Occupational Credential Portability Program if approving the license would violate an existing compact or reciprocity agreement or if the Board demonstrates by a preponderance of evidence, after notice and opportunity for a hearing, that the applicant:

1. Lacks the requisite substantially equivalent experience or credentials to practice marriage and family therapy; or

2. Has committed an act that would be grounds for disciplinary action under the law governing the practice of marriage and family therapy.

C. Criteria. In accordance with section 12-20-202(3), C.R.S., an applicant who possesses a current and unrestricted license, in good standing, to practice marriage and family therapy in another state or United States territory or through the federal government, or who holds a military occupational specialty, as defined in section 24-4-201, C.R.S., may apply to the Board for licensure by endorsement pursuant to the Occupational Credential Portability Program. To apply for endorsement, the applicant must satisfy the following criteria:

1. Applicant submits to the Board:

a. Satisfactory Proof that:

(1) Applicant holds a master's or doctoral degree in marriage and family therapy from an accredited program or holds a master's or doctoral degree from a program that was equivalent to an accredited program in marriage and family therapy.

(2) Applicant attests to having passed a national or state examination, the content of which tested competence to practice marriage and family therapy.

(3) Applicant attests that s/he had at least two years of post- master's or one year of post-doctoral practice in individual and marriage and family

therapy under CLINICAL supervision prior to licensure, certification, listing or registration in the jurisdiction through which applicant seeks licensure in Colorado; or applicant attests to the Board her/his active practice of marriage and family therapy for two years (as defined below); OR

b. Satisfactory proof that the applicant has held for at least one year a current and unrestricted license, in good standing, to practice marriage and family therapy in another jurisdiction with a scope of practice that is substantially similar to the scope of practice for marriage and family therapists pursuant to Part 5 of the Mental Health Practice Act.

2. Applicant must attest that they:

a. Have reported to the Board any injunction entered against her/him and any injunctive action pending against her/him on any license.

b. Have reported any malpractice judgment, settlement, or claim, and any pending action or claim.

c. Have reported any pending complaint, investigation, or disciplinary proceeding before the licensing, grievance, or disciplinary Board of any jurisdiction in which a license, registration, or certification to practice as a marriage and family therapist is held and where the complaint, investigation, or proceeding concerns the practice of marriage and family therapy.

d. Have reported any applicable misdemeanor or felony conviction(s).

e. Have reported to the Board any prior disciplinary action by another jurisdiction.

3. Submit verification of licensure from each jurisdiction(s) in which, and each federal agency and military branch through which, applicant has ever been licensed, registered, listed or certified. The verification can be retrieved by the applicant from the jurisdiction's or federal government agency's web site as long as the following information is included and can be verified if necessary:

a. Date license was originally issued.

b. Date of license expiration.

c. Disciplinary history, if applicable.

If the complete information is not available, then the Verification of License Form must be completed by each state or federal government agency.

4. Applicant submits proof that she/he is at least twenty-one years of age

5. As used in this Rule, "active practice of marriage and family therapy" means applicant has engaged in the practice of marriage and family therapy at least twenty hours per week, averaged over the entire time s/he has been in practice, with no more than a six month absence from the practice of marriage and family therapy. If applicant has taught marriage and family therapy, applicant may count the hours spent teaching marriage and family therapy (including time spent in preparation, meeting with students, and related activities) as hours of active practice of marriage and family therapy provided such teaching was in courses in the same or similar field of marriage and family therapy as the

competence area claimed by applicant; teaching of marriage and family therapy shall not count more than one-third of the number of active practice hours claimed by applicant.

D. Jurisprudence Examination. Each applicant shall pass a Board developed jurisprudence examination.

…

1.23 CONCERNING HEALTH CARE PROVIDER DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER

This Rule is promulgated pursuant to the rulemaking authority in sections 12-20-204, 12-30-112, and 12-245-204(4)(a), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health.

The purpose of this Rule is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider.

This Rule applies to health care providers as defined in section 10-16-102(56), C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Publicly available" means, for the purposes of this regulation, searchable on the health care provider's public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The health care provider's public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.

B. Disclosure requirements.

1. An out of network provider may balance bill a covered person for post-stabilization services in accordance with section 10-16-704, C.R.S., and covered nonemergency services in an in-network facility that are not ancillary services if the provider meets the requirements set forth in section 12-30-112(3.5), C.R.S. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix B. The health care provider shall provide the disclosure contained in Appendix B in compliance with section 12-30-112(3.5), C.R.S.

C. Noncompliance with this Rule may result in the imposition of any of discipline made available by section 12-245-224(1)(b), C.R.S.

1.24 PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401 *et seq.*, 12-245-204(4)(a), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Regulator" means as defined in section 12-20-102(14), C.R.S.

8. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

9. "Registrant" means as defined in section 12-20-102(12), C.R.S.

B. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's license or registration based solely on the applicant, registrant's, or licensee's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a professional disciplinary action or any other sanction against the applicant's, registrant's, or licensee's professional licensure or registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's registration or license based solely on the licensee's or registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.25 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-245-204(4)(a) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

4. "Licensee" means as defined in section 12-20-102(10), C.R.S.

5. "Regulator" means as defined in section 12-20-102(14), C.R.S.

6. "Registrant" means as defined in section 12-20-102(12), C.R.S.

B. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against the applicant, registrant, or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a professional disciplinary action against the applicant's, registrant's, or licensee's professional licensure or registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

…

APPENDIX B

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is

likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you believe you've been wrongly billed by a healthcare provider, please contact the State Board of Marriage and Family Therapist Examiners at dora_mentalhealthboard@state.co.us or at 303-894-7800. Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. Visit section 12-30-112, C.R.S., for more information about your rights under state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.
- Generally, your health plan must:
    - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
    - Cover emergency services by out-of-network providers.
    - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.

- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed by a healthcare provider, please contact the State Board of Marriage and Family Therapist Examiners at dora_mentalhealthboard@state.co.us or at 303-894-7800. Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. The federal phone number for information and complaints is: 1-800-985-3059.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Visit the State Board of Marriage and Family Therapist Examiners website (https://dpo.colorado.gov/MarriageFamilyTherapy) for more information about your rights under section 12-30-112, C.R.S.

Editor's Notes

History

Rule 17(a) emer. rule eff. 10/26/2007; expired eff. 01/26/2008.

Rule 17 eff. 03/01/2008.

Purpose and Scope, rules 12, 15, 19, 20 emer. rules eff. 01/01/2011.

Purpose and Scope, rules 12, 15, 19, 20 eff. 02/01/2011.

Entire rule emer. rule eff. 12/09/2011.

Entire rule eff. 02/01/2012.

Rule 12 eff. 05/02/2016.

Rules 1.6 A, 1.14 A, 1.14 C.1, 1.14 C.6.a, 1.16 A emer. rules eff. 10/23/2020.

Rules 1.6 A, 1.12, 1.14 A, 1.14 C.1, 1.14 C.6.a, 1.16 A, 1.22, Appendix A eff. 12/15/2020.

Rules 1.6 A, 1.12 C-D, 1.22, Appendix A eff. 06/30/2021.

Rule 1.8 B eff. 12/30/2021.

Annotations

Rules 1.12 C., 1.12 D., 1.22 E.4. (adopted 10/23/2020) were not extended by Senate Bill 21-152 and therefore expired 05/15/2021.

PHILIP J. WEISER
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ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00555

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Marriage and Family Therapist Examiners

on 10/28/2022

4 CCR 736-1

MARRIAGE AND FAMILY THERAPIST EXAMINERS RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/28/2022 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.

November 15, 2022 14:19:30

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Board of Licensed Professional Counselor Examiners

CCR number

4 CCR 737-1

Rule title

4 CCR 737-1 LICENSED PROFESSIONAL COUNSELOR EXAMINERS RULES AND REGULATIONS 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF REGULATORY AGENCIES

State Board of Licensed Professional Counselor Examiners

LICENSED PROFESSIONAL COUNSELOR EXAMINERS RULES AND REGULATIONS

4 CCR 737-1

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

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1.12 OCCUPATIONAL CREDENTIAL PORTABILITY PROGRAM (C.R.S.§ § 12-245-207, 12-20-202(3))

A. General. To be considered for licensure by endorsement pursuant to the Occupational Credential Portability Program pursuant to sections 12-20-202(3) and 12-245-207, C.R.S., an applicant must submit a completed application form, all supporting documentation, and the appropriate fee.

B. Complaints/inquiries, investigations, disciplinary actions. The Board may decline to issue a license to an applicant for licensure by endorsement pursuant to the Occupational Credential Portability Program if the Board demonstrates by a preponderance of evidence, after notice and opportunity for a hearing, that the applicant:

1. Lacks the requisite substantially equivalent education, experience, or credentials to practice professional counseling; or

2. Has committed an act that would be grounds for disciplinary action under the law governing the practice of professional counseling.

C. Criteria. In accordance with section 12-20-202(3), C.R.S., an applicant who possesses a current and unrestricted license, in good standing, to practice professional counseling in another state or United States territory or through the federal government, or who holds a military occupational specialty, as defined in section 24-4-201, C.R.S., may apply to the Board for licensure by endorsement pursuant to the Occupational Credential Portability Program. To apply for endorsement, the applicant must satisfy the following criteria:

1. Applicant submits to the Board:

a. Satisfactory proof that:

(1) Applicant holds a master's or doctoral degree in professional counseling from an accredited program or holds a master's or doctoral degree from a program that was equivalent to an accredited program in professional counseling as provided under Rule 1.14;

(2) At the time of application for a Colorado license by endorsement, the applicant attests to having passed an examination, the content of which tested competence to practice professional counseling, including special knowledge and skills in psychotherapy; and

(3) Applicant attests that s/he had at least two years of post- master's or one year of post-doctoral practice in psychotherapy or professional

counseling under supervision prior to licensure, certification, listing or registration in the jurisdiction through which the applicant seeks licensure in Colorado and that that post-degree experience hours obtained for licensure in another jurisdiction has substantially similar requirements to what is outlined in Board Rule 1.14 Licensure by Examination; or the applicant attests to the Board her/his active practice of professional counseling for two years (as defined below), OR

b. Satisfactory proof that the applicant has held for at least one year a current and unrestricted license, in good standing, to practice professional counseling in another jurisdiction with a scope of practice that is substantially similar to the scope of practice for licensed professional counselors pursuant to Part 6 of the Mental Health Practice Act.

2. Applicant must attest that they:

a. Have reported to the Board any injunction entered against her/him and any injunctive action pending against her/him on any license.

b. Have reported any malpractice judgment, settlement, or claim, and any pending action or claim.

c. Have reported any pending complaint, investigation, or disciplinary proceeding before the licensing, grievance, or disciplinary Board of any jurisdiction in which a license, registration or certification to practice professional counseling is held and where the complaint, investigation, or proceeding concerns the practice of professional counseling.

d. Have reported any applicable misdemeanor or felony conviction(s).

e. Have reported to the Board any prior disciplinary action by another jurisdiction.

3. Applicant submits verification of licensure from each jurisdiction(s) in which, and each federal agency or military branch through which, applicant has ever been licensed, registered, listed or certified to practice professional counseling. The verification can be retrieved by the applicant from the jurisdiction's or federal government agency's website as long as the following information is included and can be verified if necessary:

a. Date license was originally issued.

b. Date of license expiration.

c. Disciplinary history, if applicable.

If the complete information is not available, then the Verification of License Form must be completed by each state and federal agency or military branch, as applicable.

4. Applicant submits proof that he/she is at least twenty-one years of age.

5. As used in this Rule, "Active practice of professional counseling" means the applicant has engaged in the practice of professional counseling at least twenty hours per week, averaged over the entire time s/he has been in practice, with no more than a six-month absence from the practice of professional counseling. If the applicant has taught professional counseling, the applicant may count the hours spent teaching professional counseling (including time spent in preparation, in meeting with students, and in related

activities) as hours of active practice of professional counseling provided such teaching was in courses in the same or similar field of professional counseling as the competence area claimed by the applicant; teaching of professional counseling shall not count more than one-third of the number of active practice hours claimed by applicant.

D. Jurisprudence Examination. Each applicant shall pass a Board developed jurisprudence examination.

…

1.24 PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401, *et seq.*, 12-245-204(4)(a) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Regulator" means as defined in section 12-20-102(14), C.R.S.

8. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

9. "Registrant" means as defined in section 12-20-102(12), C.R.S.

B. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on the applicant's, registrant's, or licensee's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care

provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a professional disciplinary action or any other sanction against the applicant's, registrant's, or licensee's professional licensure or registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's registration or license based solely on the licensee's or registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.25 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-245-204(4)(a) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

4. "Licensee" means as defined in section 12-20-102(10), C.R.S.

5. "Regulator" means as defined in section 12-20-102(14), C.R.S.

6. "Registrant" means as defined in section 12-20-102(12), C.R.S.

B. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against the applicant, registrant, or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a professional disciplinary action against the applicant's, registrant's, or licensee's professional licensure or registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

1.26 CONCERNING HEALTH CARE PROVIDER DISCLOSURES TO CONSUMERS ABOUT THE POTENTIAL EFFECTS OF RECEIVING EMERGENCY OR NONEMERGENCY SERVICES FROM AN OUT-OF-NETWORK PROVIDER

This Rule is promulgated pursuant to the rulemaking authority in sections 12-20-204, 12-30-112, and 12-245-204(4)(a), C.R.S., in consultation with the Commissioner of Insurance and the State Board of Health.

The purpose of this Rule is to establish requirements for health care providers to provide disclosures to consumers about the potential effects of receiving emergency or non-emergency services from an out-of-network provider.

This Rule applies to health care providers as defined in section 10-16-102(56), C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Publicly available" means, for the purposes of this regulation, searchable on the health care provider's public website, displayed in a manner that is easily accessible, without barriers, and that ensures that the information is accessible to the general public, including that it is findable through public search engines. The health care provider's public website must be accessible free of charge, without having to establish a user account, password, or other credentials, accept any terms or conditions, and without having to submit any personal identifying information.

B. Disclosure requirements.

1. An out of network provider may balance bill a covered person for post-stabilization services in accordance with section 10-16-704, C.R.S., and covered nonemergency services in an in-network facility that are not ancillary services if the provider meets the requirements set forth in section 12-30-112(3.5), C.R.S. If a consumer has incurred a claim for emergency or nonemergency health care services from an out-of-network provider, the health care provider shall provide the disclosures contained in Appendix B. The health care provider shall provide the disclosure contained in Appendix B in compliance with section 12-30-112(3.5), C.R.S.

C. Noncompliance with this Rule may result in the imposition of any of discipline made available by section 12-245-224(1)(b), C.R.S.

…

APPENDIX B

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays and the full amount charged for a service. This is called "balance billing." This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're protected from balance billing for:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

If you believe you've been wrongly billed by a healthcare provider, please contact the State Board of Licensed Professional Counselor Examiners at dora_mentalhealthboard@state.co.us or at 303-894-7800.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law.

Visit section 12-30-112, C.R.S., for more information about your rights under state law.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have these protections:

- You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:

- Cover emergency services without requiring you to get approval for services in advance (also known as “prior authorization”).
- Cover emergency services by out-of-network providers.
- Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
- Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you’ve been wrongly billed by a healthcare provider, please contact the State Board of Licensed Professional Counselor Examiners at dora_mentalhealthboard@state.co.us or at 303-894-7800.

Visit the CMS No Surprises Act website (https://www.cms.gov/nosurprises/consumers) for more information about your rights under federal law. The federal phone number for information and complaints is: 1-800-985-3059.

Visit https://dpo.colorado.gov/ProfessionalCounselor for more information about your rights under section 12-30-112, C.R.S.

Editor’s Notes

History

Rules 10, 17 emer. rules eff. 01/29/2008.

Rules 10, 17 eff. 03/01/2008.

Rules 12, 15, 19, 20 emer. rules eff. 01/01/2011.

Rules 12, 15, 19, 20 eff. 03/01/2011.

Entire rule emer. rule eff. 12/13/2011.

Entire rule eff. 02/01/2012.

Rule 14 eff. 07/01/2012.

Rule 12 eff. 03/16/2016.

Rules 1.6 A, 1.6 B.2, 1.7, 1.14, 1.22 emer. rules eff. 09/25/2020.

Rules 1.6 A, 1.6 B.2, 1.7, 1.12, 1.14, 1.16, 1.22, 1.23, Appendix A eff. 11/14/2020.

Rule 1.6 A eff. 04/30/2021.

Rules 1.12 C-D, 1.23, Appendix A eff. 08/30/2021.

Rule 1.8 B eff. 10/30/2021.

Annotations

Rules 1.12 C., 1.12 D., 1.23 E.4. (adopted 09/25/2020) were not extended by Senate Bill 21-152 and therefore expired 05/15/2021.

PHILIP J. WEISER
Attorney General

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Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2022-00633

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Board of Licensed Professional Counselor Examiners

on 11/04/2022

4 CCR 737-1

LICENSED PROFESSIONAL COUNSELOR EXAMINERS RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 11/04/2022 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.

November 15, 2022 14:35:59

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Hazardous Materials and Waste Management Division

CCR number

6 CCR 1007-1 Part 07

Rule title

6 CCR 1007-1 Part 07 RADIATION CONTROL - USE OF RADIONUCLIDES IN THE HEALING ARTS 1 - eff 12/15/2022

Effective date

12/15/2022

PUBLICATION INSTRUCTIONS FOR
6 CCR 1007-1, Part 7,
Use of radionuclides in the healing arts

Adopted by the Board of Health on October 19, 2022

[Publication Instructions: STRIKE the text from the beginning of the rule through the title of the rule below the solid line, and INSERT the revised/updated/added text below to incorporate an adoption and effective date.]

[* * * indicates unaffected sections of the rule]

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Hazardous Materials and Waste Management Division

RADIATION CONTROL - USE OF RADIONUCLIDES IN THE HEALING ARTS

6 CCR 1007-1 Part 07

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

Adopted by the Board of Health October 19, 2022, effective date December 15, 2022.

PART 7: USE OF RADIONUCLIDES IN THE HEALING ARTS

USE OF RADIONUCLIDES IN THE HEALING ARTS

* * *

[Publication Instructions: STRIKE the current Section 7.1.5.1, and INSERT the revised text below to update the rulemaking effective date.]

7.1.5.1 Throughout this Part 7, federal regulations, state regulations, and standards or guidelines of outside organizations have been adopted and incorporated by reference. Unless a prior version of the incorporated material is otherwise specifically indicated, the materials incorporated by reference cited herein include only those versions that were in effect as of the most recent effective date of this Part 7 (December 15, 2022), and not later amendments or editions of the incorporated material.

* * *

[Publication Instructions: In Section 7.2 (Definitions), STRIKE the current definitions for "Authorized medical physicist", "Authorized nuclear pharmacist", and "Authorized user" and INSERT the following revised definitions, to address minor phrasing differences for consistency with federal rule.]

"Authorized medical physicist" (AMP) means an individual who meets the requirements of Appendix 7B; or

(1) Is identified as an authorized medical physicist or teletherapy physicist on:

a. A specific medical use license issued by the Department, NRC, or Agreement State;

b. A medical use permit issued by an NRC master material licensee;

c. A permit issued by an NRC or Agreement State broad scope medical use licensee; or

d. A permit issued by an NRC master material license broad scope medical use permittee.

"Authorized nuclear pharmacist" (ANP) means a pharmacist who meets the requirements of Appendix 7C; or

(1) Is identified as an authorized nuclear pharmacist on:

a. A specific license issued by the Department, NRC, or Agreement State that authorizes medical use or the practice of nuclear pharmacy;

b. A permit issued by an NRC master material licensee that authorizes medical use or the practice of nuclear pharmacy;

c. A permit issued by an NRC or Agreement State broad scope medical use licensee that authorizes medical use or the practice of nuclear pharmacy; or

d. A permit issued by an NRC master material license broad scope medical use permittee that authorizes medical use or the practice of nuclear pharmacy; or

(2) Is identified as an authorized nuclear pharmacist by a commercial nuclear pharmacy that has been authorized to identify authorized nuclear pharmacists; or

(3) Is designated as an authorized nuclear pharmacist in accordance with Part 3.

"Authorized user" (AU) means a physician, dentist, or podiatrist who meets the applicable requirements of Appendix 7D through Appendix 7M; or

(1) Is identified as an authorized user on:

a. A Department, NRC, or Agreement State license that authorizes the medical use of radioactive material;

b. A permit issued by an NRC master material licensee that is authorized to permit the medical use of radioactive material;

c. A permit issued by an NRC or Agreement State specific licensee of broad scope that is authorized to permit the medical use of radioactive material; or

d. A permit issued by an NRC master material license broad scope permittee that is authorized to permit the medical use of radioactive material.

* * *

[Publication Instructions: In Section 7.2, STRIKE the current definition for "Ophthalmic physicist" and INSERT the following revised definition for consistency with federal rule.]

"Ophthalmic physicist" means an individual who:

(1) Meets the requirements in 7.41.6.1(2) and 7.65; and

(2) Is identified as an ophthalmic physicist on a:

a. Specific medical use license issued by the Department, NRC or an Agreement State;

b. Permit issued by the Department, NRC or Agreement State broad scope medical use licensee;

c. Medical use permit issued by a NRC master material licensee; or

d. Permit issued by a NRC master material license broad scope medical use permittee.

* * *

[Publication Instructions: In Section 7.2, STRIKE the current definition for "Sealed Source and Device Registry" and INSERT the following revised definition so it is consistent with federal rule.]

"Sealed Source and Device Registry" means the national registry that contains all the registration certificates, generated by both the Nuclear Regulatory Commission and the Agreement States, that summarize the radiation safety information for the sealed sources and devices and describe the licensing and use conditions approved for the product.

* * *

[Publication Instructions: STRIKE Section 7.3.1.1, and INSERT the following revised language to update a cross-reference.]

7.3.1.1 A person may manufacture, produce, acquire, receive, possess, prepare, use, or transfer radioactive material for medical use only in accordance with a specific license issued by the Department, an Agreement State or NRC, or as allowed in 7.3.1.2.

* * *

[Publication Instructions: STRIKE Section 7.3.2.3, and INSERT the following revised language to incorporate minor text updates for consistency with current rule formatting.]

7.3.2.3 A licensee not authorized pursuant to Part 3, Section 3.11 shall apply for and receive approval of a specific amendment to its Department license before conducting research involving human subjects;

* * *

[Publication Instructions: STRIKE Section 7.3.4.5, and INSERT the following revised language to incorporate minor text updates for consistency with current rule formatting.]

7.3.4.5 An applicant that satisfies the requirements specified in Part 3, Section 3.11 may apply for a Type A specific license of broad scope.

* * *

[Publication Instructions: STRIKE Section 7.3.5.7 and 7.3.5.8, and INSERT the following revised language to incorporate minor text updates for consistency with current rule formatting.]

7.3.5.7 The mobile medical service shall designate and manage each area of use in the client's facility as a restricted area while radioactive material is present. For each location where radioactive materials will be routinely used, the licensee shall provide to the Department:

(1) A diagram of the location of use, including information about the placement of required postings; and

(2) Calculation(s) or survey(s) results that demonstrate compliance with applicable dose limits in Part 4, Sections 4.14 and 4.15 at the location of use.

7.3.5.8 The mobile medical service shall ensure that:

(1) Supervision by an authorized user is in accordance with 7.10.1;

(2) Radiation exposures to the client's personnel working in the client facility are:

(a) Below the dose limits to members of the public listed in Part 4, Section 4.14; or

(b) The client's personnel are instructed as described in Part 10, Section 10.3 and monitored for exposure in accordance with Part 4, Section 4.18 unless the licensee can demonstrate that Section 4.18 does not apply.

* * *

[Publication Instructions: STRIKE Section 7.3.6, and INSERT the following revised language to add a comma.]

7.3.6 A licensee possessing a Type A specific license of broad scope for medical use, issued under Part 3 of these regulations, is exempt from:

* * *

[Publication Instructions: STRIKE Section 7.4.2.4, and INSERT the following revised language to incorporate minor wording changes for consistency with federal rule.]

7.4.2.4 An individual who is identified as an authorized user, an authorized nuclear pharmacist, authorized medical physicist, or an ophthalmic physicist:

(1) On a NRC or Agreement State license or other equivalent permit or license recognized by the Department that authorizes the use of radioactive material in medical use or in the practice of nuclear pharmacy;

(2) On a permit issued by a NRC or Agreement State specific license of broad scope that is authorized to permit the use of radioactive material in medical use or in the practice of nuclear pharmacy;

(3) On a permit issued by a NRC master material licensee that is authorized to permit the use of radioactive material in medical use or in the practice of nuclear pharmacy; or

(4) By a commercial nuclear pharmacy that has been authorized to identify authorized nuclear pharmacists.

* * *

[Publication Instructions: STRIKE Section 7.5.2.4, and INSERT the following revised language to incorporate minor text updates for consistency with current rule formatting.]

7.5.2.4 The licensee's name changes, but the name change does not constitute a transfer of control of the license as described in Part 3, Section 3.15.2 of these regulations; or

* * *

[Publication Instructions: STRIKE Section 7.7.1, and INSERT the following revised language to incorporate minor text updates for consistency with current rule formatting.]

7.7.1 In addition to the radiation protection program requirements of Part 4, Section 4.5 of these regulations, a licensee's management shall approve in writing:

* * *

[Publication Instructions: STRIKE Section 7.10 through 7.10.2.2, and INSERT the following revised language to incorporate minor text updates for consistency with current rule formatting and alignment.]

7.10 Supervision.

7.10.1 A licensee that permits the receipt, possession, use, or transfer of radioactive material by an individual under the supervision of an authorized user as allowed by 7.3.1.2(1) shall:

7.10.1.1 In addition to the requirements of Part 10, Section 10.3 of these regulations, instruct the supervised individual in the licensee's written radiation protection procedures, written directive procedures, regulations of Part 7, and license conditions with respect to the use of radioactive material; and

7.10.1.2 Require the supervised individual to follow the instructions of the supervising authorized user for medical uses of radioactive material, written radiation protection procedures, written directive procedures, regulations of Part 7, and license conditions with respect to the medical use of radioactive material.

7.10.2 A licensee that permits the preparation of radioactive material for medical use by an individual under the supervision of an authorized nuclear pharmacist or physician who is an authorized user, as allowed by 7.3.1.2(2), shall:

7.10.2.1 In addition to the requirements of Part 10, Section 10.3, instruct the supervised individual in the preparation of radioactive material for medical use, as appropriate to that individual's use of radioactive material; and

7.10.2.2 Require the supervised individual to follow the instructions of the supervising authorized user or authorized nuclear pharmacist regarding the preparation of radioactive material for medical use, the written radiation protection procedures, the regulations of Part 7, and license conditions.

* * *

[Publication Instructions: STRIKE Section 7.23 through 7.23.7 (inclusive), and INSERT the following revised text to incorporate minor formatting/alignment changes and eliminate unneeded spaces in the current rule.]

7.23 Report and notification of a dose to an embryo/fetus or a nursing child

7.23.1 A licensee shall report any dose to an embryo/fetus that is greater than 5 mSv (500 mrem) dose equivalent that is a result of an administration of radioactive material or radiation from radioactive material to a pregnant individual unless the dose to the embryo/fetus was specifically approved, in advance, by the authorized user.

7.23.2 A licensee shall report any dose to a nursing child, that was not specifically approved, in advance, by the authorized user, that is a result of an administration of radioactive material to a breast feeding individual that:

7.23.2.1 Is greater than 5 millisievert (500 mrem) total effective dose equivalent; or

7.23.2.2 Has resulted in unintended permanent functional damage to an organ or a physiological system of the child, as determined by a physician.

7.23.3 The licensee shall notify by telephone the Department no later than the next calendar day after discovery of a dose to the embryo/fetus or nursing child that requires a report in 7.23.1 or 7.23.2.

7.23.4 The licensee shall submit a written report to the Department within 15 days after discovery of a dose to the embryo/fetus or nursing child that requires a report in 7.23.1 or 7.23.2.

7.23.4.1 The written report must include:

(1) The licensee's name;

(2) The name of the prescribing physician;

(3) A brief description of the event;

(4) Why the event occurred;

(5) The effect on the embryo/fetus or the nursing child;

(6) What actions, if any, have been taken, or are planned, to prevent recurrence; and

(7) Certification that the licensee notified the pregnant individual or mother (or the mother's or child's responsible relative or guardian), and if not, why not.

7.23.4.2 The report must not contain the individual's or child's name or any other information that could lead to identification of the individual or child.

7.23.5 The licensee shall provide notification of the event to the referring physician and also notify the pregnant individual or mother, both hereafter referred to as the mother, no later than 24 hours after discovery of an event that would require reporting under 7.23.1 or 7.23.2, unless the referring physician personally informs the licensee either that he or she will inform the mother or that, based on medical judgment, telling the mother would be harmful. The licensee is not required to notify the mother without first consulting with the referring physician. If the referring physician or mother cannot be reached within 24 hours, the licensee shall make the appropriate notifications as soon as possible thereafter. The licensee may not delay any appropriate medical care for the embryo/fetus or for the nursing child, including any necessary remedial care as a

result of the event, because of any delay in notification. To meet the requirements of 7.23.5, the notification may be made to the mother's or child's responsible relative or guardian instead of the mother, when appropriate. If a verbal notification is made, the licensee shall inform the mother, or the mother's or child's responsible relative or guardian, that a written description of the event can be obtained from the licensee upon request. The licensee shall provide such a written description if requested.

7.23.6 A licensee shall:

7.23.6.1 Annotate a copy of the report provided to the Department with the:

(1) Name of the pregnant individual or the nursing child who is the subject of the event; and

(2) Identification number or if no other identification number is available, the social security number of the individual who is the subject of the event.

7.23.7 A copy of the record required under 7.23.6 shall be provided to the referring physician, if other than the licensee, within 15 days after discovery of the event.

* * *

[Publication Instructions: STRIKE Section 7.40.3, and INSERT the following revised text to correct a typographical error.]

7.40.3 Sealed sources and devices for diagnostic medical uses may be used in research in accordance with an active Investigational Device Exemption (IDE) application accepted by the U.S. Food and Drug Administration provided the requirements of 7.14.1 are met.

* * *

[Publication Instructions: STRIKE Section G header through 7.41.6.3(2)(b), and INSERT the following revised text to make minor formatting/alignment adjustments and minor wording updates for consistency with federal rule.]

Section G – Manual Brachytherapy

7.41 Calibration measurements of brachytherapy sources.

7.41.1 Before the first medical use of a brachytherapy source, a licensee shall have:

7.41.1.1 Determined the source output or activity using a dosimetry system that meets the requirements of 7.53;

7.41.1.2 Determined source positioning accuracy within applicators; and

7.41.1.3 Used published protocols currently accepted by nationally recognized bodies to meet the requirements of 7.41.1.1 and 7.41.1.2.

7.41.2 Instead of a licensee making its own measurements as required in 7.41.1, the licensee may use measurements provided by the source manufacturer or by a calibration laboratory accredited by the American Association of Physicists in Medicine that are made in accordance with 7.41.1.

7.41.3 A licensee shall mathematically correct the outputs or activities determined in 7.41.1 for physical decay at intervals consistent with 1 percent physical decay.

7.41.4 An authorized medical physicist shall perform or review the measurements and calculations made pursuant to 7.41.1, 7.41.2, or 7.41.3.

7.41.5 A licensee shall retain a record of each calibration as follows:

7.41.5.1 A licensee shall maintain a record of the calibrations of brachytherapy sources required by 7.41.1 for 3 years after the last use of the source.

7.41.5.2 The record must include:

(1) The date of the calibration;

(2) The manufacturer's name, model number, and serial number for the source and the instruments used to calibrate the source;

(3) The source output or activity;

(4) The source positioning accuracy within the applicators; and

(5) The name of the individual, the source manufacturer, or the calibration laboratory that performed the calibration.

7.41.6 Strontium-90 sources for ophthalmic treatments.

7.41.6.1 Licensees who use strontium-90 for ophthalmic treatments must ensure that certain activities as specified in 7.41.6.2 are performed by either:

(1) An authorized medical physicist; or

(2) An individual who:

(a) Is identified as an ophthalmic physicist on a specific medical use license issued by NRC or an Agreement State; permit issued by a NRC or Agreement State broad scope medical use licensee; medical use permit issued by a NRC master material licensee; or permit issued by a NRC master material license broad scope medical use permittee; and

(b) Holds a master’s or doctor’s degree in physics, medical physics, other physical sciences, engineering, or applied mathematics from an accredited college or university; and

(c) Has successfully completed 1 year full-time training in medical physics and an additional year of full-time work experience under the supervision of a medical physicist; and

(d) Has documented training in:

(i) The creation, modification, and completion of written directives;

(ii) Procedures for administrations requiring a written directive; and

(iii) Performing the calibration measurements of brachytherapy sources as detailed in 7.41.1 through 7.41.5.

7.41.6.2 The individuals who are identified in 7.41.6.1 must:

(1) Calculate the activity of each strontium-90 source that is used to determine the treatment times for ophthalmic treatments. The decay must be based on the activity determined under 7.41.1 through 7.41.5; and

(2) Assist the licensee in developing, implementing, and maintaining written procedures to provide high confidence that the administration is in accordance with the written directive. These procedures must include the frequencies that the individual meeting the requirements in 7.41.6.1 will observe treatments, review the treatment methodology, calculate treatment time for the prescribed dose, and review records to verify that the administrations were in accordance with the written directives.

7.41.6.3 Licensees must retain a record of the activity of each strontium-90 source as follows:

(1) A licensee shall maintain a record of the activity of a strontium-90 source required by 7.41.6 for the life of the source.

(2) The record must include:

(a) The date and initial activity of the source as determined under 7.41.1 through 7.41.5; and

(b) For each decay calculation, the date and the source activity as determined under 7.41.6.

* * *

[Publication Instructions: STRIKE 7.43.2.4 through 7.44.3, and INSERT the following revised text to make minor formatting/alignment corrections and minor wording updates for consistency with current rules.]

7.43.2.4 Visitor control, including both;

(1) Routine visitation to hospitalized individuals in accordance with Part 4, Section 4.14.1.1; and

(2) Visitation authorized in accordance with Part 4, Section 4.14.3; and

7.43.2.5 Notification of the RSO, or his or her designee, and the authorized user if the patient or the human research subject dies or has a medical emergency.

7.43.3 A licensee shall retain a record of individuals receiving safety instructions required by 7.43.1 and maintain such records for 3 years. The record must include a list of the topics covered, the date of the instruction, the names(s) of the attendee(s), and the name(s) of the individual(s) who provided the instruction.

7.44 Safety precautions.

7.44.1 For each patient or the human research subject that is receiving brachytherapy and cannot be released in accordance with 7.26, a licensee shall:

7.44.1.1 Not place the patient or the human research subject in the same room with a patient who is not receiving radiation therapy;

7.44.1.2 Visibly post the patient's or human research subject's door with a "Caution: Radioactive Material" sign and note on the door or on the patient's or human research subject's chart where and how long visitors may stay in the patient's or human research subject's room.

7.44.2 A licensee shall have emergency response equipment available near each treatment room to respond to a source that inadvertently becomes:

7.44.2.1 Dislodged from the patient; or

7.44.2.2 Lodged within the patient following removal of the source applicators.

7.44.3 A licensee shall notify the RSO, or his or her designee, and an authorized user as soon as possible if the patient or human research subject has a medical emergency or dies.

* * *

[Publication Instructions: STRIKE 7.47 through 7.48.3, and INSERT the following revised text to make minor formatting/alignment adjustments and minor wording updates for consistency with federal rules.]

7.47 Therapy-related computer systems.

7.47.1 The licensee shall perform acceptance testing on the treatment planning system of therapy-related computer systems in accordance with published protocols accepted by nationally recognized bodies.

7.47.2 At a minimum, the acceptance testing required by 7.47.1 shall include, as applicable, verification of:

7.47.2.1 The source-specific input parameters required by the dose calculation algorithm;

7.47.2.2 The accuracy of dose, dwell time, and treatment time calculations at representative points;

7.47.2.3 The accuracy of isodose plots and graphic displays; and

7.47.2.4 The accuracy of the software used to determine radioactive source positions from radiographic images.

Section H - Photon Emitting Remote Afterloader Units, Teletheraphy Units, and Gamma Stereotactic Radiosurgery Units

7.48 Use of a sealed source in a remote afterloader unit, teletherapy unit, or gamma stereotactic radiosurgery unit.

7.48.1 A licensee must only use sealed sources:

7.48.1.1 Approved and as provided for in the Sealed Source and Device Registry in photon emitting remote afterloader units, teletherapy units, or gamma stereotactic radiosurgery units to deliver therapeutic doses for medical uses; or

7.48.1.2 In research involving photon-emitting remote afterloader units, teletherapy units, or gamma stereotactic radiosurgery units in accordance with an active Investigational Device Exemption (IDE) application accepted by the U.S. Food and Drug Administration provided the requirements of 7.14.1 are met.

7.48.2 A licensee must use photon-emitting remote afterloader units, teletherapy units, or gamma stereotactic radiosurgery units:

7.48.2.1 Approved in the Sealed Source and Device Registry to deliver a therapeutic dose for medical use. These devices may be used for therapeutic medical treatments that are not explicitly provided for in the Sealed Source and Device Registry, but must be used in accordance with radiation safety conditions and limitations described in the Sealed Source and Device Registry; or

7.48.2.2 In research in accordance with an active Investigational Device Exemption (IDE) application accepted by the FDA provided the requirements of 7.14.1 are met.

7.48.3 Training For Use of a Remote Afterloader Unit, Teletherapy Unit, or Gamma Stereotactic Radiosurgery Unit.

The licensee shall require an authorized user under 7.48 to meet the requirements of Appendix 7M.

* * *

[Publication Instructions: STRIKE 7.58 through 7.58.6.9, and INSERT the following revised text to make minor formatting/alignment corrections and minor wording updates for consistency with federal rule.]

7.58 Periodic spot checks for teletherapy units.

7.58.1 A licensee authorized to use teletherapy units for medical use shall perform output spot checks on each teletherapy unit once in each calendar month that include determination of:

7.58.1.1 Timer accuracy, and timer linearity over the range of use;

7.58.1.2 “On off” error;

7.58.1.3 The coincidence of the radiation field and the field indicated by the light beam localizing device;

7.58.1.4 The accuracy of all distance measuring and localization devices used for medical use;

7.58.1.5 The output for one typical set of operating conditions measured with the dosimetry system described in 7.53; and

7.58.1.6 The difference between the measurement made in 7.58.1.5 and the anticipated output, expressed as a percentage of the anticipated output (i.e., the value obtained at last full calibration corrected mathematically for physical decay).

7.58.2 A licensee shall perform spot checks required by 7.58.1 in accordance with procedures established by the authorized medical physicist. That individual need not actually perform the output spot-check measurements.

7.58.3 A licensee shall have the authorized medical physicist review the results of each spot check within 15 days. The authorized medical physicist shall notify the licensee as soon as possible in writing of the results of each spot check.

7.58.4 A licensee authorized to use a teletherapy unit for medical use shall perform safety spot checks of each teletherapy facility once in each calendar month and after each source installation to assure proper operation of:

7.58.4.1 Electrical interlocks at each teletherapy room entrance;

7.58.4.2 Electrical or mechanical stops installed for the purpose of limiting use of the primary beam of radiation restriction of source housing angulation or elevation, carriage or stand travel, and operation of the beam “on off” mechanism;

7.58.4.3 Source exposure indicator lights on the teletherapy unit, on the control console, and in the facility;

7.58.4.4 Viewing and intercom systems;

7.58.4.5 Treatment room doors from inside and outside the treatment room; and

7.58.4.6 Electrically assisted treatment room doors with the teletherapy unit electrical power turned “off”.

7.58.5 If the results of the checks required in 7.58.4 indicate the malfunction of any system, a licensee shall lock the control console in the “off” position and not use the unit except as may be necessary to repair, replace, or check the malfunctioning system.

7.58.6 A licensee shall maintain a record of each spot check required by 7.58.1 and 7.58.4, and a copy of the procedures required by 7.58.2 for 3 years. The record shall include:

7.58.6.1 The date of the spot check;

7.58.6.2 The manufacturer's name, model number, and serial number for the teletherapy unit, source, and instrument used to measure the output of the teletherapy unit;

7.58.6.3 An assessment of timer linearity and constancy;

7.58.6.4 The calculated “on off” error;

7.58.6.5 A determination of the coincidence of the radiation field and the field indicated by the light beam localizing device

7.58.6.6 The determined accuracy of each distance measuring or localization device;

7.58.6.7 The difference between the anticipated output and the measured output;

7.58.6.8 Notations indicating the operability of each entrance door electrical interlock, each electrical or mechanical stop, each source exposure indicator light, and the viewing and intercom system and doors; and

7.58.6.9 The name of the individual who performed the periodic spot check and the signature of the authorized medical physicist who reviewed the record of the spot check.

* * *

[Publication Instructions: In Appendix 7A, STRIKE 7A3.2 through 7A3.3, and INSERT the following revised text to for consistency with federal rule. For final publication, ensure each appendices begins at the top of the page.]

7A3.2 Is an authorized user, authorized medical physicist, or authorized nuclear pharmacist identified on a Department, NRC or an Agreement State license, a permit issued by a NRC master material licensee, a permit issued by a NRC or an Agreement State licensee of broad scope, or a permit issued by a NRC master material license broad scope permittee, has experience with the radiation safety aspects of similar types of use of radioactive material for which the licensee seeks the approval of the individual as the RSO or ARSO, and meets the requirements in 7A4;

or

7A3.3 Has experience with the radiation safety aspects of the types of use of radioactive material for which the individual is seeking simultaneous approval both as the Radiation Safety Officer and the authorized user on the same new medical use permit issued by a NRC master material licensee. The individual must also meet the requirements in 7A4.

* * *

[Publication Instructions: In Appendix 7C, STRIKE 7C1.1 and INSERT the following revised text to for consistency with federal rule. For final publication, ensure each appendices begins at the top of the page.]

7C1.1 Have graduated from a pharmacy program accredited by the Accreditation Council for Pharmacy Education (ACPE) (previously named the American Council on Pharmaceutical Education) or have passed the Foreign Pharmacy Graduate Examination Committee (FPGEC) examination;

* * *

[Publication Instructions: In Appendix 7P, STRIKE 7P2.2 and INSERT the following revised text to for consistency with federal rule. For final publication, ensure each appendices begins at the top of the page.]

7P2.2 Physicians, dentists, or podiatrists not identified as authorized users for the medical use of radioactive material on a license issued by the NRC or an Agreement State, a permit issued by a NRC master material licensee, a permit issued by a NRC or an Agreement State broad scope licensee, or a permit issued in accordance with a NRC master material broad scope license on or before October 24, 2005, need not comply with the training requirements of Sections D through H for those materials and uses that these individuals performed on or before October 24, 2005, as follows:

* * *

PUBLICATION INSTRUCTIONS FOR
6 CCR 1007-1, Part 17,
Transportation of radioactive materials

Adopted by the Board of Health on October 19, 2022

[Publication Instructions: STRIKE the text from the beginning of the rule through the title of the rule below the solid line, and INSERT the revised/updated/added text below to incorporate an adoption and effective date.]

[* * * indicates unaffected sections of the rule]

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Hazardous Materials and Waste Management Division

RADIATION CONTROL - TRANSPORTATION OF RADIOACTIVE MATERIALS

6 CCR 1007-1 Part 17

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

Adopted by the Board of Health October 19, 2022, effective date December 15, 2022.

PART 17: TRANSPORTATION OF RADIOACTIVE MATERIALS

* * *

[Publication Instructions: STRIKE the current Section 17.1.4.1(7) through 17.1.5.2 (inclusive), and INSERT the revised text below to make minor wording updates and align/format text.]

(7) These rules apply to any person required to obtain a Certificate of Compliance or an approved compliance plan from the NRC pursuant to 10 CFR Part 71 if the person delivers radioactive material to a common or contract carrier for transport or transports the material outside the confines of the person's plant or other authorized place of use.

17.1.4.2 The packaging and transport of radioactive material are also subject to other parts of these regulations and to the regulations of other agencies (such as the DOT, the United States Postal Service and the NRC) having jurisdiction over means of transport.

17.1.4.3 The requirements of this part are in addition to, and not in substitution for, other requirements.

17.1.5 Published Material Incorporated by Reference.

17.1.5.1 Throughout this Part 17, federal regulations, state regulations, and standards or guidelines of outside organizations have been adopted and incorporated by reference. Unless a prior version of the incorporated material is otherwise specifically indicated, the materials incorporated by reference cited herein include only those versions that were in effect as of the most recent effective date of this

Part 17 (December 2022), and not later amendments or editions of the incorporated material.

17.1.5.2 Materials incorporated by reference are available for public inspection, and copies (including certified copies) can be obtained at reasonable cost, during normal business hours from the Colorado Department of Public Health and Environment, Hazardous Materials and Waste Management Division, 4300 Cherry Creek Drive South, Denver, Colorado 80246. Additionally, https://www.colorado.gov/cdphe/radregs identifies where the incorporated material is available to the public on the internet at no cost. Due to copyright restrictions, certain materials incorporated in this Part are available for public inspection at the state publications depository and distribution center.

* * *

[Publication Instructions: In Subsection 17.2.2 (Definitions), below the definition for "Type B package", STRIKE the current footnote 1, and INSERT the revised footnote 1 below to add the word "Part" in the reference to 10 CFR (Part) 71.73 for consistency with other regulations. All other aspects of this definition remain as is in the current rule.]

1 A Type B package design is designated as B(U) or B(M). On approval, a Type B package design is designated by NRC as B(U) unless the package has a maximum normal operating pressure of more than 700kPa (100 lb/in2) gauge or a pressure relief device that would allow the release of radioactive material to the environment under the tests specified in 10 CFR Part 71.73 (hypothetical accident conditions), in which case it will receive a designation B(M). B(U) refers to the need for unilateral approval of international shipments; B(M) refers to the need for multilateral approval of international shipments. No distinction is made in how packages with these designations may be used in domestic transportation. To determine their distinction for international transportation, refer to 49 CFR Part 173. A Type B package approved prior to September 6, 1983 was designated only as Type B; limitations on its use are specified in 17.8.

* * *

[Publication Instructions: STRIKE the current Section 17.10.2, and INSERT the revised text below to incorporate the word "Part" when referencing federal rule.]

17.10.2 Each licensee is responsible for satisfying the applicable quality assurance requirements that apply to its use of a packaging for the shipment of licensed material subject to the applicable requirements set forth in Subpart H of 10 CFR Part 71 (excluding 10 CFR Part 71.101(c)(2), (d), and (e) and 10 CFR Part 71.107 through 71.125).

* * *

[Publication Instructions: STRIKE the current Section 17.11 through 17.11.4.4 (inclusive), and INSERT the revised text below to make minor formatting and alignment adjustments and for consistency with federal rule.]

17.11 Advance Notification of Shipment of Nuclear Waste.

17.11.1 As specified in 17.11.3, 17.11.4, and 17.11.5, each licensee shall provide advance notification to the governor of a state, or the governor's designee, of the shipment of licensed material (nuclear waste), within or across the boundary of the state, before the transport, or delivery to a carrier, for transport, of licensed material outside the confines of the licensee's plant or other place of use or storage.

17.11.2 As specified in 17.11.3, 17.11.4, and 17.11.5 of this section, after June 11, 2013, each licensee shall provide advance notification to the Tribal official of participating Tribes referenced in 17.11.4.3(3), or the official's designee, of the shipment of licensed material, within or across the boundary of the Tribe's reservation, before the transport, or delivery to a carrier, for transport, of licensed material outside the confines of the licensee's plant or other place of use or storage.

17.11.3 Advance notification is also required under this section for the shipment of licensed material, other than irradiated fuel, meeting the following three conditions:

17.11.3.1 The licensed material is required by this part to be in Type B packaging for transportation;

17.11.3.2 The licensed material is being transported to or across a state boundary en route to a disposal facility or to a collection point for transport to a disposal facility; and

17.11.3.3 The quantity of licensed material in a single package exceeds the least of the following:

(1) 3000 times the A1 value of the radionuclides as specified in Appendix 17A, Table A1 for special form radioactive material; or

(2) 3000 times the A2 value of the radionuclides as specified in Appendix 17A, Table A1 for normal form radioactive material; or

(3) 1000 TBq (27,000 Ci).

17.11.4 Procedures for submitting advance notification

17.11.4.1 The notification must be made in writing to:

(1) The office of each appropriate governor or governor’s designee;

(2) The office of each appropriate Tribal official or Tribal official’s designee;

(3) The Department; and

(4) The NRC’s Director, Office of Nuclear Security and Incident Response.

17.11.4.2 A notification delivered by mail must be postmarked at least 7 days before the beginning of the 7 day period during which departure of the shipment is estimated to occur.

17.11.4.3 A notification delivered by any other means than mail must reach the office of the governor or of the governor’s designee or the Tribal official, or Tribal official’s designee at least 4 days before the beginning of the 7-day period during which departure of the shipment is estimated to occur.

(1) RESERVED.

(2) Contact information for each State, including telephone and mailing addresses of governors and governors’ designees, and participating Tribes, including telephone and mailing addresses of Tribal officials and Tribal official’s designees, is available on the NRC Web site at: https://scp.nrc.gov/special/designee.pdf.

(3) A list of the names and mailing addresses of the governor’s designees and Tribal official’s designees of participating Tribes is available on request from the Director, Division of Materials Safety, Security, State, and Tribal Programs, Office of Nuclear Material Safety and Safeguards, U.S. Nuclear Regulatory Commission, Washington, DC 20555-0001.

17.11.4.4 The licensee shall retain a copy of the notification as a record for 3 years.

* * *

[Publication Instructions: STRIKE the current Section 17.17.3.1(1), and INSERT the revised text below to incorporate the word "Part" in the reference to 10 CFR 71.85(a).]

(1) Results of the determinations required by 10 CFR Part 71.85(a) through (c);

* * *

[Publication Instructions: In Appendix 17A, STRIKE the current Subsection 17A2.2, and INSERT the revised text below to add the word "Part" in the reference to 10 CFR 71.1.]

17A2.2 Not listed in Table 17A2:

(1) The exempt material activity concentration and exempt consignment activity values contained in Table 17A3 may be used.

(2) Otherwise, the licensee shall obtain prior NRC approval of the exempt material activity concentration and exempt consignment activity values for radionuclides not listed in Table 17A2, before shipping the material. The licensee shall submit such request for prior approval to NRC in accordance with 10 CFR Part 71.1.

* * *

[Publication Instructions: In Table 17A1, STRIKE the current "Specific activity" value for Sm-147 (7th column) and INSERT the value "8.5X10^{-10}" to address an error in federal rule. NOTE: The table below is abbreviated and shows only the impacted value and the lines before and after Sm-147 - all other values in Table 17A1 are retained and remain as is in the current rule.]

TABLE 17A1: A1 AND A2 VALUES FOR RADIONUCLIDES

Symbol of radionuclide	Element and atomic number	A_1 (TBq)	A_1 (Ci)b	A_2 (TBq)	A_2 (Ci).	Specific activity	
						(TBq/g)	(Ci/g)
* * *	* * *	* * *	* * *	* * *	* * *	* * *	* * *
Sm-145	Samarium (62)	1.0X10 [1]	2.7X10 [2]	1.0X10 [1]	2.7X10 [2]	9.8X10 [1]	2.6X10 [3]
Sm-147	.	Unlimited	Unlimited	Unlimited	Unlimited	8.5X10 [-10]	2.3X10 [-8]
Sm-151	.	4.0X10 [1]	1.1X10 [3]	1.0X10 [1]	2.7X10 [2]	9.7X10 [-1]	2.6X10 [1]
* * *	* * *	* * *	* * *	* * *	* * *	* * *	* * *

* * *

[NO FURTHER CHANGES TO THE RULE BEYOND THIS POINT]

PUBLICATION INSTRUCTIONS FOR
6 CCR 1007-1, Part 22,
Physical protection of category 1 and category 2 quantities of radioactive material

Adopted by the Board of Health on October 19, 2022

[Publication Instructions: STRIKE the text from the beginning of the rule through the title of the rule below the solid line, and INSERT the revised/updated/added text below to incorporate an adoption and effective date.]

[* * * indicates unaffected sections of the rule]

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Hazardous Materials and Waste Management Division

RADIATION CONTROL – PHYSICAL PROTECTION OF CATEGORY 1 AND CATEGORY 2 QUANTITIES OF RADIOACTIVE MATERIAL

6 CCR 1007-1 Part 22

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

Adopted by the Board of Health on October 19, 2022; effective date December 15, 2022.

PHYSICAL PROTECTION OF CATEGORY 1 AND CATEGORY 2 QUANTITIES OF RADIOACTIVE MATERIAL

* * *

[Publication Instructions: STRIKE the current Section 22.2 through 22.2.3.3(2) (inclusive), and INSERT the revised text below to update the rulemaking effective date, remove unneeded spaces/gaps in the current rule, and make minor adjustments to format and align text.]

22.2 Scope, Purpose and Applicability.

22.2.1 Scope and Purpose.

22.2.1.1 This Part has been established to provide the requirements for the physical protection program for any licensee that possesses an aggregated category 1 or category 2 quantity of radioactive material listed in Appendix A to this Part. These requirements provide reasonable assurance of the security of category 1 or category 2 quantities of radioactive material by protecting these materials from theft or diversion. Specific requirements for access to material, use of material, transfer of material, and transport of material are included. No provision of this Part authorizes possession of licensed material.

22.2.2 Applicability.

22.2.2.1 Sections B and C of this part apply to any person who, under these regulations, possesses or uses at any site, an aggregated category 1 or category 2 quantity of radioactive material.

22.2.2.2 Section D of this part applies to any person who, under these regulations:

(1) Transports or delivers to a carrier for transport in a single shipment, a category 1 or category 2 quantity of radioactive material; or

(2) Imports or exports a category 1 or category 2 quantity of radioactive material; the provisions only apply to the domestic portion of the transport.

22.2.3 Published material incorporated by reference.

22.2.3.1 Throughout this Part 22, federal regulations, state regulations, and standards or guidelines of outside organizations have been adopted and incorporated by reference. Unless a prior version of the incorporated material is otherwise specifically indicated, the materials incorporated by reference cited herein include only those versions that were in effect as of the most recent effective date of this Part 22 (December 15, 2022), and not later amendments or editions of the incorporated material.

22.2.3.2 Materials incorporated by reference are available for public inspection, and copies (including certified copies) can be obtained at reasonable cost, during normal business hours from the Colorado Department of Public Health and Environment, Hazardous Materials and Waste Management Division, 4300 Cherry Creek Drive South, Denver, Colorado 80246. Additionally, https://www.colorado.gov/cdphe/radregs identifies where the incorporated federal and state regulations are available to the public on the internet at no cost. A copy of the materials incorporated in this Part is available for public inspection at the state publications depository and distribution center.

22.2.3.3 Availability from Source Agencies or Organizations.

(1) All federal agency regulations incorporated by reference herein are available at no cost in the online edition of the Code of Federal Regulations (CFR) hosted by the U.S. Government Printing Office, online at www.govinfo.gov.

(2) All state regulations incorporated by reference herein are available at no cost in the online edition of the Code of Colorado Regulations (CCR) hosted by the Colorado Secretary of State's Office, online at https://www.sos.state.co.us/CCR/RegisterHome.do.

* * *

[Publication Instructions: After provision 22.2.3.3(2), INSERT new provision 22.2.4 to add standardized language for consistency with other radiation regulations.]

22.2.4 Basis and Purpose.

22.2.4.1 A statement of basis and purpose accompanies this part and changes to this part. A copy may be obtained from the Department.

* * *

[Publication Instructions: At the end of Appendix A, Table 1, following the footnotes, REPLACE (only) the current "sum of fractions" equation graphic, with the following revised "sum of fractions" equation graphic for consistency with recent federal rule changes. All other provisions of Appendix A remain as is in current rule.]

$$\frac{R_1}{AR_1} + \frac{R_2}{AR_2} + \cdots + \frac{R_n}{AR_n} \geq 1.0$$

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2022-00504

Opinion of the Attorney General rendered in connection with the rules adopted by the

Hazardous Materials and Waste Management Division

on 10/19/2022

6 CCR 1007-1 Part 07

RADIATION CONTROL - USE OF RADIONUCLIDES IN THE HEALING ARTS

The above-referenced rules were submitted to this office on 10/28/2022 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.

November 04, 2022 09:04:16

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Health and Environment

Agency

Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

CCR number

6 CCR 1011-1 Chapter 06

Rule title

6 CCR 1011-1 Chapter 06 CHAPTER 6 - ACUTE TREATMENT UNITS 1 - eff 12/15/2022

Effective date

12/15/2022

[Publication Instructions: Strike, in its entirety, current existing text.]

DEPARTMENT OF PUBLIC HEALTH AND ENVIRONMENT

Health Facilities and Emergency Medical Services Division

STANDARDS FOR HOSPITALS AND HEALTH FACILITIES CHAPTER 6 - ACUTE TREATMENT UNITS

6 CCR 1011-1 Chapter 6 – REPEALED
Repeal adopted by the Board of Health on October 19, 2022; effective November 30, 2022

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

~~**Adopted by the Board of Health on November 20, 2019. Effective January 14, 2020.**~~

~~**1.101 STATUTORY AUTHORITY AND APPLICABILITY**~~

~~(1) Authority to establish minimum standards through regulation and to administer and enforce such regulations is provided by Section 25-1.5-103, C.R.S.~~

~~(2) Acute treatment units, as defined herein, shall be in compliance with all applicable federal and state statutes and regulations, including but not limited to, the following:~~

~~(a) This Chapter 6.~~

~~(b) The following parts of 6 CCR 1011-1, Chapter 2, General Licensure Standards:~~

~~(i) Part 2, Licensure Process.~~

~~(ii) Part 4.2, Occurrence Reporting~~

~~(iii) Part 5, Waiver of Regulations for Health Facilities~~

~~(3) This chapter applies to services provided by acute treatment units, including services provided through contracts.~~

~~**1.102 DEFINITIONS.**~~

~~For purposes of this chapter, the following definitions shall apply, unless the context requires otherwise:~~

~~(1) "Acute treatment unit" means a facility or a distinct part of a facility for short-term psychiatric care, which may include substance abuse treatment, and which provides a total, twenty-four-hour therapeutically planned and professionally staffed environment for persons who do not require inpatient hospitalization but need more intense and individual services than are available on an outpatient basis, such as crisis management and stabilization services.~~

~~(2) "Auxiliary aid" means any device used by persons to overcome a physical disability and includes but is not limited to a wheelchair, walker or orthopedic appliance.~~

~~(3) "Client" means an individual who is age 18 and over in need of short-term psychiatric care.~~

~~(4) Reserved~~

(5) Reserved

(6) "Deficiency" means a violation of regulatory and/or statutory requirements governing acute treatment units, as cited by the Department.

(7) "Deficiency list" means a listing of deficiency citations which contains:

(a) a statement of the statute or regulation violated; and

(b) a statement of the findings, with evidence to support the deficiency.

(8) "Department" means the Colorado Department of Public Health and Environment or its designee.

(9) "Director" means a person who is responsible for the overall operation, daily administration, management and maintenance of the facility.

(10) Reserved

(11) "Facility" means an acute treatment unit.

(12) "Governing body" means the board of trustees, directors or other governing body in whom the ultimate authority for the conduct of the facility is vested.

(13) "Licensee" means the person or entity to whom:

(a) a license is issued by the Department pursuant to Section 25-1.5-103 (1) (a), C.R.S., to operate a facility within the definition herein provided, and

(b) a "27-10" designation has been granted by the Department of Human Services pursuant to Section 27-10-101, et. seq. and 2 CCR 502-1.

(14) "Occurrences" means information reported to the Department in accordance with 25-1-124, C.R.S. and Chapter 2, General Licensure, Part 4.2 Occurrence Reporting.

(15) Reserved

(16) "Owner" means the entity in whose name the license is issued. The entity is responsible for the financial and contractual obligations of the facility. Entity means any corporation, limited liability corporation, firm, partnership, or other legally formed body, however organized. For the purposes of this regulation, the term "owner" is used interchangeably with the terms "applicant" and "licensee."

(17) "Plan of correction" means a written plan to be submitted by facilities to the Department for approval, detailing the measures that shall be taken to correct all cited deficiencies.

(18) Reserved

(19) "Seclusion room" means a room where a client is placed alone and from where egress is involuntarily prevented.

(20) "Short-term psychiatric care" means services provided to treat persons with mental illness for an average of 3-7 days, but generally no longer than 30 days.

(21) "Staff" means employees; and contract staff intended to substitute for, or supplement staff who provide client care services.

(22) "Therapeutic diet" means a diet ordered by a physician as part of a treatment of disease or clinical condition, or to eliminate, decrease, or increase specific nutrients in the diet. Examples include, but are not limited to: a calorie counted diet, a specific sodium gram diet, and a cardiac diet.

(23) "Unit" means a locked treatment setting that serves a maximum of sixteen persons.

(24) "Warewashing" means the cleaning and sanitizing of equipment and utensils. For the purposes of this definition, equipment includes but is not limited to kitchen appliances and tables with which food normally comes into contact. For the purposes of this definition, utensils are implements used to prepare, store, transport or serve food.

1.103 DEPARTMENT OVERSIGHT

(1) General

(a) Facility Compliance. The governing body shall be responsible for the operation of the facility and for compliance with these regulations. The governing body shall delegate the responsibility for day-to-day operations to the director.

(b) Issuing Licenses. The Department shall issue or renew a license after it is satisfied that the license applicant or licensee is in compliance with the requirements set forth in this Chapter 6 and the requirements established by the Division of Mental Health, Department of Human Services. Such license issued or renewed pursuant to this section, other than a provisional license, shall expire one year from the date of issuance or renewal.

(2) Licensure Fees

(a) General. Licensure fees are specified in Section 25-3-105 (1)(c), C.R.S.

(3) Reserved

(4) Citing Deficiencies

(a) The Department is authorized to cite deficiencies.

(b) The facility shall respond to a life or limb-threatening deficiency by immediately removing the cause of the life or limb threatening risk and provide evidence, either verbal or written as required by the Department, that the risk has been removed.

(5) Plans of Correction (POCs). The Department shall require and the facility shall submit a plan of correction in response to cited deficiencies.

(a) General

(i) The facility shall develop a POC, in the format required by the Department, for every deficiency cited by the Department in the deficiency list.

(ii) The POC shall be typed or printed legibly in ink.

(iii) The date of correction for deficiencies shall be no longer than 30 calendar days from the date of the mailing of the deficiency list to the facility, unless otherwise required or approved by the Department.

(b) Process for Submission and Approval of POC

(i) A facility shall submit a POC to the Department no later than ten (10) working days of the date of the deficiency list letter sent by the Department.

(ii) If an extension of time is needed to complete the POC, the facility shall request an extension in writing from the Department prior to the POC due date. An extension of time may be granted by the Department not to exceed seven (7) calendar days.

(iii) The POC is subject to Department approval.

(6) Reserved

(7) Facility Reporting Requirements. The facility shall develop and implement policies and procedures for complying with the following reporting requirements.

(a) Occurrences

(i) Reporting. The facility shall be in compliance with occurrence reporting requirements pursuant to 6 CCR 1011, Chapter 2, Part 4.2.

(ii) Facility investigation of occurrences

(A) Occurrences shall be investigated to determine the circumstances of the event and institute appropriate measures to prevent similar future situations.

(B) Documentation regarding investigation, including the appropriate measures to be instituted, shall be made available to the Department, upon request.

(C) A report with the investigation findings will be available for review by the Department within five working days of the occurrence.

(D) Nothing in this Section 1.103 (7)(a) shall be construed to limit or modify any statutory or common-law right, privilege, confidentiality or immunity.

(b) Notification Regarding Relocations. The facility shall notify the Department within 48 hours of the relocation of one or more clients occurs due to any portion of the facility becoming uninhabitable as a result of fire or other disaster.

(c) Facility Closure. If the closure of a facility by a licensee is pending, the licensee shall notify the Department in writing at least 30 days prior to such closure.

1.104 FACILITY OPERATIONS

(1) Medications. Medications shall be stored in a manner that prevents unauthorized access and drug diversion.

(2) Staffing Requirements: Communicable Diseases

(a) General. All staff and volunteers shall be free of communicable disease that can be readily transmitted in the workplace.

(b) Tuberculosis

(i) All staff shall be required to have a tuberculin skin test prior to direct contact with the clients. In the event of a positive reaction to the skin test, evidence of a chest x-ray and other appropriate follow-up shall be required in accordance with community standards of practice.

(ii) The facility personnel files for staff members as well as for volunteers who have direct contact with clients shall include documentation evidencing TB testing and results.

(3) Emergency Preparedness

(a) The facility shall develop, update as necessary, and implement a plan for emergency preparedness that addresses the facility response to the following emergencies:

(i) Severe weather, including but not limited to floods, blizzards, and tornados.

(ii) Fire.

(iii) Bomb threats.

(iv) Explosions.

(v) Hazardous material spills.

(vi) Internal system failures, such as electrical outages.

(vii) Communicable disease outbreaks.

(b) Staff shall receive training regarding their responsibilities under the plan.

(i) Within three (3) working days of date of hire or commencement of volunteer service, the facility shall provide training in emergency preparedness.

(ii) Every two (2) months, there shall be a review of all components of the emergency preparedness plan, including each individual employee's responsibilities under the plan, with the staff of each shift.

(4) Infection Control. The facility shall adopt and implement policies and procedures regarding infection control that shall address, at minimum:

(a) housekeeping,

(b) dietary services, and

(c) linen and laundry services.

(5) Unit Safety Checks. The facility shall conduct unit safety checks every shift to identify and remedy hazards that could be used by clients to harm themselves or others. There shall be documentation of these safety checks.

1.105 DIETARY SERVICES

(1) Supervision. The governing body shall appoint an individual to be in charge of dietary services. Such individual shall have knowledge of foodbourne disease prevention, including but not limited to hygienic practices and food safety techniques pertaining to preparation, food storage and warewashing.

(2) Sanitary Conditions. Food shall be prepared, handled and stored in a sanitary manner, so that it is free from spoilage, filth or other contamination, and shall be safe for human consumption.

(3) Dishwashing. Warewashing shall be conducted in a safe and sanitary manner. Unless commercial grade dishwashers are used, a two-compartment sink or a single-compartment sink shall be used in conjunction with a domestic dishwashing machine. Dishwashing machines shall be used in accordance with manufacturer's instructions.

(4) Meals and Snacks

(a) Meals

(i) Menus shall vary daily and shall be adjusted for seasonal changes and holidays.

(ii) At least three nutritionally balanced meals in adequate portions, using a variety of foods shall be made available at regular times daily.

(iii) In the event the meal provided is unpalatable, a nutritionally balanced substitute shall be available.

(b) Snacks. Between meal snacks of nourishing quality shall be available, to the extent that such availability does not conflict with a client's service plan.

(c) Therapeutic Diets. This provision is only applicable to facilities that admit clients who require therapeutic diets. If the facility admits such clients, the following requirements shall apply.

(i) Therapeutic diets shall be prescribed by a physician.

(ii) The facility shall implement a system in order to ensure that the proper diet is provided.

(5) Food Supply. There shall be enough food and water on hand to prepare three nutritionally balanced meals for four days.

1.106 LINEN AND LAUNDRY SERVICES

(1) Provision of Laundry Services. The facility shall make laundry services available for clients' personal laundry in one of the following ways, and in accordance with these regulations:

(a) Providing laundry service for clients' personal items.

(b) Providing a designated laundry room for use by clients. Clients may do their personal laundry as part of their treatment plan.

(2) Clean Linen Supply. The facility shall maintain a sufficient supply of clean linen, including sheets and towels.

(3) Sanitary Conditions

(a) Linen and laundry services shall be conducted in a manner designed to prevent contamination of patients and personnel.

(b) Staff shall wash their hands after handling soiled linen and before handling clean linen.

(c) Storage

(i) Soiled linen shall be stored separately from clean linen. Soiled linen and clean linen shall be stored in separate enclosed areas.

1.107 INTERIOR AND EXTERIOR ENVIRONMENT

(1) Interior Environment

(a) General. The facility shall provide a clean, sanitary interior environment, free of hazards to health and safety. The facility shall have a layout, finishes, and furnishings that minimize the opportunity for residents to injure themselves or others.

(b) Maintenance. Interior areas shall be in good repair.

(c) Finishes

(i) All finishes shall promote maintenance of sanitary conditions.

(ii) Floor surfaces and coverings shall promote mobility in areas used by individuals and shall promote maintenance of sanitary conditions.

(d) Furnishings. The furnishings shall be clean, dry, free of foul orders, safe and well-maintained.

(e) Windows. Windows that can be accessed by clients shall have security glazing or other appropriate security features to reduce the possibility of patient injury or escape.

(f) Potential Infection/Injury Hazards

(i) Sharps. Sharp knives and other objects that could be used for self-harm or harm to others shall be secured in a manner inaccessible to clients.

(ii) Insect/rodent infestations. The facility shall be maintained free of infestations of insects and rodents and all openings to the outside shall be screened.

(iii) Storage of hazardous substances. Solutions, cleaning compounds and hazardous substances shall be labeled and stored in a safe manner, in an area inaccessible to the clients.

(g) Heating, Lighting, Ventilation

(i) Each room in the facility shall be installed with heat, lighting and ventilation sufficient to accommodate its use and the needs of the clients.

(ii) All interior and exterior steps and interior hallways and corridors shall be adequately illuminated.

(h) Water

(i) Potable water. There shall be an adequate supply of safe, potable water available for domestic purposes.

(ii) Hot water

(A) Hot water shall not measure more than 120 degrees Fahrenheit at taps which are accessible by clients.

(B) There shall be a sufficient supply of hot water during peak usage demands.

(i) Telephone. There shall be a telephone available for use by residents and staff.

(2) Exterior Environment

(a) General. The facility shall provide a clean, sanitary, and secure, exterior environment, free of hazards to health and safety. In addition to the interior common areas required by this regulation, the facility shall provide a safe and secure outdoor area for the use of clients year round.

(b) Potential Hazards. Exterior areas shall be well maintained.

(i) Maintenance of the grounds. Exterior premises shall be kept free of high weeds and grass, garbage and rubbish. Grounds shall be maintained to prevent hazardous slopes, holes, or other potential hazards.

(ii) Staircases. Exterior staircases of three (3) or more steps and porches shall have handrails. Staircases and porches shall be kept in good repair.

(iii) Fencing or other enclosures that prevent elopement and protect the safety and security of the clients shall be installed around secure outdoor areas.

1.108 PHYSICAL PLANT

(1) Compliance with State and Local Laws/Codes. Facilities shall be in compliance with all applicable:

(a) Local zoning, housing, fire and sanitary codes and ordinances of the city, city and county, or county where the facility is situated to the extent that such codes are consistent with the federal "Fair Housing Amendment Act of 1988", as amended, 42 U.S.C., sec. 3601, et seq.

(b) State and local plumbing laws and regulations. Plumbing shall be maintained in good repair, free of the possibility of backflow and backsiphonage, through the use of vacuum breakers and fixed air gaps, in accordance with state and local codes.

(c) Sewage disposal requirements. Sewage shall be discharged into a public sewer system or disposed of in a manner approved by the local health department, or local laws if no local health department exists, and the Colorado Water Quality Control Commission.

(2) Common Areas

(a) Common areas sufficient to reasonably accommodate all clients shall be provided.

(b) All common areas and dining areas shall be accessible to clients utilizing an auxiliary aid without requiring transfer from a wheelchair to walker or from a wheelchair to a regular chair for use in the dining area. All doors to those rooms requiring access shall be at least 32 inches wide.

(c) A minimum of two entryways shall be provided for access and egress from the building by clients utilizing a wheelchair.

(3) Dining Areas. A designated dining area accessible by all clients shall be provided in a separate area or areas capable of comfortably seating all clients.

(4) Bedrooms

(a) Bedroom Assignment. No client shall be assigned to any room other than a regularly designated bedroom.

(b) Occupancy Ratios. No more than two (2) clients shall occupy a bedroom.

(c) Square Footage Requirements

(i) Each designated bedroom shall have at least 100 square feet for single occupancy bedrooms and 60 square feet per person for double occupancy bedrooms. Bathroom areas and closets shall not be included in the determination of square footage.

(d) Storage Space. Each client shall have within his or her room separate storage facilities adequate for clothing and personal articles such as a closet or a locker. When the treatment program indicates, shelves for folded garments shall be used instead of hanging garments.

(e) Reserved

(f) Furnishings

(i) Each client bedroom shall be equipped as follows for each client:

(A) A comfortable, standard-sized bed equipped with a comfortable, clean mattress, mattress protector, and pillow. Rollaway type beds, cots, folding beds or bunk beds shall not be permitted.

(B) A standard-sized chair in good condition.

(C) A safe and sanitary method to store the client's towel, such as a breakaway towel rack.

(g) Electrical Hazards. Extension cords and multiple use electrical sockets shall be prohibited in client bedrooms.

(5) Bathrooms

(a) Number of Bathrooms Per Client. There shall be at least one full bathroom for every six (6) clients. A full bathroom shall consist of at least the following fixtures: toilet, handwashing sink, toilet paper dispenser, mirror, tub or shower, and towel rack. Bathrooms shall be equipped with soap dispensers or the facility shall have a procedure in place that prevents clients from sharing soap.

(b) Bathroom Accessibility. There shall be a bathroom on each floor having client bedrooms which is accessible without requiring access through an adjacent bedroom.

(c) Bathrooms for Clients using Auxiliary Aids. The facility shall provide at least one full bathroom as defined herein with fixtures positioned so as to be fully accessible to any client utilizing an auxiliary aid. Grab bars shall be properly installed at each tub and shower, and adjacent to each toilet.

(d) Fixtures

(i) Non-skid surfaces. Bathtubs and shower floors shall have non-skid surfaces.

(ii) Toilet seats. Toilet seats shall be constructed of non-absorbent material and free of cracks.

(e) Supplies

(i) Individualized supplies. The use of common personal care articles, including soap and towels, is prohibited.

(ii) Toilet paper. Toilet paper in a dispenser shall be available at all times in each bathroom of the facility.

(iii) Liquid soap and paper towels. Liquid soap and paper towels shall be available at all times in the common bathrooms of the facility.

(6) Seclusion rooms

(a) Client Safety

(i) The seclusion room shall be constructed to prevent patient hiding, escape, injury, or suicide.

(ii) The seclusion room shall be free of all protrusions, sharp corners, hardware, fixtures or other devices, and furnishings which may cause injury to the occupant.

(b) Temperature. The seclusion room shall maintain temperatures appropriate for the season.

(c) Location. The room shall be located in a manner affording direct observation of the patient by the nursing staff.

(d) Square Footage. The seclusion room shall have an area of at least 100 square feet.

(e) Windows. The seclusion room shall have a window that allows someone outside to see into all of the corners of the room. Windows in the seclusion room shall be constructed to prevent breakage and otherwise prevent the occupant from harming himself.

(f) Doors. Doors to the seclusion room shall be at least 32 inches wide, shall open outward.

(g) Electrical Outlets

(i) Light fixtures and other electrical outlets in the seclusion room shall be limited to those required and necessary, shall be recessed, and shall be constructed as to prevent the occupant from harming himself.

(ii) All electrical outlets, devices, and circuits accessible from inside the seclusion room shall be controlled by on/off switches located outside the seclusion room, in a secure location that is within the line of vision of the seclusion room. The switches shall be durably labeled as to their function.

(7) Linen and Laundry

(a) The facility may have laundry room(s) no larger than 100 square feet in area equipped with residential style washer(s) and one residential style dryer without such laundry rooms being classified as a hazardous area. These laundry rooms shall not be used for storage of soiled or clean linen.

(b) Facilities shall have a separate enclosed area for receiving and holding soiled linen until ready for pickup or processing in addition to a separate enclosed area for clean linen storage.

(c) There shall be hand-washing facilities in each area where un-bagged, soiled linen is handled.

1.109 ENVIRONMENTAL SAFETY

(1) Reserved

(2) Reserved

(3) Reserved

(4) Emergency Evacuation Drills

(a) During the first year of operation, emergency evacuation drills shall be conducted once per shift per month.

(b) After the first year of operation, emergency evacuation drills shall be conducted once per shift per quarter.

(c) Emergency evacuation drills conducted during normal sleeping hours do not require the activation of the fire alarm system. All other emergency evacuation drills shall include the activation of the fire alarm system.

(d) Clients should, whenever possible, participate in daytime emergency evacuation drills. Client participation in emergency evacuation drills conducted during normal sleeping hours is not required.

(5) Equipment

(a) First Aid. First aid equipment shall be maintained on the premises in a readily available location and staff shall be instructed in its use.

(b) Telephone

(i) There shall be at least one telephone, not powered by the facility's electrical system, for use by the staff for emergencies.

(ii) Current phone number and location of the nearest hospital, and current phone numbers of ambulance service, poison control center, fire station and the police shall be shall be readily accessible to staff.

Editor's Notes

6 CCR 1011-1 has been divided into separate chapters for ease of use. Versions prior to 05/01/2009 are located in the main section, 6 CCR 1011-1. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 05/01/2009, select the desired chapter, for example 6 CCR 1011-1 Chapter 04 or 6 CCR 1011-1 Chapter 18.

History

Chapter 6 entire rule eff. 04/01/2007.

~~Chapter 6 rules 1.102, 1.103, 1.109 emer. rules eff. 06/18/2008; expired 09/18/2008.~~

~~Chapter 6 rules 1.102, 1.103, 1.109 eff. 09/30/2008.~~

~~Chapter 6 rules 1.101(2)(b), 1.103(3)(b) eff. 07/30/2010.~~

~~Chapter 6 rules 1.101(2)(b), 1.102(4)-1.102(5), 1.102(10), 1.102(15), 1.102(18), 1.103(2)-1.103(3), 1.103(6), 1.106, 1.107(2), 1.108(4)(e), 1.108(7)(b), 1.109 eff. 08/14/2013; Chapter 6 rule 1.108(6)(h) repealed eff. 08/14/2013.~~

~~Chapter 6 rules 1.101(2)(b), 1.102(14), 1~~

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Office of the Attorney General

Tracking number: 2022-00503

Opinion of the Attorney General rendered in connection with the rules adopted by the

Health Facilities and Emergency Medical Services Division (1011, 1015 Series)

on 10/19/2022

6 CCR 1011-1 Chapter 06

CHAPTER 6 - ACUTE TREATMENT UNITS

The above-referenced rules were submitted to this office on 10/27/2022 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.

November 04, 2022 09:00:42

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Agriculture

Agency

Inspection and Consumer Services Division

CCR number

8 CCR 1202-6

Rule title

8 CCR 1202-6 RULES FOR COMMERCIAL FEED UNDER THE COLORADO FEED LAW, SECTIONS 35-60-101 THROUGH 115, C.R.S. 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF AGRICULTURE

Inspection and Consumer Services Division

RULES FOR COMMERCIAL FEED UNDER THE COLORADO FEED LAW, SECTIONS 35-60-101 THROUGH 115, C.R.S.

8 CCR 1202-6

Part 2. Definitions and Terms

2.1. The Official Publication of the Association of American Feed Control Officials, Inc. shall mean the 2022 Official Publication of the Association of American Feed Control Officials, Inc. ("AAFCO"), effective January 1, 2023. This rule incorporates by reference the AAFCO standards and guidelines. A copy of the Official Publication of the Association of American Feed Control Officials, Inc. shall be kept on file at the Department of Agriculture, located at 305 Interlocken Parkway, Broomfield, Colorado 80021, and shall be open to public inspection, and available for copying, during normal business hours. A copy of the official publication shall also be kept at the AAFCO Headquarters Office, located at 1800 S. Oak Street, Suite 100, Champaign, IL 61820-6974 and is available online at https://www.aafco.org/Publications. This, and any other material that is incorporated by reference, may be examined at any state publications depository library.

2.2. These Rules incorporate the Official Feed Terms as published in the 2022 Official Publication of AAFCO, incorporated herein by reference (later amendments not included), except as the Commissioner designates otherwise in specific cases.

2.3. The following commodities are hereby declared exempt from the definition of commercial feed, under the provisions of Section 35-60-102(2), C.R.S., of the Colorado Feed Law, when unground and when not mixed or intermixed with other materials: raw meat, individual chemical compounds, hay, loose salt, straw, stover, silage, cobs, husks, and hulls; provided that these commodities are not adulterated within the meaning of Section 35-60-107, C.R.S., of the Colorado Feed Law. The exemption from the definition of commercial feed does not apply to an otherwise exempted commodity that bears a label listing nutritional claims or guarantees.

Part 4. Label Information.

4.1. Commercial feed, other than customer-formula feed, shall be labeled with the information prescribed in this section.

4.1.1. Product name and brand name if any.

4.1.1.1. The brand or product name must be appropriate for the intended use of the feed and must not be misleading. If the name indicates the feed is made for a specific use, the character of the feed must conform therewith. A commercial feed for a particular animal class, must be suitable for that purpose.

4.1.1.2. Commercial, registered brand or trade names are not permitted in guarantees or ingredient listings and only in the product name of feeds produced by or for the firm holding the rights to such a name.

4.1.1.3. The name of a commercial feed shall not be derived from one or more ingredients of a mixture to the exclusion of other ingredients and shall not be one representing any components of a mixture unless all components are included in the name: Provided, that if any ingredient or combination of ingredients is intended to impart a distinctive characteristic to the product which is of significance to the purchaser, the name of that ingredient or combination of ingredients may be used as a part of the brand name or product name if the ingredients or combination of ingredients is quantitatively guaranteed in the

guaranteed analysis, and the brand or product name is not otherwise false or misleading.

4.1.1.4. The word “protein” shall not be permitted in the product name of a feed that contains added non-protein nitrogen.

4.1.1.5. When the name carries a percentage value, it shall be understood to signify protein and/or equivalent protein content only, even though it may not explicitly modify the percentage with the word “protein”: Provided, that other percentage values may be permitted if they are followed by the proper description and conform to good labeling practice. Digital numbers shall not be used in such a manner as to be misleading or confusing to the customer.

4.1.1.6. Single ingredient feeds shall have a product name in accordance with the designated definition of feed ingredients as recognized by AAFCO unless the Commissioner designates otherwise.

4.1.1.7. The word “vitamin”, or a contraction thereof, or any word suggesting vitamin can be used only in the name of a feed which is represented to be a vitamin supplement, and which is labeled with the minimum content of each vitamin declared, as specified in Part 5.3 .

4.1.1.8. The term “mineralized” shall not be used in the name of a feed except for “TRACE MINERALIZED SALT”. When so used, the product must contain significant amounts of trace minerals which are recognized as essential for animal nutrition.

4.1.1.9. The term “meat” and “meat by-products” shall be qualified to designate the animal from which the meat and meat by-products is derived unless the meat and meat by-products are made from cattle, swine, sheep and goats.

4.1.2. If a drug is used:

4.1.2.1. The word “medicated” shall appear directly following and below the product name in type size, no smaller than one-half the type size of the product name.

4.1.2.2. Purpose statement as required in Part 4.1.3.

4.1.2.3. The purpose of medication (claim statement).

4.1.2.4. An active ingredient statement listing the active drug ingredients by their established name and the amounts in accordance with Part 5.4.

4.1.3. Purpose Statement

4.1.3.1. The statement of purpose shall contain the specific species and animal class(es) for which the feed is intended as defined in Part 4.1.4.

4.1.3.2. The manufacturer shall have flexibility in describing in more specific and common language the defined animal class, species and purpose while being consistent with the category of animal class defined in Part 4.1.4 which may include, but is not limited to weight range(s), sex, or ages of the animal(s) for which the feed is manufactured.

4.1.3.3. The purpose statement may be excluded from the label if the product name includes a description of the species and animal class(es) for which the product is intended.

4.1.3.4. The purpose statement of a premix for the manufacture of feed may exclude the animal class and species and state “For Further Manufacture of Feed” if the

nutrients contained in the premix are guaranteed and sufficient for formulation into various animal species feeds and premix specifications are provided by the end user of the premix. [This section applicable to commercial feeds regulated under Part 4.1.4.10.2.10]

4.1.3.5. The purpose statement of a single purpose ingredient blend, such as a blend of animal protein products, milk products, fat products, roughage products or molasses products may exclude the animal class and species and state “For Further Manufacture of Feed” if the label guarantees of the nutrients contained in the single purpose nutrient blend are sufficient to provide for formulation into various animal species feeds. [This section applicable to commercial feeds regulated under Part 4.1.4.10.2.10.]

4.1.3.6. The purpose statement of a product shall include a statement of enzyme functionality if enzymatic activity is represented in any manner.

4.1.4. Guarantees - Crude Protein, Equivalent Crude Protein from Non Protein Nitrogen, Amino Acids, Crude Fat, Crude Fiber, Acid Detergent Fiber, Neutral Detergent Fiber, Calcium, Phosphorus, Salt and Sodium shall be the sequence of nutritional guarantees when such guarantee is stated. Other required and voluntary guarantees should follow in a general format such that the units of measure used to express guarantees (percentage, parts per million, International Units, etc.) are listed in a sequence that provides a consistent grouping of the units of measure. All guarantees shall be stated on an “as is” basis.

4.1.4.1. Required guarantees for swine formula feeds

4.1.4.1.1. Animal Classes

4.1.4.1.1.1. Pre-Starter - 2 to 11 pounds

4.1.4.1.1.2. Starter -11 to 44 pounds

4.1.4.1.1.3. Grower - 44 to 110 pounds

4.1.4.1.1.4. Finisher -110 to 242 pounds (market)

4.1.4.1.1.5. Gilts, Sows and Adult Boars

4.1.4.1.1.6. Lactating Gilts and Sows

4.1.4.1.2. Guaranteed Analysis for Swine Complete Feeds and Supplements (all animal classes)

4.1.4.1.2.1. Minimum percentage of Crude Protein

4.1.4.1.2.2. Minimum percentage of Lysine

4.1.4.1.2.3. Minimum percentage of Crude Fat

4.1.4.1.2.4. Maximum percentage of Crude Fiber

4.1.4.1.2.5. Minimum and maximum percentage of Calcium

4.1.4.1.2.6. Minimum percentage of Phosphorus

4.1.4.1.2.7. Minimum and maximum percentage of Salt (if added)

4.1.4.1.2.8. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.1.2.9. Minimum Selenium in parts per million (ppm)

4.1.4.2. Required guarantees for Formula Poultry Feeds (Broilers, Layers and Turkeys)

4.1.4.2.1. Animal Classes

4.1.4.2.1.1. Layer - Chickens that are grown to produce eggs for food, e.g., table eggs

4.1.4.2.1.1.1. Starting/Growing - From day of hatch to approximately 10 weeks of age.

4.1.4.2.1.1.2. Finisher - From approximately 10 weeks of age to time first egg is produced. (Approximately 20 weeks of age).

4.1.4.2.1.1.3. Laying - From time first egg is laid throughout the time of egg production.

4.1.4.2.1.1.4. Breeders - Chickens that produce fertile eggs for hatch replacement layers to produce eggs for food, table eggs, from time first egg is laid throughout their productive cycle.

4.1.4.2.1.2. Broilers - Chickens that are grown for human food.

4.1.4.2.1.2.1. Starting/growing - From day of hatch to approximately 5 weeks of age.

4.1.4.2.1.2.2. Finisher - From approximately 5 weeks of age to market, (42 to 52 days).

4.1.4.2.1.2.3. Breeders - Hybrid strains of chickens whose offspring are grown for human food, (broilers), any age and either sex.

4.1.4.2.1.3. Broilers, Breeders - Chickens whose offspring are grown for human food (broilers).

4.1.4.2.1.3.1. Starting/Growing - From day of hatch until approximately 10 weeks of age.

4.1.4.2.1.3.2. Finishing - From approximately 10 weeks of age to time first egg is produced, approximately 20 weeks of age.

4.1.4.2.1.3.3. Laying - Fertile egg producing chickens (broilers/roasters) from day of first egg throughout the time fertile eggs are produced.

4.1.4.2.1.4. Turkeys

4.1.4.2.1.4.1. Starting/Growing - Turkeys that are grown for human food from day of hatch to approximately 13 weeks of age (females) and 16 weeks of age (males).

4.1.4.2.1.4.2. Finisher - Turkeys that are grown for human food, females from approximately 13 weeks of age to approximately 17 weeks of age; males from 16 weeks of age to 20 weeks of age, (or desired market weight).

4.1.4.2.1.4.3. Laying - Female turkeys that are producing eggs; from time first egg is produced, throughout the time they are producing eggs.

4.1.4.2.1.4.4. Breeder - Turkeys that are grown to produce fertile eggs, from day of hatch to time first egg is produced (approximately 30 weeks of age), both sexes.

4.1.4.2.2. Guaranteed Analysis for Poultry Complete Feeds and Supplements (all animal classes)

4.1.4.2.2.1. Minimum percentage of Crude Protein

4.1.4.2.2.2. Minimum percentage of Lysine

4.1.4.2.2.3. Minimum percentage of Methionine

4.1.4.2.2.4. Minimum percentage of Crude Fat

4.1.4.2.2.5. Maximum percentage of Crude Fiber

4.1.4.2.2.6. Minimum and maximum percentage of Calcium

4.1.4.2.2.7. Minimum percentage of Phosphorus

4.1.4.2.2.8. Minimum and maximum percentage of Salt (if added)

4.1.4.2.2.9. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.3. Required Guarantees for Beef Cattle Formula Feeds

4.1.4.3.1. Animal Classes

4.1.4.3.1.1. Calves (birth to weaning)

4.1.4.3.1.2. Cattle on Pasture (may be specific as to production stage; e.g. stocker, feeder, replacement heifers, brood cows, bulls, etc.)

4.1.4.3.1.3. Feedlot Cattle

4.1.4.3.2. Guaranteed analysis for Beef Complete Feeds and Supplements (all animal classes)

4.1.4.3.2.1. Minimum percentage of Crude Protein

4.1.4.3.2.2. Maximum percentage of equivalent crude protein from Non-Protein Nitrogen (NPN) when added

4.1.4.3.2.3. Minimum percentage of Crude Fat

4.1.4.3.2.4. Maximum percentage of Crude Fiber

4.1.4.3.2.5. Minimum and maximum percentage of Calcium

4.1.4.3.2.6. Minimum percentage of Phosphorus

4.1.4.3.2.7. Minimum and maximum percentage of Salt (if added)

4.1.4.3.2.8. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.3.2.9. Minimum percentage of Potassium

4.1.4.3.2.10. Minimum Vitamin A, other than precursors of Vitamin A, in International Units per pound (if added)

4.1.4.3.3. Guaranteed analysis for Beef Mineral Feeds (if added)

4.1.4.3.3.1. Minimum and maximum percentage Calcium

4.1.4.3.3.2. Minimum percentage of Phosphorus

4.1.4.3.3.3. Minimum and maximum percentage of Salt

4.1.4.3.3.4. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.3.3.5. Minimum percentage of Magnesium

4.1.4.3.3.6. Minimum percentage of Potassium

4.1.4.3.3.7. Minimum Copper in parts per million (ppm)

4.1.4.3.3.8. Minimum Selenium in parts per million (ppm)

4.1.4.3.3.9. Minimum Zinc in parts per million (ppm)

4.1.4.3.3.10. Minimum Vitamin A, other than precursors of Vitamin A, in International Units per pound

4.1.4.4. Required Guarantees for Dairy Formula Feeds

4.1.4.4.1. Animal Classes

4.1.4.4.1.1. Veal Milk Replacer - Milk Replacer to be fed for veal production.

4.1.4.4.1.2. Herd Milk Replacer - Milk Replacer to be fed for herd replacement calves.

4.1.4.4.1.3. Starter - Approximately 3 days to 3 months.

4.1.4.4.1.4. Growing Heifers, Bulls and Dairy Beef

4.1.4.4.1.4.1. Grower 1 -3 months to 12 months of age

4.1.4.4.1.4.2 Grower 2 - More than 12 months of age

4.1.4.4.1.5. Lactating Dairy Cattle

4.1.4.4.1.6. Non-Lactating Dairy Cattle

4.1.4.4.2. Guaranteed Analysis for Veal and Herd Replacement Milk Replacer

4.1.4.4.2.1. Minimum percentage Crude Protein

4.1.4.4.2.2. Minimum percentage Crude Fat

4.1.4.4.2.3. Maximum percentage of Crude Fiber

4.1.4.4.2.4. Minimum and maximum percentage Calcium

4.1.4.4.2.5. Minimum percentage of Phosphorus

4.1.4.4.2.6. Minimum Vitamin A, other than precursors of Vitamin A, in International Units per pound (if added)

4.1.4.4.3. Guaranteed Analysis for Dairy Cattle Complete Feeds and Supplements

4.1.4.4.3.1. Minimum percentage of Crude Protein

4.1.4.4.3.2. Maximum percentage of Equivalent Crude Protein from Non-Protein Nitrogen (NPN) when added

4.1.4.4.3.3. Minimum percentage of Crude Fat

4.1.4.4.3.4. Maximum percentage of Crude Fiber

4.1.4.4.3.5. Maximum percentage of Acid Detergent Fiber (ADF)

4.1.4.4.3.6. Minimum and maximum percentage of Calcium

4.1.4.4.3.7. Minimum percentage of Phosphorus

4.1.4.4.3.8. Minimum Selenium in parts per million (ppm)

4.1.4.4.3.9. Minimum Vitamin A, other than precursors of Vitamin A, in International Units per pound (if added)

4.1.4.4.4. Required Guaranteed Analysis for Dairy Mixing and Pasture Mineral

4.1.4.4.4.1. Minimum and maximum percentage of Calcium

4.1.4.4.4.2. Minimum percentage of Phosphorus

4.1.4.4.4.3. Minimum and maximum percentage of Salt

4.1.4.4.4.4. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.4.4.5. Minimum percentage of Magnesium

4.1.4.4.4.6. Minimum percentage of Potassium

4.1.4.4.4.7. Minimum Selenium in parts per million (ppm)

4.1.4.4.4.8. Minimum Vitamin A, other than the precursors of Vitamin A, in International Units per pound

4.1.4.5. Required Guarantees for Equine Formula Feeds

4.1.4.5.1. Animal Classes

4.1.4.5.1.1. Foal

4.1.4.5.1.2. Mare

4.1.4.5.1.3. Breeding

4.1.4.5.1.4. Maintenance

4.1.4.5.2. Guaranteed Analysis for Equine Complete Feeds and Supplements (all animal classes)

4.1.4.5.2.1. Minimum percentage of Crude Protein

4.1.4.5.2.2. Minimum percentage of Crude Fat

4.1.4.5.2.3. Maximum percentage of Crude Fiber

4.1.4.5.2.4. Maximum percentage of Acid Detergent Fiber (ADF)

4.1.4.5.2.5. Maximum percentage of Neutral Detergent Fiber (NDF)

4.1.4.5.2.6. Minimum and maximum percentage of Calcium

4.1.4.5.2.7. Minimum percentage of Phosphorus

4.1.4.5.2.8. Minimum Copper in parts per million (ppm)

4.1.4.5.2.9. Minimum Selenium in parts per million (ppm)

4.1.4.5.2.10. Minimum Zinc in parts per million (ppm)

4.1.4.5.2.11. Minimum Vitamin A, other than the precursors of Vitamin A, in International Units per pound (if added)

4.1.4.5.3. Guaranteed Analysis for Equine Mineral Feeds (all animal classes)

4.1.4.5.3.1. Minimum and maximum percentage of Calcium

4.1.4.5.3.2. Minimum percentage of Phosphorus

4.1.4.5.3.3. Minimum and maximum percentage of Salt (if added)

4.1.4.5.3.4. Minimum and maximum percentage of Sodium shall be guaranteed only when the total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.5.3.5. Minimum Copper in parts per million (ppm)

4.1.4.5.3.6. Minimum Selenium in parts per million (ppm)

4.1.4.5.3.7. Minimum Zinc in parts per million (ppm)

4.1.4.5.3.8. Minimum Vitamin A, other than precursors of Vitamin A, in International Units per pound (if added)

4.1.4.6. Required Guarantees for Goat and Sheep Formula Feeds

4.1.4.6.1. Animal Classes

4.1.4.6.1.1. Starter

4.1.4.6.1.2. Grower

4.1.4.6.1.3. Finisher

4.1.4.6.1.4. Breeder

4.1.4.6.1.5. Lactating

4.1.4.6.2. Guaranteed Analysis for Goat and Sheep Complete Feeds and Supplements (all animal classes)

4.1.4.6.2.1. Minimum percentage of Crude Protein

4.1.4.6.2.2. Maximum percentage of equivalent crude protein from Non-Protein Nitrogen (NPN) when added

4.1.4.6.2.3. Minimum percentage of Crude Fat

4.1.4.6.2.4. Maximum percentage of Crude Fiber

4.1.4.6.2.5. Minimum and maximum percentage of Calcium

4.1.4.6.2.6. Minimum percentage of Phosphorus

4.1.4.6.2.7. Minimum and maximum percentage of Salt (if added)

4.1.4.6.2.8. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.6.2.9. Minimum and maximum Copper in parts per million (ppm) (if added, or if total copper exceeds 20 ppm)

4.1.4.6.2.10. Minimum Selenium in parts per million (ppm)

4.1.4.6.2.11. Minimum Vitamin A, other than precursors of Vitamin A, in International Units per pound (if added)

4.1.4.7. Required Guarantees for Duck and Geese Formula Feeds

4.1.4.7.1. Animal Classes

4.1.4.7.1.1. Ducks

4.1.4.7.1.1.1. Starter - 0 to 3 weeks of age

4.1.4.7.1.1.2. Grower - 3 to 6 weeks of age

4.1.4.7.1.1.3. Finisher - 6 weeks to market

4.1.4.7.1.1.4. Breeder Developer - 8 to 19 weeks of age

4.1.4.7.1.1.5. Breeder - 22 weeks to end of lay

4.1.4.7.1.2. Geese

4.1.4.7.1.2.1. Starter - 0 to 4 weeks of age

4.1.4.7.1.2.2. Grower - 4 to 8 weeks of age

4.1.4.7.1.2.3. Finisher - 8 weeks to market

4.1.4.7.1.2.4. Breeder Developer -10 to 22 weeks of age

4.1.4.7.1.2.5. Breeder - 22 weeks to end of lay

4.1.4.7.2. Guaranteed Analysis for Duck and Geese Complete Feeds and Supplements (for all animal classes)

4.1.4.7.2.1. Minimum percentage of Crude Protein

4.1.4.7.2.2. Minimum percentage of Crude Fat

4.1.4.7.2.3. Maximum percentage of Crude Fiber

4.1.4.7.2.4. Minimum and maximum percentage of Calcium

4.1.4.7.2.5. Minimum percentage of Phosphorus

4.1.4.7.2.6. Minimum and maximum percentage of Salt (if added)

4.1.4.7.2.7. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.8. Required Guarantees for Fish Complete Feeds and Supplements

4.1.4.8.1. Animal Species shall be declared in lieu of animal class

4.1.4.8.1.1. Trout

4.1.4.8.1.2. Catfish

4.1.4.8.1.3. Species other than trout or catfish

4.1.4.8.2. Guaranteed analysis for all Fish Complete Feeds and Supplements

4.1.4.8.2.1. Minimum percentage of Crude Protein

4.1.4.8.2.2. Minimum percentage of Crude Fat

4.1.4.8.2.3. Maximum percentage of Crude Fiber

4.1.4.8.2.4. Minimum percentage of Phosphorus

4.1.4.9. Required Guarantees for Rabbit Complete Feeds and Supplements

4.1.4.9.1. Animal Classes

4.1.4.9.1.1. Grower - 4 to 12 weeks of age

4.1.4.9.1.2. Breeder -12 weeks of age and over

4.1.4.9.2. Guaranteed analysis for Rabbit Complete Feeds and Supplements (all animal classes)

4.1.4.9.2.1. Minimum percentage of Crude Protein

4.1.4.9.2.2. Minimum percentage of Crude Fat

4.1.4.9.2.3. Minimum and maximum percentage of Crude Fiber (the maximum crude fiber shall not exceed the minimum by more than 5.0 units)

4.1.4.9.2.4. Minimum and maximum percentage of Calcium

4.1.4.9.2.5. Minimum percentage of Phosphorus

4.1.4.9.2.6. Minimum and maximum percentage of Salt (if added)

4.1.4.9.2.7. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.9.2.8. Minimum Vitamin A, other than precursors of Vitamin A, in International Units per pound (if added)

4.1.4.10. The required guarantees of grain mixtures with or without molasses and feeds other than those described in Part 4.1.4.1 through 4.1.4.9 shall include the following items, unless exempted in Part 9, in the order listed:

4.1.4.10.1. Animal class(es) and species for which the product is intended.

4.1.4.10.2. Guaranteed analysis

4.1.4.10.2.1. Minimum percentage Crude Protein

4.1.4.10.2.2. Maximum or minimum percentage of equivalent Crude Protein from Non-Protein Nitrogen as required in Section 5.5.

4.1.4.10.2.3. Minimum percentage of Crude Fat

4.1.4.10.2.4. Maximum percentage of Crude Fiber

4.1.4.10.2.5. Minerals in formula feeds, to include in the following order:

4.1.4.10.2.5.1. Minimum and maximum percentages of Calcium

4.1.4.10.2.5.2. Minimum percentage of Phosphorus

4.1.4.10.2.5.3. Minimum and maximum percentage of Salt (if added)

4.1.4.10.2.5.4. Minimum and maximum percentage of total Sodium shall be guaranteed only when total Sodium exceeds that furnished by the maximum Salt guarantee

4.1.4.10.2.5.5. Other Minerals

4.1.4.10.2.6. Minerals in feed ingredients - as specified by the Official Definitions of Feed Ingredients published in the 2022 Official Publication of AAFCO.

4.1.4.10.2.7. Vitamins in such terms as specified in Part 5.3.

4.1.4.10.2.8. Total sugars as invert on dried molasses products or products being sold primarily for their sugar content

4.1.4.10.2.9. Viable lactic acid producing microorganisms for use in silage in terms specified in Part 5.7.

4.1.4.10.2.10. A commercial feed (e.g. vitamin/mineral premix, base mix, etc.) intended to provide a specialized nutritional source for use in the manufacture of other feeds, must state its intended purpose and guarantee those nutrients relevant to such stated purpose.

4.1.4.11. Exemptions

4.1.4.11.1. A mineral guarantee for feed, excluding those feeds manufactured as complete feeds and for feed supplements intended to be mixed with grain to produce a complete feed for swine, poultry, fish, and veal and herd milk replacers, is not required when:

4.1.4.11.1.1. The feed or feed ingredient is not intended or represented or does not serve as a principal source of that mineral to the animal; or

4.1.4.11.1.2. The feed or feed ingredient is intended for non-food producing animals and contains less than 6.5% total mineral.

4.1.4.11.2. Guarantees for vitamins are not required when the commercial feed is neither formulated for nor represented in any manner as a vitamin supplement.

4.1.4.11.3. Guarantees for crude protein, crude fat, and crude fiber are not required when the commercial feed is intended for purposes other than to furnish these substances or they are of minor significance relating to the primary purpose of the product, such as drug premixes, mineral or vitamin supplements, and molasses.

4.1.4.11.4. Guarantees for microorganisms are not required when the commercial feed is intended for a purpose other than to furnish these substances or they are of minor significance relating to the primary purpose of the product, and no specific label claims are made.

4.1.4.11.5. The indication for animal class(es) and species is not required on single ingredient products if the ingredient is not intended, represented, or defined for a specific animal class(es) or species.

4.1.4.11.6. In lieu of a guaranteed analysis statement, wild bird feed labels may substitute a composition statement that lists the percentage of each ingredient. Composition statement values are allowed a variance from the actual value up to 5%.

4.1.5. Feed ingredients, collective terms for the grouping of feed ingredients, or appropriate statements as provided under the provisions of Section 35-60-106(1)(e), C.R.S. of the Colorado Feed Law.

4.1.5.1. The name of each ingredient listed in descending order of predominance by weight and as defined in the Official Definitions of Feed Ingredients published in the Official Publication of AAFCO, common or usual name, or one approved by the Commissioner.

4.1.5.2. Collective terms for the grouping of feed ingredients as defined in the Official Definitions of Feed Ingredients published in the Official Publication of AAFCO, in lieu of the individual ingredients; provided that:

4.1.5.2.1. When a collective term for a group of ingredients is used on the label, individual ingredients within that group shall not be listed on the label.

4.1.5.2.2. The manufacturer shall provide the feed control official, upon request, with a list of individual ingredients, within a defined group, that are or have been used at manufacturing facilities distributing in or into the state.

4.1.6. Directions for use and precautionary statements or reference to their location if the detailed feeding directions and precautionary statements required by Parts 8 and 9 appear elsewhere on the label.

4.1.7. Name and principal mailing address of the manufacturer or person responsible for distributing the feed. The principal mailing address shall include the street address, city, state, zip code. However, the street address may be omitted if it is shown in the current city directory or telephone directory.

4.1.8. Quantity Statement.

4.1.8.1 Net quantity shall be declared in terms of weight, liquid measure or count.

4.1.8.2. Net quantity labeled in terms of weight shall be expressed both in pounds, with any remainder in terms of ounces or common or decimal fractions of the pound and in appropriate SI metric system units; or in the case of liquid measure, both in the largest whole unit (quarts, quarts and pints, or pints, as appropriate) with any remainder in terms of fluid ounces or common or decimal fractions of the pint or whole quart and in the appropriate SI metric system units.

4.1.8.3. When the declaration of quantity of contents by count does not give the adequate information as to the quantity of feed in the container, it shall be combined with such statement of weight, liquid measure, or size of the individual units as will provide such information.

Part 7. Ingredients

7.1. The name of each ingredient or collective term for the grouping of ingredients, when required to be listed, shall be the name as defined in the Official Definitions of Feed Ingredients published in the 2022 Official Publication of AAFCO, the common or usual name, or one approved by the Commissioner.

7.2. The name of each ingredient must be shown in letters or type of the same size.

7.3. No reference to quality or grade of an ingredient shall appear in the ingredient statement of a feed.

7.4. The term “dehydrated” may precede the name of any product that has been artificially dried.

7.5. A single ingredient product as defined in the Official Definitions of Feed Ingredients published in the 2022 Official Publication of AAFCO is not required to have an ingredient statement.

7.6. Tentative definitions as published in the Official Definitions of Feed Ingredients published in the 2022 Official Publication of AAFCO for ingredients shall not be used until adopted as official, unless no official definition exists or the ingredient has a common accepted name that requires no definition, (i.e. sugar).

7.7. When the word “iodized” is used in connection with a feed ingredient, the feed ingredient shall contain not less than 0.007% iodine, uniformly distributed.

Part 9. Non-Protein Nitrogen

9.1. Urea and other non-protein nitrogen products defined in the Official Definitions of Feed Ingredients published in the 2022 Official Publication of AAFCO are acceptable ingredients only in commercial feeds for ruminant animals as a source of equivalent crude protein. If the commercial feed contains more than 8.75% of equivalent crude protein from all forms of non-protein nitrogen, added as such, or the equivalent crude protein from all forms of non-protein nitrogen, added as such, exceeds one-third of the total crude protein, the label shall bear adequate directions for the safe use of feeds and a precautionary statement: “CAUTION: USE AS DIRECTED.” The directions for use and the caution statement shall be in type of such size so placed on the label that they will be read and understood by ordinary persons under customary conditions of purchase and use.

9.2. Non-protein nitrogen defined in the Official Definitions of Feed Ingredients published in the 2022 Official Publication of AAFCO when so indicated, are acceptable ingredients in commercial feeds distributed to non-ruminant animals as a source of nutrients other than equivalent crude protein. The maximum equivalent crude protein from non-protein nitrogen sources when used in non-ruminant rations shall not exceed 1.25% of the total daily ration.

9.3. On labels such as those for medicated feeds which bear adequate feeding directions and/or warning statements, the presence of added non-protein nitrogen shall not require a duplication of the feeding directions or the precautionary statements as long as those statements include sufficient information to ensure the safe and effective use of this product due to the presence of non-protein nitrogen.

Part 10. Drug and Feed Additives

10.1. Prior to approval of a registration application and/or approval of a label for commercial feed which contains additives (including drugs, other special purpose additives, or non-nutritive additives) the distributor may be required to submit evidence to prove the safety and efficacy of the commercial feed when used according to the directions furnished on the label.

10.2. Satisfactory evidence of safety and efficacy of a commercial feed may be:

10.2.1. When the commercial feed contains such additives, the use of which conforms to the requirements of the applicable regulation in the Code of Federal Regulations, Title 21, or which are “prior sanctioned” or “informal review sanctioned” or “generally recognized as safe” for such use, or

10.2.2. When the commercial feed is itself a drug as defined in Section 35-60-102(8) of the Colorado Feed Law and is generally recognized as safe and effective for the labeled use or is marketed subject to an application approved by the Food and Drug Administration under Title 21 U.S.C. 360 b, or

10.2.3. When one of the purposes for feeding a commercial feed is to impart immunity (that is to act through some immunological process) the constituents imparting immunity have been approved for the purpose through the Federal Virus, Serum and Toxins Act of 1913, as amended, or

10.2.4. When the commercial feed is a direct fed microbial product and:

10.2.4.1. The product meets the particular fermentation product definition; and

10.2.4.2. The microbial content statement, as expressed in the labeling, is limited to the following: “Contains a source of live (viable) naturally occurring microorganisms.” This statement shall appear on the label; and

10.2.4.3. The source is stated with a corresponding guarantee expressed in accordance with Part 5.7.

10.2.5. When the commercial feed is an enzyme product and:

10.2.5.1. The product meets the particular enzyme definition as defined in the Official Definitions of Feed Ingredients published in the 2022 Official Publication of AAFCO, and

10.2.5.2. The enzyme is stated with a corresponding guarantee expressed in accordance with Part 5.8.

Part 13. Material Incorporated by Reference

These rules herein incorporate the Official Publication of the Association of American Feed Control Officials, Inc (“AAFCO”), effective January 1, 2023. This rule incorporates by reference the AAFCO standards and guidelines. This rule does not adopt any later amendments to, or editions of, the AAFCO standards and guidelines. A copy of the Official Publication of the Association of American Feed Control Officials, Inc. shall be kept on file at the Department of Agriculture, located at 305 Interlocken Parkway, Broomfield Colorado 80021, and shall be open to public inspection, and available for copying, during normal business hours. A copy of the official publication shall also be kept at the AAFCO Headquarters Office, located at 1800 S. Oak Street, Suite 100, Champaign, IL 61820-6974 and is available online at: https://www.aafco.org/Publications This, and any other material that is incorporated by reference, may be examined at any state publications depository library.

Part 17. Statements of Basis, Specific Statutory Authority and Purpose

17.10. Adopted October 12, 2022 – Effective December 15, 2022

Statutory Authority

The Commissioner's authority for the adoption of this permanent Rule amendment is set forth in § 35-60-109(1) C.R.S.

Purpose

The purpose of this rulemaking is to update the references to the 2022 publication of the Association of American Feed Control Officials.

Factual and Policy Basis

1. Numerous changes to the AAFCO Official publication have occurred since the printing of the 2017 version which is currently referenced in the rules. The change to the 2022 version is reflected throughout the rule. Updating the rule to follow the 2022 AAFCO Model regulations will make our rules more consistent with other states’ feed rules.

2. These amendments incorporate changes as a result of the department’s regulatory efficiency review process.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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DEPARTMENT OF LAW

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Office of the Attorney General

Tracking number: 2022-00519

Opinion of the Attorney General rendered in connection with the rules adopted by the

Commissioner of Agriculture

on 10/12/2022

8 CCR 1202-6

RULES FOR COMMERCIAL FEED UNDER THE COLORADO FEED LAW, SECTIONS 35-60-101 THROUGH 115, C.R.S.

The above-referenced rules were submitted to this office on 10/13/2022 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.

October 31, 2022 15:55:55

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Agriculture

Agency

Inspection and Consumer Services Division

CCR number

8 CCR 1202-7

Rule title

8 CCR 1202-7 RULES FOR PET FOOD UNDER THE COLORADO FEED LAW, SECTIONS 35-60-101 THROUGH 115, C.R.S. 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF AGRICULTURE

Inspection and Consumer Services Division

RULES FOR PET FOOD UNDER THE COLORADO FEED LAW, SECTIONS 35-60-101 THROUGH 115, C.R.S.

8 CCR 1202-7

Part 2. Definitions and Terms

2.1. The Official Publication of the Association of American Feed Control Officials, Inc. shall mean the 2022 Official Publication of the Association of American Feed Control Officials, Inc. ("AAFCO"), effective January 1, 2023. This rule incorporates by reference the AAFCO standards and guidelines. This rule does not adopt any later amendments to, or editions of, the AAFCO standards and guidelines. A copy of the official publication of the Association of American feed Control Officials, Inc. shall be kept in the Department of Agriculture, located at 305 Interlocken Parkway, Broomfield Colorado 80021, and shall be open to public inspection, and available for copying, during normal business hours. A copy of the official publication shall also be kept at the AAFCO Headquarters office, located at 1800 S. Oak Street, Suite 100 Champaign, IL 61820-6974, and is available online at: http://www.aafco.org.publications. This, and any other material that is incorporated by reference, may be examined at any state publications depository library.

2.2. These Rules incorporate the Official Feed Terms as published in the 2022 Official Publication of AAFCO, except as the Commissioner designates otherwise in specific cases.

2.3. The following commodities are hereby declared exempt from the definition of commercial feed, under the provisions of Section 35-60-102(2), C.R.S. of the Colorado Feed Law, when unground and when not mixed or intermixed with other materials: raw meat, bone and antler, individual chemical compounds, hay, loose salt, straw, stover, silage, cobs, husks, and hulls; provided that these commodities are not adulterated within the meaning of Section 35-60-107, C.R.S., of the Colorado Feed Law. The exemption from the definition of commercial feed is removed for an exempted commodity that bears a label listing nutritional claims or guarantees.

The definitions in the Colorado Feed Law shall apply in addition to the following:

2.4. "AAFCO" means the Association of American Feed Control Officials, Inc.

2.5. "AAFCO Cat Food Nutrient Profiles" means the lists of nutrients required for cat foods as published in the 2022 Official Publication of AAFCO, incorporated herein by reference (later amendments not included.)

2.6. "AAFCO Dog Food Nutrient Profiles" means the lists of nutrients required for dog foods as published in the 2022 Official Publication of AAFCO, incorporated herein by reference (later amendments not included.)

2.7. "AAFCO Family Guidelines" means the procedures for establishing pet food product families as published in the 2022 Official Publication of AAFCO, incorporated herein by reference (later amendments not included).

2.8. "AAFCO-Recognized Animal Feeding Protocols" means the AAFCO Dog and Cat Food Feeding Protocols as published in the 2022 Official Publication of AAFCO, incorporated herein by reference (later amendments not included.)

2.9. "AAFCO-Recognized Authority" means the nutritional authority for a given species of animal as published in the 2022 Official Publication of AAFCO, incorporated herein by reference (later amendments not included.)

2.10. “AAFCO-Recognized Nutrient Profile” means the list of nutrients required for specialty pet foods for specific species of specialty pets as published in the 2022 Official Publication of AAFCO, incorporated herein by reference (later amendments not included.)

2.11. “All Life Stages” means gestation/lactation, growth, and adult maintenance life stages.

2.12. “Immediate Container” means the unit, can, box, tin, bag, or other receptacle or covering in which a pet food or specialty pet food is displayed for sale to retail purchasers, but does not include containers used as shipping containers.

2.13. “Ingredient Statement” means a collective and contiguous listing on the label of the ingredients of which the pet food or specialty pet food is composed.

2.14. “Pet” means dog or cat.

2.15. “Pet Food” means any commercial feed distributed or intended to be distributed for consumption by pets.

2.16. “Principal Display Panel” means the part of a label that is most likely to be displayed, presented, shown, or examined under normal and customary conditions of display for retail sale.

2.17. “Specialty Pet” means any domesticated pet animal normally maintained in a cage or tank, such as, but not limited to, gerbils, hamsters, canaries, finches, parrots, other cage birds, tropical fish, goldfish, snakes, turtles, and iguanas.

2.18. “Specialty Pet Food” means any commercial feed distributed or intended to be distributed for consumption by specialty pets.

2.19. "Family means a group of products which are nutritionally adequate for any or all life stages based on their nutritional similarity to a lead product which has been successfully test-fed according to an AAFCO-Recognized Animal Feeding Protocol(s).

Part 6. Ingredients

6.1. Each ingredient of a pet food or specialty pet food shall be listed in the ingredient statement as follows:

6.1.1. The names of all ingredients in the ingredient statement shall be shown in letters or type of the same size and color;

6.1.2. The ingredients shall be listed in descending order by their predominance by weight in non-quantitative terms;

6.1.3. Ingredients shall be listed and identified by the name and definition published in the 2022 Official Publication of AAFCO; and

6.1.4. Any ingredient for which no name and definition have been so established shall be identified by the common or usual name of the ingredient.

6.2. The ingredients “meat” or “meat by-products” shall be qualified to designate the animal from which the meat or meat by-products are derived unless the meat or meat by-products are derived from cattle, swine, sheep, goats, or any combination thereof. For example, ingredients derived from horses shall be listed as “horsemeat” or “horsemeat by-products”.

6.3. Brand or trade names shall not be used in the ingredient statement.

6.4. A reference to the quality, nature, form, or other attribute of an ingredient shall be allowed when the reference meets all of the following:

6.4.1. The designation is not false or misleading;

6.4.2. The ingredient imparts a distinctive characteristic to the pet food or specialty pet food because it possesses that attribute; and

6.4.3. A reference to quality or grade of the ingredient does not appear in the ingredient statement.

Part 14. Material Incorporated by Reference

These rules herein incorporate by reference the Official Publication of the Association of American Feed Control Officials, Inc. (“AAFCO”), effective January 1, 2022. This rule incorporates by reference the 2022 AAFCO standards and guidelines. This rule does not adopt any later amendments to, or editions of, the AAFCO standards and guidelines. A copy of the Official Publication of the Association of American Feed Control Officials, Inc. shall be kept on file at the Department of Agriculture, located at 305 Interlocken Parkway, Broomfield Colorado 80021, and shall be open to public inspection, and available for copying, during normal business hours. A copy of the official publication shall also be kept at the AAFCO Headquarters Office, located at 1800 S. Oak Street, Suite 100, Champaign, IL 61820-6974, and is available online at: https://www.aafco.org/Publications This, and any other material that is incorporated by reference, may be examined at any state publications depository library.

Part 18. Statements of Basis, Specific Statutory Authority and Purpose

18.8. Adopted October 12, 2022 – Effective December 15, 2022

Statutory Authority

The Commissioner's authority for the adoption of this permanent Rule amendment is set forth in § 35-60-109(1) C.R.S.

Purpose

The purpose of this rulemaking is to update references throughout the Rules to the official publication of the Association of American Feed Control Officials (AAFCO) incorporated by reference to the 2022 version.

Factual Policy and Issues

1. Numerous changes to the AAFCO publication have occurred since the printing of the 2017 version which is referenced in the rules. The change to the 2022 version is reflected throughout the rule. Updating the rule to follow the 2022 AAFCO Model regulations will make our rules more consistent with other states’ feed rules.

2. These amendments incorporate changes as a result of the department’s regulatory efficiency review process.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
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Office of the Attorney General

Tracking number: 2022-00520

Opinion of the Attorney General rendered in connection with the rules adopted by the

Commissioner of Agriculture

on 10/12/2022

8 CCR 1202-7

RULES FOR PET FOOD UNDER THE COLORADO FEED LAW, SECTIONS 35-60-101 THROUGH 115, C.R.S.

The above-referenced rules were submitted to this office on 10/13/2022 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.

October 31, 2022 15:58:36

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Agriculture

Agency

Inspection and Consumer Services Division

CCR number

8 CCR 1202-17

Rule title

8 CCR 1202-17 RULES PERTAINING TO THE ADMINISTRATION AND ENFORCEMENT OF THE PRODUCE SAFETY ACT 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF AGRICULTURE

Inspection and Consumer Services Division

RULES PERTAINING TO THE ADMINISTRATION AND ENFORCEMENT OF THE PRODUCE SAFETY ACT

8 CCR 1202-17

Pursuant to the provisions and requirements of the Produce Safety Act, Title 35, Article 77, C.R.S., the following rules are hereby promulgated to enforce under Colorado law the federal Standards for the Growing, Harvesting, Packing and Holding of Produce for Human Consumption, 21 CFR § 112.

Part 3 REGISTRATION REQUIREMENT

3.1 A farm or mixed type facility, that conducts Covered Activity of any Covered Produce at any primary production farm or secondary activities farm location, and which the average annual monetary value of produce sold during the previous three-year period is more than average monetary value determined in Part 3.5 of this Rule, must register and is subject to the General Provisions in Subpart A of 21 CFR § 112, "Standards for Growing, Harvesting, Packing, and Holding of Produce for Human Consumption," published November 27, 2015.

3.2 A farm that is eligible for a qualified exemption, as defined in Subpart A of 21 CFR § 112.5, must register with the Department and is only subject to sections of Subpart A of 21 CFR § 112, "Standards for Growing, Harvesting, Packing, and Holding of Produce for Human Consumption", stated in 21 CFR § 112.6 and 112.7

3.3 Registration and the General Provisions of Subpart A of 21 CFR § 112 do not apply to a farm or mixed-type facility that has an annual monetary value of produce sold during the previous three year period that is less than the monetary value determined in Part 3.5 of this Rule, even if that farm or mixed-type facility conducts Covered Activity.

3.4 Each farm, or mixed type facility, required to register shall do so annually during the registration period of November 1 to December 31. Such registration shall be completed by the submission of a form in the manner required by the Commissioner. All such information shall be complete and accurate.

3.5 For the 2023 registration year of January 1, 2023 to December 31, 2023, a farm that sold an average monetary value of produce during 2019, 2020 and 2021 with more than $29,245 must register with the Department.

Part 27 STATEMENT OF BASIS, SPECIFIC STATUTORY AUTHORITY AND PURPOSE

27.3 Adopted October 12, 2022 – Effective December 15, 2022

Statutory Authority

The Commissioner of Agriculture adopts these rules pursuant to §35-77-106(1), C.R.S.

Purpose

The purpose of this rule change is to increase the threshold limit for farms Exempt from the rule.

Factual and Policy Basis

Increased limits allowed for Exempt status are consistent with FDA's annual adjusted for inflation calculations.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00521

Opinion of the Attorney General rendered in connection with the rules adopted by the

Commissioner of Agriculture

on 10/12/2022

8 CCR 1202-17

RULES PERTAINING TO THE ADMINISTRATION AND ENFORCEMENT OF THE PRODUCE SAFETY ACT

The above-referenced rules were submitted to this office on 10/13/2022 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.

October 31, 2022 16:00:29

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Public Safety

Agency

Division of Homeland Security and Emergency Management

CCR number

8 CCR 1507-48

Rule title

8 CCR 1507-48 Preventing Identity-Based Violence Grant Program 1 - eff 12/15/2022

Effective date

12/15/2022

COLORADO
Department of Public Safety

Division of Homeland Security and Emergency Management

Preventing Identity-Based Violence Grant Program

8 CCR 1507-48

STATEMENT OF BASIS, STATUTORY AUTHORITY, AND PURPOSE

In House Bill 2022-1234, the General Assembly added section 24-33.5-1620, C.R.S., creating a new grant program called the Preventing Identity-Based Violence Grant Program. Section 24- 33.5-1620(3)(a) directs the Department of Public Safety to promulgate rules as necessary for the administration of the grant program. These rules are intended to be consistent with the requirements of the State Administrative Procedures Act, section 24-4-101 et seq. (the "APA"). Upon delegation from the Executive Director, the DHSEM Director led the rulemaking hearing that took place on Oct. 5, 2022.

This regulation shall govern the implementation of the Preventing Identity-Based Violence Grant Program, which includes the time frames for applying for this program, the form of the program application, and the time frames for distributing program funds. 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.

Stan Hilkey, Executive Director
Colorado Department of Public Safety

10/24/2022
Date

1. Authority

This regulation is adopted pursuant to the authority in section 24-33.5-1620, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, section 24-4-101 et seq. (the “APA”).

2. Scope and Purpose

This regulation shall govern the implementation of the Colorado Preventing Identity-based Violence Grant Program, which includes the time frames for applying for these grants, the form of the grant program application, and the time frames for distributing grant funds.

3. Applicability

The provisions of these rules shall be applicable to all eligible applicants and recipients of grant funds as provided by law.

4. Definitions

“Grant program” means the Colorado Preventing Identity-based Violence Grant Program as set forth in 24-33.5-1620.

“Office” means the Office of Prevention and Security created in Section 24-33.5-1606, within the Colorado Division of Homeland Security and Emergency Management.

“Recipient” means an eligible applicant receiving an award.

“Educational Entity” means a school district; a board of cooperative services; a district charter school or an institute charter school operating pursuant to Article 30.5 of Title 22; a state institution of higher education, as defined in Section 23-18-102 (10)(a); a local district college, created pursuant to Article 71 of Title 23; an area technical college, as defined in Section 23-60-103; or a private institution of higher education, as defined in Section 23-18-102 (9).

“Prevention project(s)” means projects proposed and outlined within the application related to preventing identity-based violence.

“Award” means a financial assistance grant that provides support to accomplish a public purpose given by the state to an eligible recipient.

“Period of Performance” means the period of time during which the recipient is required to complete the grant activities and to receive and expend approved funds.

“Project Implementation and Measurement Plan” means a written form or other document determined by the Office to outline the steps necessary to achieve grant objectives and required measurements for the grant objectives.

“Quarterly Progress Report” means a written form or other document determined by the Office to indicate and report the operational and financial activity of the recipient during the time period specified.

“Summary Report” means a written form or other document determined by the Office to indicate and report the final operational and financial activity of the recipient during the time period specified.

“Reimbursement Request” means a written form or other document determined by the Office to be used by the grant recipient to request reimbursement from grant award funds for approved expenditures.

5. Program Requirements

5.1 Eligibility

A. Applicants must be from a county, municipality, or city and county, and any agency thereof; an American Indian Tribe; a law enforcement agency; a district attorney’s office; an educational entity; and a nonprofit organization that is exempt from taxation under Section 501 (c)(3) of the federal “Internal Revenue Code of 1986”, as amended, which may be a community-based nonprofit organization that has experience working with those affected by identity-based violence.

B. Eligible applicants must submit an application developed by the Office in conformance with the application and the terms of the program guidance described below.

C. Eligible applicants must indicate in the application that the grant funds will be used for the following preventing identity-based violence-related activities and purposes (including but not limited to):

1. Building awareness for the prevention and intervention of identity-based violence within Colorado communities;

2. Strengthening local collaboration and capabilities for prevention and intervention of identity-based violence;

3. Building sustainable support for the prevention and intervention of identity-based violence.

4. Any other identity-based violence prevention efforts approved by the Office.

D. Eligible applicants that are not a community-based nonprofit organization that has experience working with those affected by identity-based violence must partner with a community-based nonprofit organization with that experience to carry out the project funded by the grant program.

E. Eligible applicants must demonstrate they have sufficient authority and capacity to implement the prevention project outlined in their application, including the capability to engage the participants the eligible applicants propose to include in their projects.

F. Proposed prevention projects shall not infringe on individual privacy, civil rights, and civil liberties. Prevention projects shall describe any potential impacts to privacy, civil rights, and civil liberties and ways in which the eligible applicants will prevent or mitigate those impacts and administer their prevention projects in a nondiscriminatory manner.

G. Eligible applicants who are a law enforcement agency shall comply with the requirements set forth in 28 CFR Part 23 with regard to the collection, maintenance, and use of intelligence information learned by the agency through a project funded with an award from this grant program, regardless of whether the agency is a direct recipient or is acting in partnership with a recipient.

H. 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 the recipient's activities and expenditures.

1. The Office shall annually evaluate environmental factors that lead to identity-based violence and challenges to reducing identity-based violence. The Office may establish annual priorities for the program that address the identified factors and challenges.

5.2 Award Details

A.	Available Funding for Year 1:	$916,908
B.	Period of Performance:	12 months
C.	Funding Instrument:	Discretionary Grant

5.3 Time Frames for Application

A. Time Frames

Year 1:

Application Submission Deadline:	December 30, 2022; 5:00 PM MDT
Grant Awarded to Applicants Deadline:	January 20, 2023
Grant Award Notification on Website Deadline:	January 27, 2023
Grant Fund Distribution Deadline:	February 28, 2023
Period of Performance – 12 months:	March 01, 2023 – February 29, 2024

B. Restrictions

1. Applications that are not submitted by the stated Application Submission Deadline will not be reviewed or considered for funding;

2. All applications must include the required elements for all applications, as well as specific requirements of the projects they are proposing, including but not limited to: performance measures for each project type. Failure to provide a complete application or significant deviation from the requirements can cause an application to be ineligible or not reviewed or considered for funding;

3. Applications that describe programs, projects, or activities that do not appropriately protect privacy, civil rights, or civil liberties will be deemed ineligible for funding;

4. Recipient(s) that are not a law enforcement agency shall not collect or maintain intelligence information about the political, religious, or social views, associations, corporation, business partnership, or other organization.

5. Applications that only consist of research are not eligible under this grant program. Research is an allowable expense, however, eligible applicants must propose to implement one or more prevention capabilities during the Period of Performance and must demonstrate how any proposed research will support that implementation;

6. Equipment costs are not allowed under this program. Equipment is defined as tangible personal property (including information technology systems) having a useful life of more than one year and a per-unit acquisition cost which equals or exceeds the lesser of the capitalization level for financial statement purposes. Additionally, this grant program does not allow costs for supplies or equipment related to emergency communications, tactical response, or related costs;

7. Pre-Award Costs are NOT allowed under this grant program (costs incurred or work completed prior to the award date);

8. Extensions to the Period of Performance are not allowed;

9. A Cost Share or Cost Match is not required;

10. Up to 5% of the award may be used for management and administration of the grant funds;

11. Recipient(s) shall not use any part of an award as matching funds for other grants or cooperative agreements, or for lobbying efforts, litigation costs, or intervention in regulatory or adjudicatory proceedings.

5.4 Application Submissions

Eligible applicants must submit their acceptable signed application via email or other delivery methods as listed and allowed in the grant application and accompanying guidance.

5.5 Grant Guidance

The Office is responsible for the implementation of this grant program and will develop and publish a grant application and guidance. Grant guidance will include the following reporting requirements:

1. A Project Implementation and Measurement Plan;

2. Quarterly Progress Reports

3. A final Summary Report

4. Reimbursement Requests;

5. Any other documents required by the application, terms and conditions of the award, or other guidance provided by the Office.

The amount of each award will be determined by the quality and completeness of the application in accordance with the criteria outlined in these rules, as well as the proposed use of funding as it relates to the priorities outlined in the application.

Editor's Notes

History
New Rules

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
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Office of the Attorney General

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Division of Homeland Security and Emergency Management

on 10/24/2022

8 CCR 1507-48

Preventing Identity-Based Violence Grant Program

The above-referenced rules were submitted to this office on 10/24/2022 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.

November 08, 2022 15:36:11

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Treasury

Agency

State Treasurer

CCR number

8 CCR 1508-3

Rule title

8 CCR 1508-3 Rules Governing the Colorado Secure Savings Program 1 - eff 12/15/2022

Effective date

12/15/2022

DEPARTMENT OF THE TREASURY

Colorado Secure Savings Program

8 CCR 1508-3

Rules Governing the Colorado Secure Savings Program

1508-3.1 Authority

This regulation is adopted by the Board of the Colorado Secure Savings Program pursuant to its powers described in paragraphs (b), (f), and (i) in C.R.S. 24-54.3-103.5(1) and C.R.S 24.54.3-107. Pursuant to paragraphs (a), (b), (g), (h), (k), and (L) of C.R.S. 24-54.3-104(2), this regulation reflects the obligation of the Board to design the Program to promote greater retirement savings for private sector employees in a convenient, low-cost, and portable manner. Furthermore, the regulation is intended to be consistent with the requirements of the State Administrative Procedures Act 24-4-101 et seq. (the "APA"), C.R.S., the Colorado Secure Savings Program Act, and ERISA.

1508-3.2 Scope and Purpose

This regulation governs Employers defined in C.R.S. 24-54.3-102(3), Employees defined in C.R.S. 24-54.3-102(2), Voluntary Participants, Treasury Staff, Colorado Department of Labor and Employment, the Board, and the Program Administrator with respect to the Colorado Secure Savings Program. Pursuant to C.R.S 24-54.3-104(6) the regulations establish Participation requirements for Employers defined in 24.54.3-102(3). Furthermore, these regulations intend to satisfy the rulemaking obligations of the Board outlined in C.R.S. 24-54.3-107.

1508-3.3 Reserved

1508-3.4 Definitions

The following definitions shall apply for purposes of the Program unless otherwise indicated in these rules:

"Acceptable Submission Method" means one or more modes of document submission detailed on the Program website.

"Account" means, individually or collectively as the context may require, each Roth IRA and Traditional IRA that has been established under the Program.

"Account Holder" means an individual for whom an Account is held under the Program. Account Holders include Onboarded Employees after the Opt-Out Period and Voluntary Participants for whom an Account is established.

"Act" means SB20-200 and the C.R.S. 24.54.3 Colorado Secure Savings Program Act.

"Automatic Escalation" means an additional 1% annual increase in an Account Holder's Contributions at the beginning of each subsequent calendar year following the Account Holder's Onboarding.

"Beneficiary" means the individual(s), person(s), or entity(ies) entitled to receive the proceeds of an Account upon the death of an Account Holder.

"Board" means the Colorado Secure Savings Program Board defined in C.R.S. 24-54.3-102(1).

“Capital Preservation Investment” means a Money Market account selected by the Board where Payroll Deductions are held during the Opt-Out period.

“CDLE” means the Colorado Department of Labor and Employment.

“Certificate of Exemption” means a record provided by the Program Administrator to a business entity that acknowledges said entity’s Exemption.

“Code” means the Internal Revenue Code of 1986, as amended, and any U.S. Department of Treasury regulations, rulings, announcements or other guidance issued thereunder.

“Coemployer” means, in accordance with C.R.S. 8-70-114, either an Employee Leasing Company or a Work-Site Employer.

“Confirmation Notice” means a document sent by the Program Administrator to Participating Employers, Account Holders, and Voluntary Account Holders after Onboarding Information is provided.

“Contribution” means monies contributed to an Account.

“Contribution Rate” means the whole-integer percentage of Wages contributed to an Account by an Account Holder.

“Custom Contribution Rate” means any Contribution Rate elected by the Account Holder as made available by the Program Administrator.

“Custom Investment” means any of the asset classes chosen by the Board besides the Default Investment Option

“Default Contribution Rate” means five percent of Account Holder’s Wages.

“Default Investment Option” means the Target Date fund chosen by the Board, which correlates to the Account Holder’s birth year.

“Employee” means Employee as defined in C.R.S. 24-54.3-102(2).

“Employee Leasing Company” means any person, business, or other entity that provides services to a Work-Site Employer pursuant to an Employee Leasing Company Contract, as defined in paragraph (2)(a) of C.R.S. 8-70-114.

“Employee Leasing Company Contract” means any written staff leasing contract, extended employee staffing or supply contract, or other contract under which an Employee Leasing Company procures or receives from a Work-Site Employer specified Coemployer responsibilities for specified employees, designating itself as employer of such employees, and retaining the right of direction and control of such employees with regard to those employer responsibilities, including the rights and responsibilities set forth in paragraph (b) of subsection (2) of C.R.S. 8-70-114.

“Employer” means Employer as defined in C.R.S. 24-54.3-102(3).

“ERISA” means the Employee Retirement Income Security Act of 1974, as amended.

“Exempt” means not required to Onboard or Participate in the Program.

“Exemption” means the certification by a business entity to the Program Administrator online through the Program website affirming that said entity does not meet the definition of Employer and therefore is neither required to Onboard nor Participate in the Program.

“Fee” means Fee as defined in C.R.S. 24-54.3-102(4).

“FEIN” means Federal Employment Identification Number provided by the IRS.

“Form 5500 Filing” means the Annual Return/Report of Employee Benefit Plan that is required to be filed for certain employee benefit plans under sections 104 and 4065 of ERISA and sections 6057(b) and 6058(a) of the Code.

“Grant” means a sum of money given by the Program to Participating Employers with between five and twenty-five Employees, as mandated in C.R.S. 24-54.3-103.5(f), for the purpose of incentivizing compliance with the Program and defraying costs incurred by this category of Employers.

“Hold and Sweep Period” means the 30 day period after the Opt-Out Period, during which time Contributions are held in a Capital Preservation Investment on behalf of Participating Employees.

“In Business” means (i) (ii) (ii) or (iv), the date which occurred closest to the present day: (i) the date of the IRS Form SS-4 or (ii) the date as of which the Colorado Secretary of State recorded the business formation document or (iii) the issue date of the Colorado Sales Tax License or (iv) the month and year when the business became liable for wage withholding with the CDLE.

“Inactive” means an Account to which no funds have been deposited for at least 12 months; or from which all funds have been withdrawn, rolled-over (out), or transferred.

“IRA” means, individually or collectively as the context may require, a Roth Individual Retirement Account or a Traditional Individual Retirement Account.

“IRS” means the Internal Revenue Service.

“Launch Date” means the date when the Program is open to the public.

“Non-Compliant Employer” means Employers that have neither certified Exemption nor are Participating Employers.

“Non-Payroll Contribution” means any amount, greater than or equal to five dollars, elected by an Account Holder that Account Holder remits outside of a Payroll Deduction Contribution.

“Onboard” means to furnish information to the Program Administrator in order to Participate in the Program.

“Onboarding” means the process by which Employers and Employees and Self-Employed Individuals furnish information to the Program Administrator in order to participate in the Program.

“Onboarding Information” means the information detailed in 1508-3.5.4 and required to be provided by an Employer, an Employee, or a Voluntary Participant to the Program Administrator to enable participation in the Program.

“Opt-Out Period” means the 30 day account revocation period following completion of Onboarding with the Program Administrator.

“Participate” means to remit either Employee Payroll Deduction Contributions or Contributions of Voluntary Participants to the Program Administrator.

“Participating Employer” means an Employer that is remitting Payroll Deduction Contributions to the Program Administrator.

"Participation" means the remittance of either Employee Payroll Deduction Contributions or Contributions of Voluntary Participants to the Program Administrator.

"Participating Individual" means either a Self-Employed Individual or a Voluntary Participant whose Onboarding Information has been received by the Program Administrator and who is remitting Contributions to an Account.

"Payroll Deduction Contributions" means Contributions made by an Onboarded Employee via a payroll deduction through a Participating Employer.

"Program" means the Colorado Secure Savings Program, which has been created by the Board pursuant to C.R.S. 24.54.3-103

"Program Administrator" means the third-party entity procured by the Board to assist in carrying out the requirements of the Act.

"Program Information" means a document provided by the Program Administrator after onboarding to both Employees and to Voluntary Participants, which outlines the program features including, but not limited to the items listed in C.R.S. 24-54.3-107.

"Registration Date" means a date established by the Board on which Employers are required to complete Onboarding into the Program.

"Roth IRA" means an individual retirement account within the meaning of section 408A of the Code.

"Self-Employed Individual" means an individual who either (i) carries on a trade or business as a sole proprietor or an independent contractor, or (ii) is a member of a partnership that carries on a trade or business, or (iii) is otherwise in business for himself or herself (including a part-time business or a "gig worker") and who meets the qualifications to open an IRA.

"Tax-Qualified Retirement Plan" means, for purposes of the Program, an employee benefit plan that is qualified under section 401(a), 401(k), 403(a), 403(b), 408(k), 408(p), or 457(b) of the Code.

"Traditional IRA" means an individual retirement account within the meaning of section 408 of the Code.

"Treasury Staff" means one or more of the employees of the State of Colorado Department of Treasury.

"Voluntary Participant" means an individual who meets the qualifications to open an IRA but who does not meet the definition of Employee as defined in C.R.S. 24-54.3-102(2) and who are willing and able to provide Onboarding Information to the Program Administrator.

"Wages" means Wages as defined in C.R.S. 24-54.3-102(7).

"Work-Site Employee" means an individual who is in an employment relationship with both an Employee Leasing Company and a Work-Site Employer and has received written notice of coemployment with the Employee Leasing Company.

"Work-Site Employer" means any person, business, or other entity that procures the services of an Employee Leasing Company under an Employee Leasing Company Contract and otherwise retains direction and control of the employees specified in the contract regarding responsibilities not specified in the contract pertaining to the business of the work-site employer.

1508-3.5 Employers

1508-3.5.1. Multi-Party Employment Relationships.

A. Pursuant to C.R.S. 24-54.3-107(g)(2), existing state forms and state compliance structures are to be used for exemption reporting; therefore, the Employer or business entity whose EIN appears in CDLE's records of payment unemployment insurance premiums per C.R.S.8-70-114 (2)(b)(VII) determines which employing unit is responsible for either certifying Exemption, or both Onboarding with the Program and Onboarding Employees.

B. Any Wages paid to the Work-Site Employee by the Employee Leasing Company with respect to services provided under the Employee Leasing Company Contract, shall be treated as Wages received from the Work-Site Employer.

C. Nothing in these rules prohibits an Employee Leasing Company and its Work-Site Employer from entering into an Employee Leasing Company Contract or other agreement under which the Employee Leasing Company agrees to assist the Work-Site Employer with the performance of some or all of the Work-Site Employer's responsibilities under this section.

1508-3.5.2 Incentive Grants

A. Participating Employers with between five and twenty-five Employees may apply for a Grant via the Colorado Treasury website after remitting at least one Payroll Deduction Contribution to the Program Administrator.

B. Treasury Staff will cross-check Grant applications with the monthly Payroll Deduction Contribution reports provided by the Program Administrator and will process Grant payments via U.S. Mail as soon as administratively possible.

1508-3.5.3 Employer Exemption

A. Treasury Staff or Program Administrator may send Employers that are identified as not having a current Form 5500 on file with the U.S. Department of Labor written notice(s) directing the business entity to either Onboard with the Program or certify Exemption per process detailed in the ensuing section.

B. Process for certain business entities to certify Exemption

1. An authorized representative of a business entity shall certify, through the Program website that said entity either presently offers a Tax Qualified Retirement Plan, or has fewer than five Employees, or has been In Business for less than two years.

    a. The business entity may reference the following state forms and compliance structures when determining its eligibility for Exemption

        i. business formation document(s) from Colorado Secretary of State

        ii. Sales Tax License from Colorado Department of Revenue, if applicable; and

        iii. CDLE's Form UITR or other CDLE form that determines when the business became liable for wage withholding.

2. Upon receipt of the employer's online certification of its reason for Exemption, the Program Administrator shall provide a Certificate of Exemption that will remain in effect so long as the business entity continues to offer a Tax Qualified Retirement Plan to some or all of its Employees or maintains fewer than five Employees.

1508-3.5.4 Employer Onboarding

A. By or before its Registration Date in 2023, Employers shall either Onboard with the Program or obtain a Tax-Qualified Retirement Plan.

B. Employers shall submit the following Onboarding Information to the Program Administrator via the Program website or an Acceptable Submission Method:

1. Employer name and assumed business name, if any;

2. Federal Employer Identification Number;

3. Employer mailing address

4. Name, title, telephone number and email address of an individual designated by the employer to serve as the point of contact;

5. Number of Employees; and

6. Any additional information necessary to complete Onboarding.

C. In the event that the Program Administrator finds that any of the information listed in this subsection (b) is not available on the online portal or is inaccurate, employers shall provide the missing or correct information, as applicable

1508-3.5.5 Employer Restrictions

A. Business entities that offer a Tax-Qualified Retirement Plan are not required to Onboard or Participate in the Program.

B. Business entities without a Tax Qualified Retirement Plan, that have been In Business for fewer than two years and have five or more Employees are not required to Onboard with the Program until the Employer achieves two years In Business.

1. Business entities without a Tax Qualified Retirement Plan that have been In Business for fewer than two years and have between two to four Employees will be allowed to Onboard and Participate in the Program by July 1st, 2024.

C. Business entities with between two to four Employees will be allowed to Onboard and Participate in the Program by July 1st, 2024.

D. Employers shall not:

1. Prohibit, restrict, or discourage Employee Participation in the Program.

2. Provide Account Holders or Beneficiaries of deceased Account Holders advice or direction regarding investment choices, Contribution Rates, Automatic Escalation, or any other decision about the Program.

3. Remit any Payroll Deduction Contributions for any Onboarded Employee who opted out of the Program.

4. Exercise any authority, control, or responsibility regarding the Program, other than those duties specifically described in sections 1508-3.5.6 and 1508-3.5.7.

5. Contribute to Account Holder’s Account.

1508-3.5.6 Onboarding of Employees by Participating Employer

A. No later than 30 days following an individual's 180th day of employment at a Participating Employer, the Employer shall provide the following information to the Program Administrator for each Employee:

1. Full legal name;

2. Social security number or taxpayer ID number;

3. Date of birth;

4. Mailing address;

5. Employee's designated email address, if available;

6. Employee's phone number, if available; and

7. Any additional information needed to complete the Onboarding when the information submitted for Onboarding is unclear or insufficient, or when further information is required for purposes of administering the Program

B. Per C.R.S. 24-54.3-104(2)(L), prior to an individual's 180th day of employment by an Employer, an individual may Onboard into the Program as a Voluntary Participant may remit Contributions voluntarily.

1508-3.5.7 Withholding and Remitting of Payroll Deduction Contributions by Participating Employer

A. Participating Employers shall not remit Payroll Deduction Contributions until after the Opt-Out Period.

B. During the Hold and Sweep Period, Participating Employers shall remit all Payroll Deduction Contributions to the Program Administrator as soon as administratively practicable, no later than fourteen days of Contribution being withheld from an Account Holder's Wages.

C. Amounts withheld by the Participating Employer shall not exceed the amount of the Account Holder's Wages remaining after any payroll deductions required by law or employer payroll practice to have higher precedence, including a court order.

1508-3.5.8 Responsibilities of Program Administrator to Participating Employers

A. Onboarded and Participating Employers may contact the Program Administrator if they desire technical assistance in completing Program requirements.

B. Upon receiving the Employee's Onboarding Information from the Employer, the Program Administrator shall email a confirmation to the Employer and send the Program Information to each Employee.

1508-3.6. Employees

1508-3.6.1 Right To Opt-Out

A. An Employee Onboarded into the Program by an Employer may Opt-Out of the Program at any time.

B. No Account will be established if Employee opts-out during the Opt-Out Period.

C. Program Administrator shall send Program Information to Employees as soon as administratively possible after Onboarding is completed and shall send other important information including legal or other material information a reasonable investor would want to know before contributing by payroll deduction or directly.

D. Employees Onboarded by Employers are deemed to have read and understood the Program Information content, which includes instructions about how to Opt Out of the Program, as required by C.R.S. 24-54.3-107(k)3.

E. Those who opt out of the Program may re-Onboard at any time by providing the required Onboarding Information through the Program Website or an Acceptable Submission Method.

1508.3.7 Voluntary Participants

A. Self-Employed Individuals and Voluntary Participants may Onboard with the Program as long as they meet the qualifications to open an IRA and provide the Onboarding Information required by the Program Administrator as follows:

1. Full legal name;

2. Social security number or taxpayer ID number;

3. Date of birth;

4. Mailing address;

5. Email address, if available;

6. Phone number, if available; and

7. Any additional information needed to complete the Onboarding when the information submitted for Onboarding is unclear or insufficient, or when further information is required for purposes of administering the Program

B. Program Administrator shall send Program Information to Voluntary Participants and Self-Employed Individuals as soon as administratively possible after Onboarding is completed and shall send them the mandatory disclosures pursuant to C.R.S. 24-54.3-107(K).

C. Voluntary Participants and Self-Employed Individuals shall have one Account, regardless of whether the Voluntary Participant also makes Contributions from a single Participating Employer or multiple Participating Employers (simultaneously or separately throughout Account Holder's lifetime).

D. After the Program Administrator establishes an Account for the Voluntary Participant or Self-Employed Individuals, the individual is considered an Account Holder.

1508-3.8 Accounts

1508-3.8.1 Contributions

A. Minimum and Maximum Contribution Levels

1. It shall be the responsibility of the Account Holder or Voluntary Participant to determine whether he/she/they are eligible per the Code to make Contributions to an Account and

whether the amount of their Contributions to an Account complies with the contribution limits established under the Code, and whether or not such Contributions are deductible.

B. Default Investment and Custom Investment options

1. The Program Information provided by Program Administrator shall instruct Account Holders on how to select Custom Investments versus the Default Investment Option.

2. In the Employee portal on the Program website, Account Holders may direct their Contributions to any of the available fund options offered by the Program.

3. During the Hold and Sweep Period, Contributions will be directed into the Capital Preservation Investment.

4. After the Hold and Sweep Period, Program Administrator shall direct Contributions from the Capital Preservation Investment into the Default Investment Option, unless an Account Holder has elected a Custom Investment.

5. Account Holders may change their investment choice at any time after Employer completes Onboarding.

C. Default Contribution Rate and Custom Contribution Rate

1. The Program Information provided by Program Administrator shall instruct Account Holders on how to elect a Custom Contribution Rate distinct from the Default Contribution Rate.

2. In the Employee portal on the Program website, Account Holders may elect any Contribution Rate that is a whole-number percentage and may direct their Contributions to any of the available fund options offered by the Program.

3. During Hold and Sweep Period, Participating Employers will remit the Default Contribution Rate on behalf of Account Holder into the Capital Preservation Investment, unless the Account Holder elected a Custom Contribution Rate during the Opt Out Period.

4. Account Holder Contributions made subsequent to the Hold and Sweep Period will be made at the Default Contribution Rate unless a participant has elected a Custom Contribution Rate.

5. Account Holders may change their Contribution Rate to any whole integer percentage at any time after Employer completes Onboarding of Employees.

1508-3.8.2 Non-Payroll Contributions

A. Any Account Holder may choose to make Non-Payroll Contributions to the Program.

B. Such Contributions must not exceed, in combination with Payroll Deduction Contributions, the annual IRA contribution limit as determined by the Code and related rules promulgated by the IRS.

C. The Program Administrator will establish the minimum contribution for Non-Payroll Contributions and the Program website will be current with this information.

D. Non-Payroll Contributions may be made electronically or by personal check.

1508-3.8.3 Automatic Escalation

A. Contributions for Account Holders who have Participated in the Program for at least six months will automatically increase by 1% of an Account Holder's Wages at the beginning of each subsequent calendar year, up to a maximum of 8% of an Account Holder's wages.

B. On an annual basis, the Program Administrator shall notify all Account Holders in advance of any Contribution increase to allow for Account Holders to opt out of Automatic Escalation or to change their Contribution Rate.

C. Account Holders may adjust the rate of their Automatic Escalation, or opt in to Automatic Escalation, or opt out of Automatic Escalation at any time through the Program website.

1508-3.8.4 Termination of Participating Employer Status through Program Exemption

A. Participating Employers who begin offering a Tax Qualified Retirement Plan must notify the Program Administrator at least sixty days prior to the cessation of Payroll Deduction Contributions.

B. Upon a Participating Employer becoming Exempt, remittance of Payroll Deduction Contributions on behalf of Account Holders is prohibited.

C. Participating Employers that have become Exempt must notify Account Holders at least thirty days before Payroll Deduction Contributions cease and provide them with information describing how to contact the Program Administrator.

D. Unless Account Holders elect otherwise, Accounts will remain in the Program after the Participating Employer certifies its Exemption.

E. Conversion of status of Account Holders

1. If the Participating Employer became Exempt due to its number of Employees falling below five, the status of the remaining Employees of the now-Exempt Employer automatically convert to Voluntary Participants.

2. Exempt Employers with 2-4 Employees are prohibited from remitting Payroll Deduction Contributions for Voluntary Participants.

1508-3.8.5 Portability

A. Rollovers and Transfers

1. Rollover or Transfer In

a. An Account Holder may receive rollovers and transfers from other retirement savings vehicles in accordance with the time limits established under Title 26 of the Code.

2. Rollover or Transfer Out

a. The Program Administrator shall determine the process through which an Account Holder or Beneficiary may roll over or transfer all or a portion of a Program IRA to a different retirement savings vehicle in accordance with the Code.

1508-3.8.6 Withdrawals

A. Account Holder may withdraw all or a portion of funds from their Account at any time by submitting a completed request to the Program Administrator, in a form or format established by the Program and permitted by the IRS.

B. The Program shall not assess any penalty for withdrawals. Withdrawals shall be subject to any applicable State and federal income tax obligations and may be subject to penalties under the Code.

1508-3.8.7 Account Closure

A. The Program Administrator and Treasury Staff will agree determine a process for closing Inactive Accounts.

1508-3.8.8 Abandoned Accounts

A. An Account shall be presumed abandoned according to the unclaimed property law of the state of the last known address of the Participating Employee or Participating Individual. If the last known address of the Participating Employee or Participating Individual is in Colorado, the provisions of the Uniform Disposition of Unclaimed Property shall apply. If there is no last known address of the Account Holder in the Program records, federal common law shall determine the state with the first priority claim.

1508-3.9 Enforcement

A. The Program will partner with CDLE to enforce compliance with the Act.

B. CDLE will fine Non-compliant Employers one-hundred dollars for each Employee per year, not to exceed five thousand dollars in a calendar year.

C. Process

1. Treasury Staff together with Program Administrator shall determine Registration Dates for Employers based on number of Employees.

2. Treasury Staff together with Program Administrator will notify Employers via first-class US Mail not only of their respective Registration Dates but also in advance of receiving Final Notice of Penalty Application.

3. After Registration Dates have passed, CDLE will send three Notices of Non-Compliance to Non-Compliant Employers which provide instructions on how either to Onboard with the Program or to certify Exemption.

4. Fines shall commence no earlier than twelve months after the Registration Date or one year after an Employer is scheduled to enter the program, whichever is later. In no event shall a fine be assessed earlier than three months after the first Notice of Non-Compliance is postmarked.

5. Within 30 days of the date listed on the Final Notice of Penalty Application, Non-Compliant Employers shall remit to CDLE annual fines according to section 1508-3.5.9(B)1 above.

1508-3.10 Confidentiality

Program Administration shall comport with C.R.S. 24-54.3-110.

1508-3.11 Severability

If any portion of these rules is found to be invalid, the remaining portion of the rules shall remain in force and effect.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2022-00286

Opinion of the Attorney General rendered in connection with the rules adopted by the

State Treasurer

on 10/14/2022

8 CCR 1508-3

Rules Governing the Colorado Secure Savings Program

The above-referenced rules were submitted to this office on 10/18/2022 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.

November 03, 2022 10:47:57

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Permanent Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY 1 - eff 12/15/2022

Effective date

12/15/2022

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Concerning Private Duty Nursing Benefits, Section 8.540.2
Rule Number: MSB 22-08-29-A
BSMD /Cassandra Keller / 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 22-08-29-A, Revision to the Medical Assistance Act Rule concerning Private Duty Nursing Benefits, Section 8.540.2

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) 8.540.2, Colorado Department of Health Care Policy and Financing, (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? <Select One>

   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 8.540.2.D with the proposed text beginning at 8.540.2.D through the end of 8.540.2.D. This rule is effective November 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Concerning Private Duty Nursing Benefits, Section 8.540.2
Rule Number: MSB 22-08-29-A
BSMD /Cassandra Keller / 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).

   This rule sets forth the authority for the Private Duty Nursing benefit under the Health First Colorado State Plan. Private Duty Nursing provides nursing services for beneficiaries who require more individual and continuous care than is available from a visiting nurse or routinely provided by the nursing staff of the hospital or skilled nursing facility. In order to meet the urgent care needs of our members, the Department must create an exception process to meet the potentially unmet needs of our members. Current regulation states that adult members may not receive more than 16 hours per day of Private Duty Nursing. By revising the regulations to allow for an exception process to the limit, members will have access to medically necessary nursing services they require.

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 C.F.R. § 440.80

4. State Authority for the Rule:

   Section § 25.5-5-303. (2022)
   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022)

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Concerning Private Duty Nursing Benefits, Section 8.540.2
Rule Number: MSB 22-08-29-A
BSMD /Cassandra Keller / 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.

   The proposed rule will have an impact on members who utilize Private Duty Nursing (PDN). Adult members who have extraordinary medical needs that require more than 16 hours per day of PDN and receive approval to exceed the limit will benefit from this change.

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

   Members will have access to obtain all medically necessary skilled nursing care through the private duty nursing benefit, rather than having to supplement private duty nursing hours with additional skilled nursing hours provided through other benefits, and may obtain all skilled nursing services through a single provider.

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 expects the increase in PDN expenditure to be offset by a reduction of ($2,282,695) in Home- and Community-Based Services (HCBS) expenditure, leading to a net increase of $1,574,085 per state fiscal year. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Without revising these regulations, the Department does not have the authority to develop an exception to the unit limit.

8. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.

   There are no less intrusive or costly methods to achieve this purpose. This change must be done with a change to the regulations.

DO NOT PUBLISH THIS PAGE

9. 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 estimates the rule change will increase PDN expenditure by $3,856,780 per year. The regulations outline a hard cap of 16-hours that cannot be exceeded. Rule must be revised in order to allow for exception to this limit.

8.540 PRIVATE DUTY NURSING SERVICES

8.540.2 BENEFITS

8.540.2.A. Beginning November 1, 2021, providers must submit a prior authorization request for all new PDN services. For members currently receiving PDN services initiated prior to November 1, 2021, providers must submit a prior authorization request in accordance with the schedule provided in Section 8.540.7.G.

8.540.2.B. A pediatric client may be approved for up to 24 hours per day of PDN services if the client meets the URC medical necessity criteria. PDN for pediatric clients is limited to the hours determined medically necessary by the URC pursuant to Section 8.540.4.A, as applicable.

1. The URC shall determine the number of appropriate pediatric PDN hours by considering age, stability, need for frequent suctioning and the ability to manage the tracheostomy.

2. The URC shall consult with the Home Health Agency and the attending physician or primary care physician, to provide medical case management with the goal of resolving the problem that precipitated the need for extended PDN care of more than 16 hours.

3. The URC shall consider combinations of technologies and co-morbidities when making medical criteria determinations.

8.540.2.C. Twenty-four hour care may be approved for pediatric clients during periods when the family caregiver is unavailable due to illness, injury or absence periodically for up to 21 days in a calendar year.

8.540.2.D. Adult clients may be approved for up to 16 hours of PDN per day. The Department may authorize additional hours up to 23 hours per day when determined medically necessary.

8.540.2.E. A client who is eligible and authorized to receive PDN services in the home may receive care outside the home during those hours when the client's activities of daily living take him or her away from the home. The total hours authorized shall not exceed the hours that would have been authorized if the client received all care in the home.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Colorado Dental Health Care Program for Low-Income Seniors Schedule A, Section 8.960
Rule Number: MSB 22-08-29-B
Division / Contact / Phone: Special Financing / Chandra Vital / 303-866-5506

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-08-29-B, Revision to the Special Financing Division Colorado Dental Health Care Program for Low-Income Seniors Schedule A, Section 8.960

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   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 8.960 with the proposed text beginning at 8.960 through the end of 8.960. Replace the text at Appendix A with the proposed text beginning at Appendix A through the end of Appendix A. This rule is effective November 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Colorado Dental Health Care Program for Low-Income Seniors Schedule A, Section 8.960
Rule Number: MSB 22-08-29-B
Division / Contact / Phone:Special Financing / Chandra Vital / 303-866-5506

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Current rule mandates that the Colorado Dental Health Care Program for Low-Income Senior max program payments on Schedule A may not be less than Medicaid dental rates. Effective July 1, 2022, Medicaid dental rates were increased and two procedures under the program fell below the Medicaid rate. The procedures to be increased to match Medicaid rates are D1354, interim caries arresting medicament application-per tooth and D9219, evaluation for moderate sedation, deep sedation or general anesthesia.

   The Dental Advisory Committee also recommended the addition of two new procedures. D7261, primary closure of a sinus perforation, this is exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fistulous tract. At this time, if seniors need this repair done the program does not cover this procedure. This leaves the senior with side effects and prosthodontics are not able to be placed. The low-income aging population is not able to pay for this type of repair. The other procedure is D9239, intravenous moderate (conscious) sedation/analgesia, first 15 minutes. Sedation is currently covered through the program, except for the first 15 minutes. Many seniors will forgo having much needed oral health care due to not being able to afford the first 15 minutes of sedation.

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 C.F.R. 162-1002(a)(4)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022); 25.5-2-101, C.R.S. (2022)

Initial Review
Proposed Effective Date
Final Adoption
Emergency Adoption

DOCUMENT #

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25.5-3-404(4), C.R.S. (2022)

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

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Title of Rule: Revision to the Special Financing Division Colorado Dental Health Care Program for Low-Income Seniors Schedule A, Section 8.960
Rule Number: MSB 22-08-29-B
Division / Contact / Phone:Special Financing / Chandra Vital / 303-866-5506

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The max program payment increases for D1354 and D9219 on Schedule A will put the program in line with current rule that no max program payment will be below the current Medicaid dental rates and grantees will receive the accurate amount for these procedures. Adding D7261 and D9239 will benefit all low-income aging individuals that are need of oral health but elect to forgo due to not having the funds to pay for these procedures. There will be no incurred costs for the program, the seniors within the program, the grantees, nor the Department due to the set allocated amount of the grant.

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

   This rule update will ensure that the grantees of the program receive the correct amount for procedures performed and the seniors of the program will be able to receive two new procedures that they would not otherwise be able to afford.

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

   The Department will have no fiscal impact with this rule change. The funds for the Colorado Dental Health Care Program for Low-Income Seniors are appropriated and this rule update will have no effect on the appropriation of funds.

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

   The increase of max program payment for D1354 and D9219 on Schedule A is required due to the max program payment amount falling below the

Medicaid dental rate. The addition of D7261 and D9239 will allow seniors of the program to receive the needed oral health care required. Seniors of the program are not able to pay for these two new procedures and forgo much needed oral health care.

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

   The Department does not foresee any fiscal impact on this rule change and there are not any less costly methods that were considered.

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.

   Updating these rules is the only method available to ensure compliance with current Medicaid dental rates and there is no alternative method for the new recommended procedures.

8.960 COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS

8.960.1 Definitions

Arrange For or Arranging For means demonstrating established relations with Qualified Providers for any of the Covered Dental Care Services not directly provided by the applicant.

Covered Dental Care Services include Diagnostic Imaging, Emergency Services, Endodontic Services, Evaluation, Oral and Maxillofacial Surgery, Palliative Treatment, Periodontal Treatment, Preventive Services, Prophylaxis, Removable Prosthesis, and Restorative Services as listed by alphanumeric procedure code in Appendix A.

C.R.S. means the Colorado Revised Statutes.

Dental Health Professional Shortage Area or Dental HPSA means a geographic area, population group, or facility so designated by the Health Resources and Services Administration of the U.S. Department of Health and Human Services.

Dental Prosthesis means any device or appliance replacing one or more missing teeth and associated structures if required.

Department means the Colorado Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2020).

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation.

Economically Disadvantaged means a person whose Income is at or below 250% of the most recently published federal poverty level for a household of that size.

Eligible Senior or Client means an adult who is 60 years of age or older, who is Economically Disadvantaged, who is not eligible for dental services under Medicaid or the Old Age Pension Health and Medical Care Program, and who does not have private dental insurance. An Eligible Senior or client is not ineligible solely because he/she is receiving dental benefits under Medicare or Medicare Advantage Plans.

Emergency Services means the need for immediate intervention by a Qualified Provider to stabilize an oral cavity condition.

Endodontic Services means services which are concerned with the morphology, physiology and pathology of the human dental pulp and periradicular tissues, including pulpectomy.

Evaluation means an assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions.

Federally Qualified Health Center means a federally funded nonprofit health center or clinic that serves medically underserved areas and populations as defined in 42 U.S.C. section 1395x (aa)(4).

Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, or interest that are received by an individual or family. Income may be self-declared. Resources are not included in Income.

Max Allowable Fee means the total reimbursement listed by procedure for Covered Dental Care Services under the Colorado Dental Health Care Program for Low-Income Seniors in Appendix A. The Max Allowable Fee is the sum of the Program Payment and the Max Client Co-Pay.

Max Client Co-Pay means the maximum amount that a Qualified Provider may collect from an Eligible Senior listed by procedure in Appendix A for Covered Dental Services under the Colorado Dental Health Care Program for Low-Income Seniors.

Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S. (2020).

Medicare means the federal health insurance program for people who are 65 or older; certain younger people with disabilities; or people with End-Stage Renal Disease.

Medicare Advantage Plans mean the plans offered by Medicare-approved private companies that must follow rules set by Medicare and may provide benefits for services Medicare does not, such as vision, hearing, and dental care.

Old Age Pension Health and Medical Care Program means the program described at 10 CCR 2505-10, section 8.940 et. seq. and as defined in sections 25.5-2-101 and 26-2-111(2), C.R.S. (2020).

Oral and Maxillofacial Surgery means the diagnosis, surgical and adjunctive treatment of diseases, injuries and defects involving both the functional and esthetic aspects of the hard and soft tissues of the oral and maxillofacial region.

Palliative Treatment for dental pain means emergency treatment to relieve the client of pain; it is not a mechanism for addressing chronic pain.

Periodontal Treatment means the therapeutic plan intended to stop or slow periodontal disease progression.

Preventive Services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries.

Program Payment means the maximum amount by procedure listed in Appendix A for Covered Dental Care Services for which a Qualified Grantee may invoice the Department under the Colorado Dental Health Care Program for Low-Income Seniors. Program Payment must not be less than the reimbursement schedule for fee-for-service dental fees under the medical assistance program established in Articles 4, 5, and 6 of 10 CCR 2505-10.

Prophylaxis means the removal of dental plaque and calculus from teeth, in order to prevent dental caries, gingivitis and periodontitis.

Qualified Grantee means an entity that can demonstrate that it can provide or Arrange For the provision of Covered Dental Care Services and may include but is not limited to:

1. An Area Agency on Aging, as defined in section 26-11-201, C.R.S. (2020);

2. A community-based organization or foundation;

3. A Federally Qualified Health Center, safety-net clinic, or health district;

4. A local public health agency; or

5. A private dental practice.

Qualified Provider means a licensed dentist or dental hygienist in good standing in Colorado or a person who employs a licensed dentist or dental hygienist in good standing in Colorado and who is willing to accept reimbursement for Covered Dental Services. A Qualified Provider may also be a Qualified Grantee if the person meets the qualifications of a Qualified Grantee.

Removable Prosthesis means complete or partial Dental Prosthesis, which after an initial fitting by a dentist, can be removed and reinserted by the eligible senior.

Restorative Services means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic needs of the client.

Senior Dental Advisory Committee means the advisory committee established pursuant to section 25.5-3-406, C.R.S. (2020).

8.960.2 Legal Basis

The Colorado Dental Health Care Program for Low-Income Seniors is authorized by state law at part 4 of article 3 of title 25.5, C.R.S. (2020).

8.960.3 Request of Grant Proposals and Grant Award Procedures

8.960.3.A Request for Grant Proposals

Grant awards shall be made through an application process. The request for grant proposals form shall be issued by the Department and posted for public access on the Department's website at https://www.colorado.gov/hcpf/research-data-and-grants at least 30 days prior to the due date.

8.960.3.B Evaluation of Grant Proposals

Proposals submitted for the Colorado Dental Health Care Program for Low-Income Seniors will be evaluated by a review panel in accordance with the following criteria developed under the advice of the Senior Dental Advisory Committee.

1. The review panel will be comprised of individuals who are deemed qualified by reason of training and/or experience and who have no personal or financial interest in the selection of any particular applicant.

2. The sole objective of the review panel is to recommend to the Department's executive director those proposals which most accurately and effectively meet the goals of the program within the available funding.

3. Preference will be given to grant proposals that clearly demonstrate the applicant's ability to:

    a. Outreach to and identify Eligible Seniors;

    b. Collaborate with community-based organizations; and

    c. Serve a greater number of Eligible Seniors or serve Eligible Seniors who reside in a geographic area designated as a Dental HPSA.

4. The review panel shall consider the distribution of funds across the state in recommending grant proposals for awards. The distribution of funds should be based on

the estimated percentage of Eligible Seniors in the state by Area Agency on Aging region as provided by the Department.

8.960.3.C Grant Awards

The Department's executive director, or his or her designee, shall make the final grant awards to selected Qualified Grantees for the Colorado Dental Health Care Program for Low-Income Seniors.

8.960.3.D Qualified Grantee Responsibilities

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors is required to:

1. Identify and outreach to Eligible Seniors and Qualified Providers;

2. Demonstrate collaboration with community-based organizations;

3. Ensure that Eligible Seniors receive Covered Dental Care Services efficiently without duplication of services;

4. Maintain records of Eligible Seniors serviced, Covered Dental Care Services provided, and moneys spent for a minimum of six (6) years;

5. For Eligible Seniors with dental coverage through a Medicare Advantage Plan, bill the Medicare Advantage Plan for dental procedures covered by the Medicare Advantage Plan prior to seeking payment from the Department. The Colorado Dental Health Care Program is secondary to the Medicare Advantage Plan dental coverage;

6. Distribute grant funds to Qualified Providers in its service area or directly provide Covered Dental Care Services to Eligible Seniors;

7. Expend no more than seven (7) percent of the amount of its grant award for administrative purposes; and

8. Submit an annual report as specified under section 8.960.3.F.

8.960.3.E Invoicing

A Qualified Grantee that is awarded a grant under the Colorado Dental Health Care Program for Low-Income Seniors shall submit invoices on a form and schedule specified by the Department. Covered Dental Care Services shall be provided before a Qualified Grantee may submit an invoice to the Department.

1. Invoices shall include the number of Eligible Seniors served, the alphanumeric code and procedure description as listed in Appendix A, and any other information required by the Department.

2. The Department will pay no more than the established Program Payment per procedure rendered, as listed in Appendix A.

3. Eligible Seniors shall not be charged more than the Max Client Co-Pay as listed in Appendix A.

4. Qualified Grantees shall not bill the Department for any procedures covered by Medicare Advantage Plans that have been billed and paid by the Medicare Advantage Plans;

5. Qualified Grantees shall indicate on the invoice if the Eligible Senior has dental coverage through a Medicare Advantage Plan and any claim to the Medicare Advantage Plan was adjudicated prior to billing the Department;

6. Qualified Grantees may invoice for no more than seven (7) percent of the Program Payment for administrative costs.

8.960.3.F Annual Report

On or before September 1, 2016, and each September 1 thereafter, each Qualified Grantee receiving funds from the Colorado Dental Health Care Program for Low-Income Seniors shall submit a report to the Department following the state fiscal year contract period.

The annual report shall be completed in a format specified by the Department and shall include:

1. The number of Eligible Seniors served;

2. The types of Covered Dental Care Services provided;

3. An itemization of administrative expenditures;

4. The procedures and amounts billed to Medicare Advantage Plans for Eligible Seniors; and

5. Any other information deemed relevant by the Department.

10 CCR 2505-10 § 8.960 APPENDIX A: COLORADO DENTAL HEALTH CARE PROGRAM FOR LOW-INCOME SENIORS COVERED SERVICES AND PROCEDURE CODES

Capitalized terms within this appendix shall have the meaning specified in the Definitions section.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodic oral evaluation - established client	D0120	$46.00	$46.00	$0.00	Evaluation performed on a client of record to determine any changes in the client's dental and medical health status since a previous comprehensive or periodic evaluation. This may include an oral cancer evaluation and periodontal evaluation, diagnosis, treatment planning. Frequency: One time per 6 month period per client.
Limited oral evaluation - problem focused	D0140	$62.00	$52.00	$10.00	Evaluation limited to a specific oral health problem or complaint. This code must be used in association with a specific oral health problem or complaint and is not to be used to address situations that arise during multi-visit treatments covered by a single fee, such as, endodontic or post-operative visits related to treatments including prosthesis. Specific problems may include dental emergencies, trauma, acute infections, etc. Cannot be used for adjustments made to prosthesis provided within previous 6 months. Cannot be used as an encounter fee.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Comprehensive oral evaluation - new or established client	D0150	$81.00	$81.00	$0.00	Evaluation used by general dentist or a specialist when evaluating a client comprehensively. Applicable to new clients; established clients with significant health changes or other unusual circumstances; or established clients who have been absent from active treatment for three or more years. It is a thorough evaluation and recording of the extraoral and intraoral hard and soft tissues, and an evaluation and recording of the client's dental and medical history and general health assessment. A periodontal evaluation, oral cancer evaluation, diagnosis and treatment planning should be included. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0180.
Comprehensive periodontal evaluation - new or established client	D0180	$88.00	$88.00	$0.00	Evaluation for clients presenting signs & symptoms of periodontal disease & clients with risk factors such as smoking or diabetes. It includes evaluation of periodontal conditions, probing and charting, evaluation and recording of the client's dental and medical history and general health assessment. It may include the evaluation and recording of dental caries, missing or unerupted teeth, restorations, occlusal relationships and oral cancer evaluation. Frequency: 1 per 3 years per client. Cannot be charged on the same date as D0150.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - complete series of radiographic images	D0210	$125.00	$125.00	$0.00	Radiographic survey of whole mouth, usually consisting of 14-22 periapical & posterior bitewing images intended to display the crowns & roots of all teeth, periapical areas of alveolar bone. Panoramic radiographic image & bitewing radiographic images taken on the same date of service shall not be billed as a D0210. Payment for additional periapical radiographs within 60 days of a full month series or a panoramic film is not covered unless there is evidence of trauma. Frequency: 1 per 5 years per client. Any combination of x-rays taken on the same date of service that equals or exceeds the max allowable fee for D0210 must be billed and reimbursed as D0210. Should not be charged in addition to panoramic film D0330. Either D0330 or D0210 per 5 year period.
Intraoral - periapical first radiographic image	D0220	$25.00	$25.00	$0.00	D0220 one (1) per day per client. Report additional radiographs as D0230. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Intraoral - periapical each additional radiographic image	D0230	$23.00	$23.00	$0.00	D0230 must be utilized for additional films taken beyond D0220. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210. D0210 will only be reimbursed every 5 years.
Bitewing - single radiographic image	D0270	$26.00	$26.00	$0.00	Frequency: 1 in a 12 month period. Report more than 1 radiographic image as: D0272 two (2); D0273 three (3); D0274 four (4). Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - two radiographic images	D0272	$42.00	$42.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Bitewings - three radiographic images	D0273	$52.00	$52.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Bitewings - four radiographic images	D0274	$60.00	$60.00	$0.00	Frequency: 1 time in a 12 month period. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Vertical bitewings – seven to eight radiographic images	D0277	$68.32	$68.32	$0.00	Frequency: 1 time in a 12-month period. This does not constitute a full mouth intraoral radiographic series. Any combination of D0220, D0230, D0270, D0272, D0273, D0274, or D0277 taken on the same date of service that exceeds the max allowed fee for D0210 is reimbursed at the same fee as D0210.
Panoramic radiographic image	D0330	$63.00	$63.00	$0.00	Frequency: 1 per 5 years per client. Cannot be charged in addition to full mouth series D0210. Either D0330 or D0210 per 5 years.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Prophylaxis - adult	D1110	$88.00	$88.00	$0.00	Removal of plaque, calculus and stains from the tooth structures with intent to control local irritational factors. Frequency: • 1 time per 6 calendar months; 2 week window accepted. • May be billed for routine prophylaxis. • D1110 may be billed with D4341 and D4342 one time during initial periodontal therapy for prophylaxis of areas of the mouth not receiving nonsurgical periodontal therapy. When this option is used, individual should still be placed on D4910 for maintenance of periodontal disease. D1110 can only be charged once, not per quadrant, and represents areas of the mouth not included in the D4341 or D4342 being reimbursed. • May be alternated with D4910 for maintenance of periodontally-involved individuals. • D1110 cannot be billed on the same day as D4346 • Cannot be used as 1 month re-evaluation following nonsurgical periodontal therapy.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Topical application of fluoride varnish	D1206	$52.00	$52.00	$0.00	Topical fluoride application is to be used in conjunction with prophylaxis or preventive appointment. Should be applied to whole mouth. Frequency: up to four (4) times per 12 calendar months. Cannot be used with D1208.
Topical application of fluoride - excluding varnish	D1208	$52.00	$52.00	$0.00	Any fluoride application, including swishing, trays or paint on variety, to be used in conjunction with prophylaxis or preventive appointment. Frequency: one (1) time per 12 calendar months. Cannot be used with D1206. D1206 varnish should be utilized in lieu of D1208 whenever possible.
Interim caries arresting medicament application – per tooth	D1354	$5.71	$5.71	$0.00	Two of D1354 per 12 months per patient per tooth for primary and permanent teeth. Not to exceed 4 times per tooth in a lifetime. Cannot be billed on the same day as D1355 or any D2000 series code (D2140–D2954). Must Report both tooth number and surface(s).
Caries preventive medicament application – per tooth	D1355	$5.47	$5.47	$0.00	For primary prevention or remineralization. Medicaments applied do not include topical fluorides. Medicaments that may be applied during the delivery of D1355 procedure include Silver Diamine Fluoride (SDF), Silver Nitrate (SN), thymol-CHX varnish, and topical povidone iodine (PVP-I). Cannot be billed on the same day as: D1206, D1208, D1354, D0140, D9110, or any restoration codes on the same day or within 12 months of D2140 thru D2954. Maximum of four D1355 per tooth per lifetime. Must report both tooth number and surface(s).

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Amalgam - one surface, primary or permanent	D2140	$112.67	$102.67	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - two surfaces, primary or permanent	D2150	$141.20	$131.20	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - three surfaces, primary or permanent	D2160	$170.88	$160.88	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Amalgam - four or more surfaces, primary or permanent	D2161	$204.96	$194.96	$10.00	Includes tooth preparation, all adhesives, liners, polishing, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, anterior	D2330	$115.00	$105.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - two surfaces, anterior	D2331	$146.00	$136.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, anterior	D2332	$179.00	$169.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Resin-based composite - four or more surfaces or involving incisal angle (anterior)	D2335	$212.00	$202.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - one surface, posterior	D2391	$134.00	$124.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite -two surfaces, posterior	D2392	$176.00	$166.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - three surfaces, posterior	D2393	$218.00	$208.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Resin-based composite - four or more surfaces, posterior	D2394	$268.00	$258.00	$10.00	Includes tooth preparation, all adhesives, liners, etching, and bases. Adjustments are included. Frequency: 36 months for the same restoration. See Explanation of Restorations.
Crown - porcelain/ceramic	D2740	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - porcelain fused to high noble metal	D2750	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to predominantly base metal	D2751	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - porcelain fused to noble metal	D2752	$780.00	$730.00	$50.00	Only one the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 cast predominantly base metal	D2781	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - 3/4 cast noble metal	D2782	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - 3/4 porcelain/ceramic	D2783	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast high noble metal	D2790	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - full cast predominantly base metal	D2791	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Crown - full cast noble metal	D2792	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Crown - titanium	D2794	$780.00	$730.00	$50.00	Only one of the following will be reimbursed each 84 months per client per tooth: D2740, D2750, D2751, D2752, D2781, D2782, D2783, D2790, D2791, D2792, or D2794. Second molars are only covered if it is necessary to support a partial denture or to maintain eight posterior teeth in occlusion.
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	D2910	$87.00	$77.00	$10.00	Not allowed within 6 months of placement.
Re-cement or re-bond crown	D2920	$89.00	$79.00	$10.00	Not allowed within 6 months of placement.
Core buildup, including any pins when required	D2950	$225.00	$200.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of coronal structure when there is insufficient retention for a separate extracoronal restorative procedure. A core buildup is not a filler to eliminate any undercut, box form, or concave irregularity in a preparation. Not payable on the same tooth and same day as D2951.
Pin retention per tooth	D2951	$50.00	$40.00	$10.00	Pins placed to aid in retention of restoration. Can only be used in combination with a multi-surface amalgam.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Cast post and core in addition to crown	D2952	$332.00	$307.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Prefabricated post and core in addition to crown	D2954	$269.00	$244.00	$25.00	Only one of the following will be reimbursed per 84 months per client per tooth. D2950, D2952, or D2954. Core is built around a prefabricated post. This procedure includes the core material and refers to building up of anatomical crown when restorative crown will be placed. Not payable on the same tooth and same day as D2951.
Endodontic therapy, anterior tooth (excluding final restoration)	D3310	$566.40	$516.40	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 6-11 and 22-27.
Endodontic therapy, premolar tooth (excluding final restoration)	D3320	$661.65	$611.65	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 4, 5, 12, 13, 20, 21, 28, and 29.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Endodontic therapy, molar tooth (excluding final restoration)	D3330	$786.31	$736.31	$50.00	Complete root canal therapy; Includes all appointments necessary to complete treatment; also includes intra-operative radiographs. Does not include diagnostic evaluation and necessary radiographs/diagnostic images. Teeth covered: 2, 3, 14, 15, 18, 19, 30, and 31.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - four or more teeth per quadrant	D4341	$177.00	$167.00	$10.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. D4341 and D1110 can be reported on same service date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Diagnosis and classification of the periodontology case type must be in accordance with documentation as currently established by the American Academy of Periodontology. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting. Documentation of other treatment provided at same time will be requested. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal scaling & root planing - one to three teeth per quadrant	D4342	$128.00	$128.00	$0.00	Involves instrumentation of the crown and root surfaces of the teeth to remove plaque and calculus from these surfaces. For clients with periodontal disease and is therapeutic, not prophylactic. D4342 and D1110 can be reported on same service date when date when D1110 is utilized for areas of the mouth that are not affected by periodontal disease. D1110 can only be charged once, not per quadrant; A diagnosis of periodontitis with clinical attachment loss (CAL) included. Current periodontal charting must be present in client chart documenting active periodontal disease. Frequency: • 1 time per quadrant per 36 month interval. • No more than 2 quadrants may be considered in a single visit in a non-hospital setting.. Documentation of other treatment provided at same time will be requested. • Cannot be charged on same date as D4346. • Any follow-up and re-evaluation are included in the initial reimbursement.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	D4346	$102.00	$92.00	$10.00	The removal of plaque, calculus, and stains from supra- and sub-gingival tooth surfaces when there is generalized moderate or severe gingival inflammation in the absence of periodontitis. It is indicated for patients who have swollen, inflamed gingiva, generalized suprabony pockets, and moderate to severe bleeding on probing. Should not be reported in conjunction with prophylaxis, scaling and root planing, or debridement procedures. Frequency: once in a lifetime. • Any follow-up and re-evaluation are included in the initial reimbursement. • Cannot be charged on the same date as D1110, D4341, D4342, or D4910.
Full mouth debridement to enable a comprehensive evaluation and diagnosis on a subsequent visit	D4355	$94.02	$84.02	$10.00	One of (D4335) per 3 year(s) per patient. Prophylaxis D1110 is not reimbursable when provided on the same day of service as D4355. D4355 is not reimbursable if patient record indicates D1110 or D4910 have been provided in the previous 12 month period. Other D4000 series codes are not reimbursable when provided on the same date of service as D4355.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Periodontal maintenance procedures	D4910	$136.00	$136.00	$0.00	Procedure following periodontal therapy D4341 or D4342. This procedure includes removal of the bacterial plaque and calculus from supragingival and subgingival regions, site specific scaling and root planing where indicated and polishing the teeth. Frequency: • Up to four times per fiscal year per client. • Cannot be charged on the same date as D4346. • Cannot be charged within the first three months following active periodontal treatment.
Complete denture - maxillary	D5110	$874.52	$794.52	$80.00	Reimbursement made upon delivery of a complete maxillary denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130 or D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Complete denture - mandibular	D5120	$875.94	$795.94	$80.00	Reimbursement made upon delivery of a complete mandibular denture to the client. D5110 or D5120 cannot be used to report an immediate denture, D5130, D5140. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A complete denture is made after teeth have been removed and the gum and bone tissues have healed - or to replace an existing denture. Complete dentures are provided once adequate healing has taken place following extractions. This can vary greatly depending upon client, oral health, overall health, and other confounding factors. Frequency: Program will only pay for one per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate denture – maxillary	D5130	$874.52	$794.52	$80.00	Reimbursement made upon delivery of an immediate maxillary denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5130 can be reimbursed only once per lifetime per client. Complete denture, D5110, may be considered 5 years after immediate denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.
Immediate denture – mandibular	D5140	$875.94	$795.94	$80.00	Reimbursement made upon delivery of an immediate mandibular denture to the client. Routine follow-up adjustments/soft tissue condition relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate denture is made prior to teeth being extracted and is inserted same day of extraction of remaining natural teeth. Frequency: D5140 can be reimbursed only once per lifetime per client. Complete dentures, D5120, may be considered 5 years after immediate denture was reimbursed – documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5211	$700.00	$640.00	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5211 and D5212 are considered definitive treatments. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin maxillary per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture - resin base (including retentive/clasping materials, rests, and teeth)	D5212	$778.00	$718.00	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5211 and D5212 are considered definitive treatment. Routine follow-up adjustments/relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial resin base denture can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial resin base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one resin mandibular per every 3 years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5213	$844.31	$784.31	$60.00	Reimbursement made upon delivery of a complete partial maxillary denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can also be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one maxillary per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5214	$844.31	$784.31	$60.00	Reimbursement made upon delivery of a complete partial mandibular denture to the client. D5213 and D5214 are considered definitive treatment. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. A partial cast metal base can be made right after having teeth extracted (healing from only a few teeth is not as extensive as healing from multiple). A partial cast metal base denture can also be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: Program will only pay for one mandibular per every five years - documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	D5221	$607.61	$547.61	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5221 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and “try-in” appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	D5222	$607.61	$547.61	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5222 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 3 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5223	$844.31	$784.31	$60.00	Reimbursement made upon delivery of an immediate partial maxillary denture to the client. D5223 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months is to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A maxillary partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	D5224	$844.31	$784.31	$60.00	Reimbursement made upon delivery of an immediate partial mandibular denture to the client. D5224 can be reimbursed only once per lifetime per client and must be on the same date of service as the extraction. Routine follow-up adjustments or relines within 6 months are to be anticipated and are included in the initial reimbursement. An immediate partial cast metal framework with resin base denture can be made before having teeth extracted if the teeth being removed are in the front or necessary healing will be minimal. Several impressions and "try-in" appointments may be necessary and are included in the cost. Frequency: A mandibular partial denture may be considered 5 years after immediate partial denture was reimbursed. Documentation that existing prosthesis cannot be made serviceable must be maintained.
Repair broken complete denture base, mandibular	D5511	$123.70	$113.70	$10.00	Repair broken complete denture base, mandibular
Repair broken complete denture base, maxillary	D5512	$123.70	$113.70	$10.00	Repair broken complete denture base, maxillary
Replace missing or broken teeth - complete denture (each tooth)	D5520	$92.91	$82.91	$10.00	Replacement/repair of missing or broken teeth.
Repair resin partial denture base, mandibular	D5611	$95.00	$85.00	$10.00	Repair resin partial denture base, mandibular
Repair resin partial denture base, maxillary	D5612	$95.00	$85.00	$10.00	Repair resin partial denture base, maxillary
Repair cast partial framework, mandibular	D5621	$121.29	$111.29	$10.00	Repair cast partial framework, mandibular
Repair cast partial framework, maxillary	D5622	$121.29	$111.29	$10.00	Repair cast partial framework, maxillary
Repair or replace broken retentive/clasping materials – per tooth	D5630	$131.00	$121.00	$10.00	Repair of broken clasp on partial denture base – per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Replace broken teeth-per tooth	D5640	$94.02	$84.02	$10.00	Repair/replacement of missing tooth.
Add tooth to existing partial denture	D5650	$109.00	$99.00	$10.00	Adding tooth to partial denture base. Documentation may be requested when charged on partial delivered in last 12 months.
Add clasp to existing partial denture	D5660	$136.05	$126.05	$10.00	Adding clasp to partial denture base – per tooth. Documentation may be requested when charged on partial delivered in last 12 months.
Rebase complete maxillary denture	D5710	$322.00	$297.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase complete mandibular denture	D5711	$322.00	$297.00	$25.00	Rebasing the denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Rebase maxillary partial denture	D5720	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Rebase mandibular partial denture	D5721	$304.00	$279.00	$25.00	Rebasing the partial denture base material due to alveolar ridge resorption. Frequency: one (1) time per 12 months. Completed at laboratory. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a reline in a 12 month period.
Reline complete maxillary denture (chairside)	D5730	$182.00	$172.00	$10.00	Chair side reline that resurfaces without processing denture base. Frequency: One (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (chairside)	D5731	$182.00	$172.00	$10.00	Chair side reline that resurfaces without processing denture base. Frequency: One (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (chairside)	D5740	$175.82	$165.82	$10.00	Chair side reline that resurfaces without processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (chairside)	D5741	$177.49	$167.49	$10.00	Chair side reline that resurfaces without processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Reline complete maxillary denture (laboratory)	D5750	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with processing denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline complete mandibular denture (laboratory)	D5751	$243.00	$218.00	$25.00	Laboratory reline that resurfaces with processing denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline maxillary partial denture (laboratory)	D5760	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Reline mandibular partial denture (laboratory)	D5761	$239.00	$214.00	$25.00	Laboratory reline that resurfaces with processing partial denture base. Frequency: one (1) time per 12 months. Cannot be charged on denture provided in the last 6 months. Cannot be charged in addition to a rebase in a 12 month period.
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)	D7140	$111.78	$101.78	$10.00	Routine removal of tooth structure, including minor smoothing of socket bone, and closure as necessary. Treatment notes must include documentation that an extraction was done per tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Surgical removal of erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	D7210	$172.88	$162.88	$10.00	Includes removal of bone, and/or sectioning of erupted tooth, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth.
Removal of impacted tooth-soft tissue	D7220	$207.25	$187.25	$20.00	Occlusal surface of tooth covered by soft tissue; requires mucoperiosteal flap elevation. Teeth 1-32 One of D7220 per 1 lifetime per patient per tooth
Removal of impacted tooth-partially bony	D7230	$255.53	$235.53	$20.00	Part of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7230 per 1 lifetime per patient per tooth
Removal of impacted tooth-completely bony	D7240	$296.38	$276.38	$20.00	Most or all of crown covered by bone; requires mucoperiosteal flap elevation and bone removal. Teeth 1-32 One of D7240 per 1 lifetime per patient per tooth.
Removal of impacted tooth-completely boney, with unusual surgical complications	D7241	$389.20	$369.20	$20.00	Most or all of crown covered by bone; unusually difficult or complicated due to factors such as nerve dissection required, separate closure of maxillary sinus required or aberrant tooth position. Teeth 1-32 One of D7241 per lifetime per patient per tooth.
Surgical removal of residual tooth roots (cutting procedure)	D7250	$182.30	$172.30	$10.00	Includes removal of bone, and/or sectioning of residual tooth roots, smoothing of socket bone and closure as necessary. Treatment notes must include documentation that a surgical extraction was done per tooth. Can only be charged once per tooth. Cannot be charged for removal of broken off roots for recently extracted tooth.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Primary closure of a sinus perforation	D7261	$452.46	$442.46	$10.00	Subsequent to surgical removal of tooth, exposure of sinus requiring repair, or immediate closure of oroantral or oralnasal communication in absence of fisulous tract. Narrative of medical necessity may be required and if the sinus perforation was caused by a current grantee or provider of the program.
Incisional biopsy of oral tissue-soft	D7286	$381.00	$381.00	$0.00	Removing tissue for histologic evaluation. Treatment notes must include documentation and proof that biopsy was sent for evaluation.
Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7310	$150.00	$140.00	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7311	$139.42	$129.42	$10.00	Substantially reshaping the bone after an extraction procedure, much more than minor smoothing of the bone. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	D7320	$200.47	$190.47	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	D7321	$200.47	$190.47	$10.00	Substantially reshaping the bone after an extraction procedure, correcting anatomical irregularities. Reported per quadrant.
Removal of lateral exostosis (maxilla or mandible)	D7471	$290.11	$280.11	$10.00	Removal of a benign bony outgrowth (bone spur) for proper prosthesis fabrication. Reported per arch.
Removal of torus palatinus	D7472	$341.08	$331.08	$10.00	To remove a malformation of bone for proper prosthesis fabrication.

Procedure Description	Alpha-numeric Code	Max Allowable Fee	Program Payment	Max Client Co-Pay	PROGRAM GUIDELINES
Removal of torus mandibularis	D7473	$332.69	$322.69	$10.00	To remove a malformation of bone for proper prosthesis fabrication.
Incision & drainage of abscess - intraoral soft tissue	D7510	$193.00	$183.00	$10.00	Incision through mucosa, including periodontal origins.
Palliative (emergency) treatment of dental pain - minor procedure	D9110	$78.23	$53.23	$25.00	Emergency treatment to alleviate pain/discomfort. This code cannot be used for filing claims or writing or calling in a prescription to the pharmacy or to address situations that arise during multi-visit treatments covered by a single fee such as surgical or endodontic treatment. Report per visit, no procedure. Frequency: Limit 1 time per year. Maintain documentation that specifies problem and treatment.
Evaluation for moderate sedation, deep sedation or general anesthesia	D9219	$41.72	$41.72	$0.00	One of D9219 or D9310 per 12 month(s) per provider or location
Deep sedation/general anesthesia-each 15 minute increment	D9223	$103.40	$93.40	$10.00	Ten of D9223 per 1 day per patient. Not allowed with D9243
Intravenous moderate (conscious) sedation/analgesia-first 15 minutes	D9239	$109.23	$99.23	$10.00	One of D9239 per 1 day per patient.
Intravenous moderate (conscious)sedation/analgesia-each 15 minute increment	D9243	$103.40	$93.40	$10.00	Fourteen of D9243 per 1 day per patient. Not allowed with D9223

EXPLANATION OF RESTORATIONS		
Location	Number of Surfaces	Characteristics
Anterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Incisal, Lingual, or Labial.
	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial–Lingual.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual–Mesial–Labial.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Incisal-Lingual-Labial.
Posterior	1	Placed on one of the following five surface classifications – Mesial, Distal, Occlusal, Lingual, or Buccal.

	2	Placed, without interruption, on two of the five surface classifications – e.g., Mesial-Occlusal.
	3	Placed, without interruption, on three of the five surface classifications – e.g., Lingual-Occlusal-Distal.
	4 or more	Placed, without interruption, on four or more of the five surface classifications – e.g., Mesial-Occlusal-Lingual-Distal.

NOTE: Tooth surfaces are reported using the letters in the following table.

Surface	Code
Buccal	B
Distal	D
Facial (or Labial)	F
Incisal	I
Lingual	L
Mesial	M
Occlusal	O

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health Prior Authorization Correction, Section 8.520.8.C
Rule Number: MSB 22-08-29-C
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-08-29-C, Revision to the Medical Assistance Act Rule concerning Long-Term Home Health Prior Authorization Correction, Section 8.520.8.C Correction

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) 8.520.8, 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*

Insert the newly proposed language at 8.520.8.C. This rule is effective November 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health Prior Authorization Correction, Section 8.520.8.C
Rule Number: MSB 22-08-19-C
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The original language of Section 8.520.8.C.1 was inadvertently deleted along with the new prior authorization reinstatement language in Sections 8.520.8.C.1.a-j. This emergency rulemaking restores the original Section 8.520.8.C.1 language that preceded the addition of the prior authorization reinstatement language in Sections 8.520.8.C.1.a-j. This does not alter the current Department policy to temporarily pause the pediatric long-term home health prior authorization reinstatement process, effective November 1, 2021 until at least March 2024.

   The Department recently met with Health First Colorado (Colorado's Medicaid program) members and families, providers, and other stakeholders about concerns related to the pediatric long-term home health (LTHH) benefit prior authorization request (PAR) reinstatement process. Based on these conversations, the Department has made the decision to temporarily pause the PAR process effective November 1, 2021 until at least March 2024.

   The pause allows the Department and partners time to robustly engage with stakeholders, train providers on operational changes, evaluate benefit policy, and notify Health First Colorado members before the pause is lifted. This also gives the Department time to ensure full compliance with federal and state policy while keeping Health First Colorado members and their needs front and center.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

Initial Review Final Adoption
Proposed Effective Date Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Long-Term Home Health Prior Authorization Correction, Section 8.520.8.C
Rule Number: MSB 22-08-29-C
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members receiving pediatric long-term home health services, and the providers of such services, are impacted by this rule.

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

   The proposed rule maintains the removal of the requirement that pediatric long-term home health services be prior authorized in accordance with the tiered reinstatement of long-term home health prior authorizations established in previous Sections 8.520.8.C.1.a-j, temporarily pausing the pediatric long-term home health prior authorization reinstatement process, effective November 1, 2021 until at least March 2024.

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

   The Department anticipates that expenditure for pediatric long-term home health services would remain in line with spending for the last two years when all prior authorizations for such services were suspended.

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

   The benefit of the proposed rule is providing the Department and stakeholders time to discuss long-term solutions concerning prior authorization of pediatric long-term home health services. The cost of the proposed rule is suspension of prior authorization requirements for such services. The cost of inaction would be continuing the tiered reinstatement of prior authorization of such services while the

Department is actively working with stakeholders to discuss the long-term solutions. There are no benefits to inaction.

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

   There are no less costly or less intrusive methods for pausing the prior authorization of the services at issue in order to provide the Department and stakeholders time to discuss long-term solutions.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for pausing the prior authorization of the services at issue in order to provide the Department and stakeholders time to discuss long-term solutions.

8.520 HOME HEALTH SERVICES

8.520.8.C. Long-Term Home Health

1. Long-term Home Health Services do not require prior authorization under Section 8.017.E.2. When an agency accepts an HCBS waiver client to long-term Home Health Services, the Home Health Agency shall contact the client's case management agency to inform the case manager of the client's need for Home Health Services.

3. The complete formal written PAR shall include:

   a. A completed Department-prescribed Prior Authorization Request Form, see Section 8.058;

   b. A home health Plan of Care, which includes all clinical assessments and current clinical summaries or updates of the client. The Plan of Care shall be on the CMS-485 form, or a form that is identical in content to the CMS-485, and all sections of the form shall be completed. For clients 20 years of age or younger, all therapy services requested shall be included in the Plan of Care or addendum, which lists the specific procedures and modalities to be used and the amount, duration, frequency and goals. If extended aide units, as described in 8.520.9.B. are requested, there shall be sufficient information about services on each visit to justify the extended units. Documentation to support any PRN visits shall also be provided. If there are no nursing needs, the Plan of Care and assessments may be completed by a therapist if the client is 20 years of age or younger and is receiving home health therapy services;

   c. Written documentation of the results of the EPSDT medical screening, or other equivalent examination results provided by the client's third-party insurance;

   d. Any other medical information which will document the medical necessity for the Home Health Services;

   e. If applicable, written instructions from the therapist or other medical professional to support a current need when range of motion or other therapeutic exercise is the only skilled service performed on a CNA visit;

   f. When the PAR includes a request for nursing visits solely for the purpose of pre-pouring medications, evidence that the client's pharmacy was contacted, and advised the Home Health Agency that the pharmacy will not provide medication set-ups, shall be documented; and

   g. When a PAR includes a request for reimbursement for two aides at the same time to perform two-person transfers, documentation supporting the current need for two-person transfers, and the reason adaptive equipment cannot be used instead, shall be provided.

   h. Long Term Home Health Services for clients 20 years of age or younger require prior authorization by the Department or its Designee using the approved utilization management tool.

4. Authorization time frames:

a. PARs shall be submitted for, and may be approved for up to a one year period.

b. The Department or its Designee may initiate PAR revisions if the Plans of Care indicate significantly decreased services.

c. PAR revisions for increases initiated by Home Health Agencies shall be submitted and processed according to the same requirements as for new PARs, except that current written assessment information pertaining to the increase in care may be submitted in lieu of the CMS-485.

5. The PAR shall not be backdated to a date prior to the 'from' date of the CMS-485.

6. The Department or its Designee shall approve or deny according to the following guidelines for safeguarding clients:

a. PAR Approval: If services requested are in compliance with Medicaid rules are medically necessary and appropriate for the diagnosis and treatment plan, the services are approved retroactively to the start date on the PAR form. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

b. PAR Denial:

i) The Department or its Designee shall notify Home Health Agencies in writing of denials that result from non-compliance with Medicaid rules or failure to establish medical necessity (e.g, the PAR is not consistent with the client's documented medical needs and functional capacity). Denials based on medical necessity shall be determined by a registered nurse or physician.

ii) When denied or reduced, services shall be approved for 60 additional days after the date on which the notice of denial is mailed to the client, through August 31, 2022. If the denial is appealed by the member in accordance with Section 8.057, services will be maintained for the duration of the appeal until the final agency action is rendered. After August 31, 2022, services shall be approved for an additional 15 days after the date on which the notice of denial is mailed to the client. Services may be approved retroactively for no more than 10 days prior to the PAR submission date.

c. Interim Services: Services provided during the period between the provider’s submission of the PAR form to the Department or its Designee, to the final approval or denial by the Department may be approved for payment. Payment may be made retroactive to the start date on the PAR form, or up to 30 working days, whichever is shorter.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning In-State Inpatient Hospital High Acuity Rate Negotiation, Section 8.300.5.G
Rule Number: MSB 22-04-06-A
Division / Contact / Phone:Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-04-06-A, Revision to the Medical Assistance Act Rule concerning In-State Inpatient Hospital High Acuity Rate Negotiation, Section 8.300.5.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) 8.300.5.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 8.500.3.G with the proposed text beginning at 8.500.3.G.1 through the end of 8.500.3.G.1.c. This rule is effective November 30, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning In-State Inpatient Hospital High Acuity Rate Negotiation, Section 8.300.5.G
Rule Number: MSB 22-04-06-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The in-state inpatient hospital high acuity rate negotiation rule section requires updating to match a State Plan Amendment (SPA) recently approved by CMS. The SPA includes more specific requirements and limitations not currently included in the broad rule language. In particular, the SPA language is more specific than the broad language of the rule by requiring the hospital to submit evidence that the standard inpatient methodology is insufficient (including, but not limited to, an anticipated cost report for Department review) and limiting the negotiated high acuity rate increase to no more than 100% of the costs anticipated by the hospital (as indicated in the hospital's anticipated cost report). This rulemaking is necessary to align the rule with the State Plan.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 440.10 (2021)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   Section 25.5-5-102(1)(a), C.R.S. (2021)

Initial Review **08/12/22** Final Adoption **10/14/22**
Proposed Effective Date **11/30/22** Emergency Adoption

DOCUMENT #

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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.

   High acuity members, and the hospitals that serve high acuity members, are affected by this rule. Hospitals bear the cost of submitting an anticipated cost report for Department review to justify a negotiated high acuity rate increase for inpatient hospital services.

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

   Hospitals will not receive more than 100% of the anticipated costs associated with a high acuity member when a high acuity rate is negotiated with, and deemed necessary by, the Department.

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

   The Department anticipates that this proposed rule will be budget neutral as it aligns the Department's rules with current practice under the approved state plan requirements.

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

   The costs of the proposed rule are requiring hospitals to submit an anticipated cost report for Department review to justify higher reimbursement for high acuity members. The benefit of the proposed rule is aligning Department rule with the State Plan. The cost of inaction is maintaining broad rule language that does not specify the requirements in the State Plan that hospitals provide an anticipated cost report to justify the higher rate and limitation of the negotiated rate to 100% of anticipated costs. There are no benefits to inaction.

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

   There are no less costly or less intrusive methods to align Department rule with the State Plan.

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6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for aligning Department rule with the State Plan.

8.300 HOSPITAL SERVICES

8.300.5 Payment for Inpatient Hospital Services

8.300.5.G Payment for High Acuity In-State Services

1. The Department may negotiate a higher reimbursement rate for in-state inpatient hospital services up to, but no greater than, 100% of the costs anticipated by the hospital—which must be demonstrated by evidence, including but not limited to an anticipated cost report submitted to the Department for review—where, as determined by the Department, all of the following conditions are fulfilled:

    a. The in-state inpatient payment methodology insufficiently accounts for the level of acuity;

    b. All other placement options have been exhausted; and

    c. The services have been reviewed and authorized by the Medical Director for the Department.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2022-00516

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 10/14/2022

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY

The above-referenced rules were submitted to this office on 10/14/2022 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.

November 02, 2022 09:03:12

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Chiropractic Examiners

CCR number

3 CCR 707-1

Rule title

3 CCR 707-1 CHIROPRACTIC EXAMINERS RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

Expiration date

02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

Board of Chiropractic Examiners

CHIROPRACTIC EXAMINERS RULES AND REGULATIONS

3 CCR 707-1

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

…

1.31 EXPANDED SCOPE OF PRACTICE FOR CHIROPRACTORS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the State Board of Chiropractic Examiners ("Board") set forth in section 24-1-122(3)(h), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 028 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of the Department of Regulatory Agencies, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Chiropractors may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Chiropractors are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Chiropractors shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Chiropractors shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Chiropractors shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services outside of statutory scope of practice regardless of delegation.

…

1.36 EXPANDED SCOPE OF PRACTICE FOR CHIROPRACTORS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the State Board of Chiropractic Examiners ("Board") set forth in section 24-1-122(3)(h), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 028 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Chiropractors may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

   a. Chiropractors are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

   b. Chiropractors shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

   c. Chiropractors shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

   d. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

   e. Chiropractors shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the Governor temporarily suspended the rulemaking authorities set forth in C.R.S. § 24-1-122(3)(m)(I) (Colorado Medical Board), C.R.S. § 24-1-122(3)(gg) (State Board of Nursing), C.R.S. § 24-1-122(3)(h) (Colorado State Board of Chiropractic Examiners, C.R.S. § 24-1-122(3)(k) (Colorado Dental Board), C.R.S. § 24-1- 122(3)(m)(II) (Colorado Podiatry Board), C.R.S. § 24-1-122(3)(p) (Colorado State Board of Optometry), C.R.S. § 24-1-122(3)(y) (State Board of Veterinary Medicine), and C.R.S. § 12-285-105(1)(b) (State Physical Therapy Board), and directed the Executive Director of DORA, through the Director of DPO, to promulgate and issue temporary emergency rules consistent with the Executive Order.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division

Director), is promulgating these emergency rules expanding delegation in order to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

_____

Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00674

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Chiropractic Examiners

on 10/26/2022

3 CCR 707-1

CHIROPRACTIC EXAMINERS RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 15, 2022 11:11:55

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Colorado Dental Board

CCR number

3 CCR 709-1

Rule title

3 CCR 709-1 DENTISTS, DENTAL THERAPISTS & DENTAL HYGIENISTS RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

Expiration date

02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

Colorado Dental Board

DENTISTS & DENTAL HYGIENISTS RULES AND REGULATIONS

3 CCR 709-1

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

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1.27 EXPANDED SCOPE OF PRACTICE FOR DENTISTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the Colorado Dental Board ("Board") set forth in section 24-1-122(3)(k), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of the Department of Regulatory Agencies, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Dentists may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Dentists are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Dentists shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Dentists shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Dentists shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services outside of statutory scope of practice regardless of delegation.

1.28 EXPANDED SCOPE OF PRACTICE FOR DENTISTS AND DENTAL HYGIENISTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the Colorado Dental Board ("Board") set forth in section 24-1-122(3)(k), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Dentists and dental hygienists may counsel patients and administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting.

    a. Dentists and dental hygienists are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

    b. Dentists and dental hygienists shall not administer the COVID-19 vaccination if the licensee does not possess the knowledge, skill or training to administer the vaccination or treat a reaction to the vaccination.

    c. This service shall not be delegated to another person or licensee by the licensee.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the Governor temporarily suspended the rulemaking authorities set forth in C.R.S. § 24-1-122(3)(m)(I) (Colorado Medical Board), C.R.S. § 24-1-122(3)(gg) (State Board of Nursing), C.R.S. § 24-1-122(3)(h) (Colorado State Board of Chiropractic Examiners, C.R.S. § 24-1-122(3)(k) (Colorado Dental Board), C.R.S. § 24-1- 122(3)(m)(II) (Colorado Podiatry Board), C.R.S. § 24-1-122(3)(p) (Colorado State Board of Optometry), C.R.S. § 24-1-122(3)(y) (State Board of Veterinary Medicine), and C.R.S. § 12-285-105(1)(b) (State Physical Therapy Board), and directed the Executive Director of DORA, through the Director of DPO, to promulgate and issue temporary emergency rules consistent with the Executive Order.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division

Director), is promulgating these emergency rules expanding delegation in order to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

_____

Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00675

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Colorado Dental Board

on 10/26/2022

3 CCR 709-1

DENTISTS, DENTAL THERAPISTS & DENTAL HYGIENISTS RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 15, 2022 10:57:53

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Colorado Podiatry Board

CCR number

3 CCR 712-1

Rule title

3 CCR 712-1 PODIATRY RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

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02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

Colorado Podiatry Board

PODIATRY RULES AND REGULATIONS

3 CCR 712-1

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

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1.22 EXPANDED SCOPE OF PRACTICE FOR PODIATRISTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the Colorado Podiatry ("Board") set forth in section 24-1-122(m)(II), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of the Department of Regulatory Agencies, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Podiatrists may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Podiatrists are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Podiatrists shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Podiatrists shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Podiatrists shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services outside of statutory scope of practice regardless of delegation.

1.23 EXPANDED SCOPE OF PRACTICE FOR PODIATRISTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the Colorado Podiatry Board ("Board") set forth in section 24-1-122(3)(m)(II), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice in Order to Administer the COVID-19 Vaccination. Podiatrists may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

1. Podiatrists are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

2. Podiatrists shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

3. Podiatrists shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

4. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

5. Podiatrists shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the Governor temporarily suspended the rulemaking authorities set forth in C.R.S. § 24-1-122(3)(m)(I) (Colorado Medical Board), C.R.S. § 24-1-122(3)(gg) (State Board of Nursing), C.R.S. § 24-1-122(3)(h) (Colorado State Board of Chiropractic Examiners, C.R.S. § 24-1-122(3)(k) (Colorado Dental Board), C.R.S. § 24-1- 122(3)(m)(II) (Colorado Podiatry Board), C.R.S. § 24-1-122(3)(p) (Colorado State Board of Optometry), C.R.S. § 24-1-122(3)(y) (State Board of Veterinary Medicine), and C.R.S. § 12-285-105(1)(b) (State Physical Therapy Board), and directed the Executive Director of DORA, through the Director of DPO, to promulgate and issue temporary emergency rules consistent with the Executive Order.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division

Director), is promulgating these emergency rules expanding delegation in order to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

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Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2022-00683

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Colorado Podiatry Board

on 10/26/2022

3 CCR 712-1

PODIATRY RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 15, 2022 10:50:36

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Office of Occupational Therapy Licensure

CCR number

3 CCR 715-1

Rule title

3 CCR 715-1 OCCUPATIONAL THERAPY RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

Expiration date

02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

Office of Occupational Therapy Licensure

OCCUPATIONAL THERAPY RULES AND REGULATIONS

3 CCR 715-1

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

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1.18 EXPANDED SCOPE OF PRACTICE FOR OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 028 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, et. seq., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Director of the Division of Professions and Occupations (Director) to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Occupational therapists and occupational therapy assistants may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Occupational therapists and occupational therapy assistants are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Occupational therapists and occupational therapy assistants shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Occupational therapists and occupational therapy assistants shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Occupational therapists and occupational therapy assistants shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services regardless of delegation.

…

1.21 EXPANDED SCOPE OF PRACTICE FOR OCCUPATIONAL THERAPISTS AND OCCUPATIONAL THERAPY ASSISTANTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 028 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, et. seq., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Occupational therapists and occupational therapy assistants may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

   a. Occupational therapists and occupational therapy assistants are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

   b. Occupational therapists and occupational therapy assistants shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

   c. Occupational therapists and occupational therapy assistants shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

   d. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

e. Occupational therapists and occupational therapy assistants shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from the COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, Governor Jared Polis directed the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division Director), is promulgating these emergency rules expanding scope of practice for physical therapists and physical therapist assistants in order to provide hospitals and inpatient

facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency

declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

_____

Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2022-00679

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Office of Occupational Therapy Licensure

on 10/26/2022

3 CCR 715-1

OCCUPATIONAL THERAPY RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 14, 2022 16:35:54

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Board of Nursing

CCR number

3 CCR 716-1

Rule title

3 CCR 716-1 NURSING RULES AND REGULATIONS 1 - eff 10/19/2022

Effective date

10/19/2022

Expiration date

02/16/2023

DEPARTMENT OF REGULATORY AGENCIES

Division of Professions and Occupations - State Board of Nursing

NURSING RULES AND REGULATIONS

3 CCR 716-1

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

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1.33 PROTECTIONS FOR PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401 *et seq.*, 12-255-107(1), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding and abetting, complicity, and conspiracy in the provision of reproductive health care.

2. "Certificate holder" or "certificant" means as defined in section 12-20-102(3), C.R.S.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options counseling, and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Registrant" means as defined in section 12-20-102(12), C.R.S.

8. "Regulator" means as defined in section 12-20-102(14), C.R.S.

9. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

B. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on the applicant or registrant's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on a civil or criminal judgment against the applicant or registrant arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on a professional disciplinary action or any other sanction against the applicant's or registrant's professional registration, certification or licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's or registrant's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on the applicant/licensee/registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate, or license based solely on a civil or criminal judgment against the applicant or registrant arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.34 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-255-107(1) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Certificate holder" or "certificant" means as defined in section 12-20-102(3), C.R.S.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

7. "Registrant" means as defined in section 12-20-102(12), C.R.S.

8. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on a civil or criminal judgment against the applicant or registrant regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny registration, certification, or licensure to an applicant or impose disciplinary action against an individual's registration, certificate or license based solely on a professional disciplinary action against the applicant's or registrant's professional registration, certification or licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's or registrant's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

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Editor's Notes

History

Chapter 1 eff. 07/02/2007.
Chapters XIII; XX eff 10/01/2007. Chapter XVIII repealed eff. 10/01/2007.
Chapters I, IX, XI eff. 12/31/2007.
Chapter XII repealed eff. 06/01/2008.
Chapters I, VII, XVI eff. 10/01/2008.
Chapters I, XIV, XV eff. 12/30/2008.
Chapter X eff. 03/30/2009.
Chapters IX, XX eff. 06/30/2009.
Chapter XXI emergency rule eff. 07/14/2009
Chapter XXI eff. 10/14/2009.
Chapter II eff. 10/30/2009.
Chapter I eff. 12/30/2009.
Chapter XIX repealed eff. 12/30/2009.
Chapters II, III eff. 03/31/2010.
Chapter XIII eff. 06/30/2010. Chapter XXI repealed eff. 06/30/2010.
Chapters XIV, XV eff. 07/01/2010.
Chapters XII, XIX eff. 01/01/2010.
Chapter VII repealed eff. 03/17/2011.
Chapter I eff. 09/14/2011.
Chapters I, IX eff. 07/01/2012.
Chapter XV eff. 09/14/2012.
Chapters 1, 5, 10, 16, 19 eff. 12/15/2012.
Chapters 1, 2, 5, 10, 19 eff. 03/18/2013.
Chapters 20, 22, 23 eff. 06/14/2013.
Chapters 2, 11, 13 eff. 06/14/2014.
Chapters 10, 13 emer. rules eff. 08/05/2015.
Chapter 15 emer. rule eff. 09/01/2015.
Chapters 10, 13 eff. 09/14/2015.
Chapter 15 eff. 11/14/2015.
Chapter 24 eff. 12/30/2015.
Chapter 2 eff. 06/30/2016.
Chapter 13 eff. 06/14/2017
Chapters 5, 6, 14, 15 eff. 09/14/2017.

Chapter 2 eff. 06/14/2018.
Chapters 1, 20 eff. 03/17/2019.
Rules 1.15 K.4, 1.15 L.2, 1.25 eff. 12/15/2019.
Rule 1.26 emer. rule eff. 05/01/2020; expired 08/29/2020.
Rule 1.27 emer. rule eff. 05/11/2020; expired 09/08/2020.
Rule 1.26 emer. rule eff. 08/30/2020.
Rule 1.27 emer. rule eff. 09/09/2020.
Rules 1.1-1.6, 1.10-1.17, 1.19-1.24 emer. rules eff. 10/28/2020.
Rule 1.26 emer. rule eff. 12/07/2020.
Rule 1.27 emer. rule eff. 12/28/2020.
Rules 1.1-1.6, 1.9 F.4, 1.10-1.17, 1.19-1.24, 1.28, Appendix A eff. 12/30/2020.
Rule 1.28 emer. rule eff. 01/11/2021.
Rule 1.26 emer. rule eff. 04/06/2021.
Rule 1.27 emer. rule eff. 04/27/2021.
Rule 1.28 emer. rule eff. 05/11/2021.
Rules 1.29, 1.30, Appendix A eff. 06/14/2021.
Rules 1.26, 1.27, 1.28 emer. rules eff. 07/12/2021.
Rule 1.31 emer. rule eff. 11/01/2021.
Rules 1.26, 1.27, 1.28 emer. rules eff. 11/02/2021.
Rules 1.1 F, G, 1.2 F, G, H, 1.5 A, 1.10 E, 1.13 H.7, 1.14 D, 1.15 B, F, G, 1.16 B, 1.31 eff. 12/15/2021.
Rules 1.26, 1.27, 1.28 emer. rules eff. 03/02/2022.

Annotations

Rule 1.28 E.4 (adopted 10/28/2020) was not extended by Senate Bill 21-152 and therefore expired 05/15/2021.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

On July 6, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 032, "Directing State Agencies to Protecting Access to Reproductive Health Care in Colorado."

On July 14, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 034, "Protecting Colorado's Workforce and Expanding Licensing Opportunities."

Basis

The basis for these rules is Executive Order D 2022 032 and Executive Order D 2022 034.

Through Executive Order D 2022 032, Governor Jared Polis directed all state agencies not to share any information or data, including patient medical records, patient-level data or related billing information, or expend time, money, facilities property, equipment, personnel, or other resources to assist or further any investigation or proceeding initiated in or by another state that seeks to impose criminal or civil liability or professional sanction upon a person for conduct that would be legal in Colorado related to providing, assisting, seeking, or obtaining reproductive health care, unless pursuant to a court order.

Governor Jared Polis also directed the Department of Regulatory Agencies (DORA) to work with all programs and boards of professional licensure operating under its purview to promulgate and issue necessary rules that will ensure that no person shall be subject to a disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care as provided is consistent with professional conduct and standards of care within the State of Colorado.

Through Executive Order D 2022 034, Governor Jared Polis directed the Department of Regulatory Agencies to work with all programs and boards of professional licensure operating under its purview to promulgate and issue rules as necessary to ensure that no person shall be subject to disciplinary action against a professional license or disqualified from professional licensure for any civil or criminal judgment, discipline, or other sanction or threat imposed under the laws of another state as long as the actions are lawful and consistent with professional conduct and standards of care within the State of Colorado.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2022 032 and Executive Order D 2022 034.

As stated in Executive Order D 2022 032, Colorado is experiencing workforce shortage in many professions, and disqualifying people because they were prosecuted for taking actions in other states that are fully legal under Colorado law would hurt our economy and our State.

Colorado is committed to protecting access to reproductive health care. No one who is lawfully providing, assisting, seeking, or obtaining reproductive health care in Colorado should be subject to legal liability or professional sanctions in Colorado or any other state, nor will Colorado cooperate with criminal or civil investigations for actions that are fully legal in Colorado.

As stated in Executive Order D 2022 034, employers are having difficulty recruiting and retaining qualified employees, many of whom need professional licenses. The exclusion of people from the workforce because of marijuana-related activities that are lawful in Colorado, but illegal in other states, hinders our economy and our State.

Justification

As set forth in Executive Order D 2022 032, the need exists to immediately protect access to reproductive health care in Colorado by promulgating rules ensuring no licensee, certificant, or registrant shall be subject to disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care provided is lawful and consistent with professional conduct and standards of care within the State of Colorado.

As set forth in Executive Order D 2022 034, the Order ensures that all Coloradans are afforded protections and rights under Colorado law.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Regulator, as defined in section 12-20-102(14), C.R.S., hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2022 032, to protect access to reproductive health care in Colorado. The adoption of emergency rules is imperatively necessary for the preservation of the public health, safety, and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Regulator finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 19, 2022, and remain in effect for up to a maximum of 120 days after adoption of these temporary/emergency rules.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2022-00665

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Board of Nursing

on 10/19/2022

3 CCR 716-1

NURSING RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/24/2022 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.

November 08, 2022 10:37:09

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Plumbing Board

CCR number

3 CCR 720-1

Rule title

3 CCR 720-1 PLUMBING RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

Expiration date

02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

State Plumbing Board

PLUMBING RULES AND REGULATIONS

3 CCR 720-1

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

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1.10 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-155-105(1)(e) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

4. "Licensee" means as defined in section 12-20-102(10), C.R.S.

5. "Registrant" means as defined in section 12-20-102(12), C.R.S.

6. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a civil or criminal judgment against the registrant or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a professional disciplinary action against the applicant's, registrant's, or licensee's professional registration or license in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

Editor's Notes

History

Entire rule eff. 01/01/2008.

Entire rule eff. 04/01/2010.

Rules 2.3.A, 2.4.1-2.4.2, 6.4 eff. 09/01/2011.

Entire rule eff. 03/15/2014.

Rules 2.3, 3.1 eff. 12/15/2014.

Entire rule eff. 02/14/2016.

Rules 2.5.1.27, 4.1, 4.2, 4.5.4, 4.5.5, 4.6-4.13, 6.1, 7.4 eff. 04/01/2016.

Rules 1.2 A-C, 1.2 D.4, 1.2 D.7-10, 1.2 E, 1.3, 1.4 A, 1.4 E, 1.6 B.8 eff. 06/14/2020. Rule 1.4.D repealed eff. 06/14/2020.

Rule 1.3 C eff. 08/30/2021.

Rule 1.4 L.2 eff. 12/15/2021.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULE

On July 14, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 034, "Protecting Colorado's Workforce and Expanding Licensing Opportunities."

Basis

The basis for this rule is Executive Order D 2022 034.

Through Executive Order D 2022 034, Governor Jared Polis directed the Department of Regulatory Agencies to work with all programs and boards of professional licensure operating under its purview to promulgate and issue rules as necessary to ensure that no person shall be subject to disciplinary action against a professional license or disqualified from professional licensure for any civil or criminal judgment, discipline, or other sanction or threat imposed under the laws of another state as long as the actions are lawful and consistent with professional conduct and standards of care within the State of Colorado.

Purpose

The purpose of this emergency rule is to effectuate Executive Order D 2022 034.

As stated in Executive Order D 2022 034, employers are having difficulty recruiting and retaining qualified employees, many of whom need professional licenses. The exclusion of people from the workforce because of marijuana-related activities that are lawful in Colorado, but illegal in other states, hinders our economy and our State.

Justification

As set forth in Executive Order D 2022 034, the Order ensures that all Coloradans are afforded protections and rights under Colorado law.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Regulator, as defined in section 12-20-102(14), C.R.S., hereby finds the immediate adoption of this emergency rule is imperatively necessary to comply with Executive Order D

2022 034, to protect Colorado's Workforce and Expanding Licensing Opportunities. The adoption of this emergency rule is imperatively necessary for the preservation of the public welfare, and cannot wait the several months required for permanent rulemaking and therefore an emergency rule is appropriate pursuant to the Administrative Procedure Act.

The Regulator finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rule; to the extent practicable, the rule is clearly and simply stated so that their meaning will be understood by any required to comply with the rule; the rule does not conflict with other provisions of the law; and any duplication or overlapping of the rule, if any, has been explained.

This temporary/emergency rule take effect October 26, 2022, and remain in effect for up to a maximum of 120 days after adoption of these temporary/emergency rules.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2022-00672

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Plumbing Board

on 10/26/2022

3 CCR 720-1

PLUMBING RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 14, 2022 16:32:54

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Veterinary Medicine

CCR number

4 CCR 727-1

Rule title

4 CCR 727-1 VETERINARY MEDICINE RULES AND REGULATIONS 1 - eff 10/13/2022

Effective date

10/13/2022

Expiration date

02/10/2023

DEPARTMENT OF REGULATORY AGENCIES

State Board of Veterinary Medicine

VETERINARIAN AND VETERINARY TECHNICIAN RULES AND REGULATIONS

4 CCR 727-1

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

…

1.21 PROTECTIONS FOR PROVISION OF HUMAN REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, sections 25-6-401 *et seq.*, 12-315-105(6)(g), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Registrant" means as defined in section 12-20-102(12), C.R.S.

8. "Regulator" means as defined in section 12-20-102(14), C.R.S.

9. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

B. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on the applicant's or registrant's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a professional disciplinary action or any other sanction against the applicant's, registrant's, or licensee's professional registration or licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on the applicant/licensee/registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.22 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, sections 12-315-105(6)(g) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, or a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

7. "Registrant" means as defined in section 12-20-102(12), C.R.S.

8. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a civil or criminal judgment against the applicant, registrant, or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny registration or licensure to an applicant or impose disciplinary action against an individual's registration or license based solely on a professional disciplinary action against the applicant's, registrant's, or licensee's professional registration or licensure in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on

the applicant's, registrant's, or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

Editor's Notes

History

Rules 1.00, 4.00 eff. 09/30/2007.
Rule 4.00 eff. 01/30/2008.
Entire rule eff. 12/30/2011.
Rule I.B eff. 08/30/2012.
Rule I.B emer. rule eff. 02/08/2013.
Rules I.A, 1.B, 1.E eff. 05/30/2013.
Rule I.A eff. 06/14/2013.
Rules I.B, II.A.17 eff. 09/30/2013.
Rule I eff. 08/14/2014.
Rules 1.2 A.8-18, 1.2 E.4, 1.2 G eff. 11/30/2019.
Rule 1.23 emer. rule eff. 05/01/2020; expired 08/29/2020.
Rule 1.24 emer. rule eff. 05/11/2020; expired 09/08/2020.
Rule 1.23 emer. rule eff. 08/30/2020; expired 12/28/2020.
Rule 1.24 emer. rule eff. 09/09/2020.
Entire rule eff. 10/15/2020.
Rule 1.10 B eff. 12/15/2020.
Rules 1.24, 1.25 emer. rules eff. 12/28/2020.
Rule 1.25 emer. rule eff. 01/11/2021.
Rules 1.4 E-F, 1.12 C eff. 04/14/2021.
Rules 1.24, 1.25 emer. rules eff. 04/27/2021.
Rule 1.25 emer. rule eff. 05/11/2021.
Rules 1.24, 1.25 emer. rules eff. 07/12/2021.
Rule 1.26 emer. rule eff. 11/01/2021.
Rules 1.24, 1.25 emer. rules eff. 11/02/2021.
Rules 1.17 C.1, 1.26 eff. 11/30/2021.
Rules 1.24, 1.25 emer. rules eff. 03/02/2022.
Rules 1.24, 1.25 emer. rules eff. 06/28/2022.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

On July 6, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 032, "Directing State Agencies to Protecting Access to Reproductive Health Care in Colorado."

On July 14, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 034, "Protecting Colorado's Workforce and Expanding Licensing Opportunities."

Basis

The basis for these rules is Executive Order D 2022 032 and Executive Order D 2022 034.

Through Executive Order D 2022 032, Governor Jared Polis directed all state agencies not to share any information or data, including patient medical records, patient-level data or related billing information, or expend time, money, facilities property, equipment, personnel, or other resources to assist or further any investigation or proceeding initiated in or by another state that seeks to impose criminal or civil liability or professional sanction upon a person for conduct that would be legal in Colorado related to providing, assisting, seeking, or obtaining reproductive health care, unless pursuant to a court order.

Governor Jared Polis also directed the Department of Regulatory Agencies (DORA) to work with all programs and boards of professional licensure operating under its purview to promulgate and issue necessary rules that will ensure that no person shall be subject to a disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care as provided is consistent with professional conduct and standards of care within the State of Colorado.

Through Executive Order D 2022 034, Governor Jared Polis directed the Department of Regulatory Agencies to work with all programs and boards of professional licensure operating under its purview to promulgate and issue rules as necessary to ensure that no person shall be subject to disciplinary action against a professional license or disqualified from professional licensure for any civil or criminal judgment, discipline, or other sanction or threat imposed under the laws of another state as long as the actions are lawful and consistent with professional conduct and standards of care within the State of Colorado.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2022 032 and Executive Order D 2022 034.

As stated in Executive Order D 2022 032, Colorado is experiencing workforce shortage in many professions, and disqualifying people because they were prosecuted for taking actions in other states that are fully legal under Colorado law would hurt our economy and our State.

Colorado is committed to protecting access to reproductive health care. No one who is lawfully providing, assisting, seeking, or obtaining reproductive health care in Colorado should be subject to legal liability or professional sanctions in Colorado or any other state, nor will Colorado cooperate with criminal or civil investigations for actions that are fully legal in Colorado.

As stated in Executive Order D 2022 034, employers are having difficulty recruiting and retaining qualified employees, many of whom need professional licenses. The exclusion of people from the workforce because of marijuana-related activities that are lawful in Colorado, but illegal in other states, hinders our economy and our State.

Justification

As set forth in Executive Order D 2022 032, the need exists to immediately protect access to reproductive health care in Colorado by promulgating rules ensuring no licensee, certificant, or registrant shall be subject to disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care provided is lawful and consistent with professional conduct and standards of care within the State of Colorado.

As set forth in Executive Order D 2022 034, the Order ensures that all Coloradans are afforded protections and rights under Colorado law.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Regulator, as defined in section 12-20-102(14), C.R.S., hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2022 032, to protect access to reproductive health care in Colorado. The adoption of emergency rules is imperatively necessary for the preservation of the public health, safety, and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Regulator finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 13, 2022, and remain in effect for up to a maximum of 120 days after adoption of these temporary/emergency rules.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00664

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Veterinary Medicine

on 10/13/2022

4 CCR 727-1

VETERINARIAN AND VETERINARY TECHNICIAN RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/18/2022 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.

November 02, 2022 16:02:31

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Veterinary Medicine

CCR number

4 CCR 727-1

Rule title

4 CCR 727-1 VETERINARY MEDICINE RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

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02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

State Board of Veterinary Medicine

VETERINARY MEDICINE RULES AND REGULATIONS

4 CCR 727-1

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

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1.18 EXPANDED SCOPE OF PRACTICE FOR VETERINARIANS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the State Board of Veterinary Medicine ("Board") set forth in section 24-1-122(3)(y), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of the Department of Regulatory Agencies, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Veterinarians may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Veterinarians are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Veterinarians shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Veterinarians shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Veterinarians shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services outside of statutory scope of practice regardless of delegation.

1.19 EXPANDED SCOPE OF PRACTICE FOR VETERINARIANS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the State Board of Veterinary Medicine ("Board") set forth in section 24-1-122(3)(y), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Veterinarians may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

    a. Veterinarians are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

    b. Veterinarians shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

    c. Veterinarians shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

    d. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

    e. Veterinarians shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the Governor temporarily suspended the rulemaking authorities set forth in C.R.S. § 24-1-122(3)(m)(I) (Colorado Medical Board), C.R.S. § 24-1-122(3)(gg) (State Board of Nursing), C.R.S. § 24-1-122(3)(h) (Colorado State Board of Chiropractic Examiners, C.R.S. § 24-1-122(3)(k) (Colorado Dental Board), C.R.S. § 24-1- 122(3)(m)(II) (Colorado Podiatry Board), C.R.S. § 24-1-122(3)(p) (Colorado State Board of Optometry), C.R.S. § 24-1-122(3)(y) (State Board of Veterinary Medicine), and C.R.S. § 12-285-105(1)(b) (State Physical Therapy Board), and directed the Executive Director of DORA, through the Director of DPO, to promulgate and issue temporary emergency rules consistent with the Executive Order.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division

Director), is promulgating these emergency rules expanding delegation in order to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

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Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00677

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Veterinary Medicine

on 10/26/2022

4 CCR 727-1

VETERINARIAN AND VETERINARY TECHNICIAN RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 15, 2022 10:40:05

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Board of Optometry

CCR number

4 CCR 728-1

Rule title

4 CCR 728-1 STATE BOARD OF OPTOMETRY RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

Expiration date

02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

State Board of Optometry

STATE BOARD OF OPTOMETRY RULES AND REGULATIONS

4 CCR 728-1

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

…

1.27 EXPANDED SCOPE OF PRACTICE FOR OPTOMETRISTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the State Board of Optometry ("Board") set forth in section 24-1-122(3)(p), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of the Department of Regulatory Agencies, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Optometrists may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses. certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Optometrists are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Optometrists shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Optometrists shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Optometrists shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services outside of statutory scope of practice regardless of delegation.

1.28 EXPANDED SCOPE OF PRACTICE FOR OPTOMESTRISTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 028, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the State Board of Optometry ("Board") set forth in section 24-1-122(3)(p), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Optometrists may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

    a. Optometrists are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

    b. Optometrists shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

    c. Optometrists shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

    d. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

    e. Optometrists shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the Governor temporarily suspended the rulemaking authorities set forth in C.R.S. § 24-1-122(3)(m)(I) (Colorado Medical Board), C.R.S. § 24-1-122(3)(gg) (State Board of Nursing), C.R.S. § 24-1-122(3)(h) (Colorado State Board of Chiropractic Examiners, C.R.S. § 24-1-122(3)(k) (Colorado Dental Board), C.R.S. § 24-1- 122(3)(m)(II) (Colorado Podiatry Board), C.R.S. § 24-1-122(3)(p) (Colorado State Board of Optometry), C.R.S. § 24-1-122(3)(y) (State Board of Veterinary Medicine), and C.R.S. § 12-285-105(1)(b) (State Physical Therapy Board), and directed the Executive Director of DORA, through the Director of DPO, to promulgate and issue temporary emergency rules consistent with the Executive Order.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division

Director), is promulgating these emergency rules expanding delegation in order to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

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Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
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Office of the Attorney General

Tracking number: 2022-00676

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Board of Optometry

on 10/26/2022

4 CCR 728-1

STATE BOARD OF OPTOMETRY RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 15, 2022 11:05:15

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Physical Therapy Board

CCR number

4 CCR 732-1

Rule title

4 CCR 732-1 PHYSICAL THERAPY RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

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02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

State Physical Therapy Board

PHYSICAL THERAPY RULES AND REGULATIONS

4 CCR 732-1

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

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1.11 EXPANDED SCOPE OF PRACTICE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the State Board of Physical Therapy ("Board") set forth in section 12-285-105(1)(b), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of the Department of Regulatory Agencies, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Physical therapists and physical therapist assistants may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Physical therapists and physical therapist assistants are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Physical therapists and physical therapist assistants shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Physical therapists and physical therapist assistants shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Physical therapists and physical therapist assistants shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services outside of statutory scope of practice regardless of delegation.

1.12 EXPANDED SCOPE OF PRACTICE FOR PHYSICAL THERAPISTS AND PHYSICAL THERAPIST ASSISTANTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis temporarily suspended the emergency rulemaking authorities for the State Board of Physical Therapy ("Board") set forth in section 12-285-105(1)(b), C.R.S., and directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Physical therapists and physical therapist assistants may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

   a. Physical therapists and physical therapist assistants are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

   b. Physical therapists and physical therapist assistants shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

   c. Physical therapists and physical therapist assistants shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

   d. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

e. Physical therapists and physical therapist assistants shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the Governor temporarily suspended the rulemaking authorities set forth in C.R.S. § 24-1-122(3)(m)(I) (Colorado Medical Board), C.R.S. § 24-1-122(3)(gg) (State Board of Nursing), C.R.S. § 24-1-122(3)(h) (Colorado State Board of Chiropractic Examiners, C.R.S. § 24-1-122(3)(k) (Colorado Dental Board), C.R.S. § 24-1- 122(3)(m)(II) (Colorado Podiatry Board), C.R.S. § 24-1-122(3)(p) (Colorado State Board of Optometry), C.R.S. § 24-1-122(3)(y) (State Board of Veterinary Medicine), and C.R.S. § 12-285-105(1)(b) (State Physical Therapy Board), and directed the Executive Director of DORA, through the Director of DPO, to promulgate and issue temporary emergency rules consistent with the Executive Order.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division

Director), is promulgating these emergency rules expanding delegation in order to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

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Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
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Office of the Attorney General

Tracking number: 2022-00678

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Physical Therapy Board

on 10/26/2022

4 CCR 732-1

PHYSICAL THERAPY RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 15, 2022 11:35:10

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - State Board of Unlicensed Psychotherapists

CCR number

4 CCR 734-1

Rule title

4 CCR 734-1 UNLICENSED PSYCHOTHERAPISTS RULES AND REGULATIONS 1 - eff 10/21/2022

Effective date

10/21/2022

Expiration date

02/18/2023

DEPARTMENT OF REGULATORY AGENCIES

State Board of Unlicensed Psychotherapists

UNLICENSED PSYCHOTHERAPISTS RULES AND REGULATIONS

4 CCR 734-1

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

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1.18 PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401 *et seq.*, 12-245-204(4)(a), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

5. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

6. "Registrant" means as defined in section 12-20-102(12), C.R.S.

7. "Regulator" means as defined in section 12-20-102(14), C.R.S.

8. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

B. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on the applicant or registrant's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a civil or criminal judgment against the applicant or registration arising from the provision of, or assistance in the provision of reproductive health care

in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a professional disciplinary action or any other sanction against the applicant's or registrant's professional registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant or registrant's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on the registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a civil or criminal judgment against the applicant or registration arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.19 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-245-204(4)(a) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

4. "Registrant" means as defined in section 12-20-102(12), C.R.S.

5. "Regulator" means as defined in section 12-20-102(14), C.R.S.

B. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a civil or criminal judgment against the applicant or registrant regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny registration to an applicant or impose disciplinary action against an individual's registration based solely on a professional disciplinary action against the applicant's or registrant's professional registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's or registrant's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

…

Editor's Notes

History

Entire rule emer. rule eff. 12/16/2011.

Entire rule eff. 02/15/2012.

Authority, Purpose and Scope, rules 1.1 A, 1.1 E, 1.4 B.1, 1.6, 1.7 B.3, 1.8 - 1.10, 1.12, 1.14 emer. rules eff. 10/16/2020.

Authority, Purpose and Scope, rules 1.1 A, 1.1 E, 1.4 B.1, 1.6, 1.7 B.3, 1.8 - 1.10, 1.12 - 1.16, Appendix A eff. 12/15/2020.

Rules 1.6 A, 1.16, Appendix A eff. 06/14/2021.

Rule 1.8 B eff. 12/15/2021.

Annotations

Rule 1.16 E.4. (adopted 10/16/2020) was not extended by Senate Bill 21-152 and therefore expired 05/15/2021.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

On July 6, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 032, "Directing State Agencies to Protecting Access to Reproductive Health Care in Colorado."

On July 14, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 034, "Protecting Colorado's Workforce and Expanding Licensing Opportunities."

Basis

The basis for these rules is Executive Order D 2022 032 and Executive Order D 2022 034.

Through Executive Order D 2022 032, Governor Jared Polis directed all state agencies not to share any information or data, including patient medical records, patient-level data or related billing information, or expend time, money, facilities property, equipment, personnel, or other resources to assist or further any investigation or proceeding initiated in or by another state that seeks to impose criminal or civil liability or professional sanction upon a person for conduct that would be legal in Colorado related to providing, assisting, seeking, or obtaining reproductive health care, unless pursuant to a court order.

Governor Jared Polis also directed the Department of Regulatory Agencies (DORA) to work with all programs and boards of professional licensure operating under its purview to promulgate and issue necessary rules that will ensure that no person shall be subject to a disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care as provided is consistent with professional conduct and standards of care within the State of Colorado.

Through Executive Order D 2022 034, Governor Jared Polis directed the Department of Regulatory Agencies to work with all programs and boards of professional licensure operating under its purview to promulgate and issue rules as necessary to ensure that no person shall be subject to disciplinary action against a professional license or disqualified from professional licensure for any civil or criminal judgment, discipline, or other sanction or threat imposed under the laws of another state as long as the actions are lawful and consistent with professional conduct and standards of care within the State of Colorado.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2022 032 and Executive Order D 2022 034.

As stated in Executive Order D 2022 032, Colorado is experiencing workforce shortage in many professions, and disqualifying people because they were prosecuted for taking actions in other states that are fully legal under Colorado law would hurt our economy and our State.

Colorado is committed to protecting access to reproductive health care. No one who is lawfully providing, assisting, seeking, or obtaining reproductive health care in Colorado should be subject to legal liability or professional sanctions in Colorado or any other state, nor will Colorado cooperate with criminal or civil investigations for actions that are fully legal in Colorado.

As stated in Executive Order D 2022 034, employers are having difficulty recruiting and retaining qualified employees, many of whom need professional licenses. The exclusion of people from the workforce because of marijuana-related activities that are lawful in Colorado, but illegal in other states, hinders our economy and our State.

Justification

As set forth in Executive Order D 2022 032, the need exists to immediately protect access to reproductive health care in Colorado by promulgating rules ensuring no licensee, certificant, or registrant shall be subject to disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care provided is lawful and consistent with professional conduct and standards of care within the State of Colorado.

As set forth in Executive Order D 2022 034, the Order ensures that all Coloradans are afforded protections and rights under Colorado law.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Regulator, as defined in section 12-20-102(14), C.R.S., hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2022 032, to protect access to reproductive health care in Colorado. The adoption of emergency rules is imperatively necessary for the preservation of the public health, safety, and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Regulator finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 21, 2022, and remain in effect for up to a maximum of 120 days after adoption of these temporary/emergency rules.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2022-00668

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - State Board of Unlicensed Psychotherapists

on 10/21/2022

4 CCR 734-1

UNLICENSED PSYCHOTHERAPISTS RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/24/2022 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.

November 08, 2022 15:59:09

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Board of Marriage and Family Therapist Examiners

CCR number

4 CCR 736-1

Rule title

4 CCR 736-1 MARRIAGE AND FAMILY THERAPIST EXAMINERS RULES AND REGULATIONS 1 - eff 10/28/2022

Effective date

10/28/2022

Expiration date

02/25/2023

DEPARTMENT OF REGULATORY AGENCIES

Board of Marriage and Family Therapist Examiners

MARRIAGE AND FAMILY THERAPIST EXAMINERS RULES AND REGULATIONS

4 CCR 736-1

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

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1.24 PROVISION OF REPRODUCTIVE HEALTH CARE IN COLORADO

This Rule is promulgated pursuant to Executive Order D 2022 032, and sections 25-6-401 *et seq.*, 12-245-204(4)(a), and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Assisting in the provision reproductive health care" means aiding, abetting or complicity in the provision of reproductive health care.

3. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

4. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

5. "Licensee" means as defined in section 12-20-102(10), C.R.S.

6. "Provision of reproductive health care," includes but is not limited to, transportation for reproductive health care, referrals for reproductive health care and related services, funding or assisting with payment of reproductive health care, prescribing, shipping or dispensing medications for reproductive health care in accordance with state and federal law, all options and mental health counseling and treatment related to reproductive health care. The "provision of reproductive health care" also includes all treatment contemplated in the definition of section 25-6-402(4), C.R.S.

7. "Regulator" means as defined in section 12-20-102(14), C.R.S.

8. "Reproductive health care" means as defined in section 25-6-402(4), C.R.S.

9. "Registrant" means as defined in section 12-20-102(12), C.R.S.

B. The regulator shall not deny licensure to an applicant or impose disciplinary action against an individual's license or registration based solely on the applicant, registrant's, or licensee's provision of or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice as defined in Colorado law and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against

the applicant, registrant, or licensee arising from the provision of, or assistance in the provision of reproductive health care in this state or any other state or U.S. territory, so long as the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

D. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a professional disciplinary action or any other sanction against the applicant's, registrant's, or licensee's professional licensure or registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's provision of, or assistance in the provision of, reproductive health care and the care provided was consistent with generally accepted standards of practice and did not otherwise violate Colorado law.

E. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's registration or license based solely on the licensee's or registrant's own personal effort to seek or obtain reproductive health care for themselves. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against the applicant, registrant, or licensee arising from the individual's own personal receipt of reproductive health care in this state or any other state or U.S. territory.

1.25 PROTECTING COLORADO'S WORKFORCE AND EXPANDING LICENSING OPPORTUNITIES

This Rule is promulgated pursuant to Executive Order D 2022 034, and sections 12-245-204(4)(a) and 12-20-204, C.R.S.

A. Definitions, for purposes of this Rule, are as follows:

1. "Applicant" means as defined in section 12-20-102(2), C.R.S.

2. "Civil judgment" means a final court decision and order resulting from a civil lawsuit.

3. "Criminal judgment" means a guilty verdict, a plea of guilty, a plea of nolo contendere, *or* a deferred judgment or sentence.

4. "Licensee" means as defined in section 12-20-102(10), C.R.S.

5. "Regulator" means as defined in section 12-20-102(14), C.R.S.

6. "Registrant" means as defined in section 12-20-102(12), C.R.S.

B. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a civil or criminal judgment against the applicant, registrant, or licensee regarding the consumption, possession, cultivation, or processing of marijuana so long as the actions are lawful and consistent with professional conduct and standards of care within Colorado and did not otherwise violate Colorado law.

C. The regulator shall not deny licensure or registration to an applicant or impose disciplinary action against an individual's license or registration based solely on a professional disciplinary action against the applicant's, registrant's, or licensee's professional licensure or registration in this, or any other state or U.S. territory so long as the professional disciplinary action is based solely on the applicant's, registrant's, or licensee's consumption, possession, cultivation, or processing of marijuana and did not otherwise violate Colorado law.

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Editor's Notes

History

Rule 17(a) emer. rule eff. 10/26/2007; expired eff. 01/26/2008.

Rule 17 eff. 03/01/2008.

Purpose and Scope, rules 12, 15, 19, 20 emer. rules eff. 01/01/2011.

Purpose and Scope, rules 12, 15, 19, 20 eff. 02/01/2011.

Entire rule emer. rule eff. 12/09/2011.

Entire rule eff. 02/01/2012.

Rule 12 eff. 05/02/2016.

Rules 1.6 A, 1.14 A, 1.14 C.1, 1.14 C.6.a, 1.16 A emer. rules eff. 10/23/2020.

Rules 1.6 A, 1.12, 1.14 A, 1.14 C.1, 1.14 C.6.a, 1.16 A, 1.22, Appendix A eff. 12/15/2020.

Rules 1.6 A, 1.12 C-D, 1.22, Appendix A eff. 06/30/2021.

Rule 1.8 B eff. 12/30/2021.

Annotations

Rules 1.12 C., 1.12 D., 1.22 E.4. (adopted 10/23/2020) were not extended by Senate Bill 21-152 and therefore expired 05/15/2021.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

On July 6, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 032, "Directing State Agencies to Protecting Access to Reproductive Health Care in Colorado."

On July 14, 2022, Colorado Governor Jared Polis ("Governor") signed Executive Order D 2022 034, "Protecting Colorado's Workforce and Expanding Licensing Opportunities."

Basis

The basis for these rules is Executive Order D 2022 032 and Executive Order D 2022 034.

Through Executive Order D 2022 032, Governor Jared Polis directed all state agencies not to share any information or data, including patient medical records, patient-level data or related billing information, or expend time, money, facilities property, equipment, personnel, or other resources to assist or further any investigation or proceeding initiated in or by another state that seeks to impose criminal or civil liability or professional sanction upon a person for conduct that would be legal in Colorado related to providing, assisting, seeking, or obtaining reproductive health care, unless pursuant to a court order.

Governor Jared Polis also directed the Department of Regulatory Agencies (DORA) to work with all programs and boards of professional licensure operating under its purview to promulgate and issue necessary rules that will ensure that no person shall be subject to a disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care as provided is consistent with professional conduct and standards of care within the State of Colorado.

Through Executive Order D 2022 034, Governor Jared Polis directed the Department of Regulatory Agencies to work with all programs and boards of professional licensure operating under its purview to promulgate and issue rules as necessary to ensure that no person shall be subject to disciplinary action against a professional license or disqualified from professional licensure for any civil or criminal judgment, discipline, or other sanction or threat imposed under the laws of another state as long as the actions are lawful and consistent with professional conduct and standards of care within the State of Colorado.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2022 032 and Executive Order D 2022 034.

As stated in Executive Order D 2022 032, Colorado is experiencing workforce shortage in many professions, and disqualifying people because they were prosecuted for taking actions in other states that are fully legal under Colorado law would hurt our economy and our State.

Colorado is committed to protecting access to reproductive health care. No one who is lawfully providing, assisting, seeking, or obtaining reproductive health care in Colorado should be subject to legal liability or professional sanctions in Colorado or any other state, nor will Colorado cooperate with criminal or civil investigations for actions that are fully legal in Colorado.

As stated in Executive Order D 2022 034, employers are having difficulty recruiting and retaining qualified employees, many of whom need professional licenses. The exclusion of people from the workforce because of marijuana-related activities that are lawful in Colorado, but illegal in other states, hinders our economy and our State.

Justification

As set forth in Executive Order D 2022 032, the need exists to immediately protect access to reproductive health care in Colorado by promulgating rules ensuring no licensee, certificant, or registrant shall be subject to disciplinary action against a professional license or disqualified from professional licensure for providing or assisting in the provision of reproductive health care or as a consequence of any civil or criminal judgment, discipline, or other sanction threatened or imposed under the laws of another state so long as the care provided is lawful and consistent with professional conduct and standards of care within the State of Colorado.

As set forth in Executive Order D 2022 034, the Order ensures that all Coloradans are afforded protections and rights under Colorado law.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Regulator, as defined in section 12-20-102(14), C.R.S., hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2022 032, to protect access to reproductive health care in Colorado. The adoption of emergency rules is imperatively necessary for the preservation of the public health, safety, and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Regulator finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 28, 2022, and remain in effect for up to a maximum of 120 days after adoption of these temporary/emergency rules.

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

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Office of the Attorney General

Tracking number: 2022-00685

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Board of Marriage and Family Therapist Examiners

on 10/28/2022

4 CCR 736-1

MARRIAGE AND FAMILY THERAPIST EXAMINERS RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/28/2022 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.

November 15, 2022 14:23:37

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Office of Respiratory Therapy Licensure

CCR number

4 CCR 741-1

Rule title

4 CCR 741-1 RESPIRATORY THERAPY RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

Expiration date

02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

Office of Respiratory Therapy Licensure

RESPIRATORY THERAPY RULES AND REGULATIONS

4 CCR 741-1

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

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1.14 EXPANDED DELEGATION PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. These Emergency Rules are adopted by the Director of the Division of Professions and Occupations (Director) to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Delegation

1. In addition to any delegation authorized by section 12-300-112(1)(i), C.R.S., respiratory therapists may delegate services within their scope of practice to the following Colorado licensed professionals working in a hospital or inpatient facility:

   a. Podiatrists

   b. Optometrists

   c. Chiropractors

   d. Veterinarians

   e. Physical Therapists

   f. Physical Therapy Assistants

   g. Occupational Therapists

h. Occupational Therapy Assistants

i. Speech-Language Pathologists

j. Surgical Assistants

k. Surgical Technologists

l. Volunteer Retired Nurses

m. Nurse Aides

2. Respiratory therapists may delegate services within their scope of practice to the following unlicensed persons working in a hospital or inpatient facility:

a. Volunteer Nursing Students

b. Medical Assistants

3. In addition to the provisions of section 12-300-112(1)(i), C.R.S., respiratory therapists are authorized to provide training to the Colorado licensed professionals and unlicensed persons set forth in Rule 1.10(C)(1) and (2).

4. In order to delegate services pursuant to Rule 1.10(C)(1) and (2), the Respiratory Therapist shall ensure, prior to the delegation, that the delegated service is within the knowledge, skill and training of the delegatee.

5. The respiratory therapists shall ensure on-premises availability to provide direction and supervision of the delegatee.

6. The delegated services shall be routine, technical services, the performance of which do not require the special skill or decision making ability of a respiratory therapist.

7. The prescription or selection of medications, performance of surgical or other invasive procedures and anesthesia services may not be delegated.

1.15 EXPANDED SCOPE OF PRACTICE FOR RESPIRATORY THERAPISTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical

personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Respiratory therapists may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

a. Respiratory therapists are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

b. Respiratory therapists shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

c. Respiratory therapists shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

d. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

e. Respiratory therapists shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from the COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, Governor Jared Polis directed the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division Director), is promulgating these emergency rules expanding scope of practice for physical therapists and physical therapist assistants in order to provide hospitals and inpatient

facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency

declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

_____

Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
Attorney General

NATALIE HANLON LEH
Chief Deputy Attorney General

ERIC R. OLSON
Solicitor General

STATE OF COLORADO
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Office of the Attorney General

Tracking number: 2022-00682

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Office of Respiratory Therapy Licensure

on 10/26/2022

4 CCR 741-1

RESPIRATORY THERAPY RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 11/04/2022 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.

November 15, 2022 11:20:01

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Office of Surgical Assistant and Surgical Technologist Registration

CCR number

4 CCR 745-1

Rule title

4 CCR 745-1 SURGICAL ASSISTANT AND SURGICAL TECHNOLOGIST RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

Expiration date

02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

Surgical Assistant and Surgical Technologist Registration

SURGICAL ASSISTANT AND SURGICAL TECHNOLOGIST RULES AND REGULATIONS

4 CCR 745-1

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

…

1.7 EXPANDED SCOPE OF PRACTICE FOR SURGICAL TECHNOLOGISTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, et. seq., C.R.S.

B. These Emergency Rules are adopted by the Director of the Division of Professions and Occupations (Director) to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Surgical Assistants and Surgical Technologists may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Surgical Assistants and Surgical Technologists are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Surgical Assistants and Surgical Technologists shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Surgical Assistants and Surgical Technologists shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Surgical Assistants and Surgical Technologists shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services outside of their statutory scope of practice regardless of delegation.

…

1.9 EXPANDED SCOPE OF PRACTICE FOR SURGICAL ASSISTANTS AND SURGICAL TECHNOLOGISTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, et. seq., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Surgical assistants and surgical technologists may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

a. Surgical assistants and surgical technologists are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

b. Surgical assistants and surgical technologists shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

c. Surgical assistants and surgical technologists shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

d. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

e. Surgical assistants and surgical technologists shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from the COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, Governor Jared Polis directed the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division Director), is promulgating these emergency rules expanding scope of practice for physical therapists and physical therapist assistants in order to provide hospitals and inpatient

facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency

declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

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Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
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Chief Deputy Attorney General

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Office of the Attorney General

Tracking number: 2022-00681

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Office of Surgical Assistant and Surgical Technologist Registration

on 10/26/2022

4 CCR 745-1

SURGICAL ASSISTANT AND SURGICAL TECHNOLOGIST RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 15, 2022 11:27:02

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Regulatory Agencies

Agency

Division of Professions and Occupations - Office of Speech-Language Pathology Certification

CCR number

4 CCR 748-1

Rule title

4 CCR 748-1 SPEECH-LANGUAGE PATHOLOGIST RULES AND REGULATIONS 1 - eff 10/26/2022

Effective date

10/26/2022

Expiration date

02/23/2023

DEPARTMENT OF REGULATORY AGENCIES

Office of Speech-Language Pathology Certification

SPEECH-LANGUAGE PATHOLOGIST RULES AND REGULATIONS

4 CCR 748-1

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

…

1.20 EXPANDED SCOPE OF PRACTICE FOR SPEECH-LANGUAGE PATHOLOGISTS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.,* C.R.S.

B. These Emergency Rules are adopted by the Director of the Division of Professions and Occupations (Director) to effectuate Executive Order D 2022 040, extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice. Speech-language pathologists may perform services while working in a hospital or inpatient facility as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, professional nurses and respiratory therapists.

1. Speech-language pathologists are authorized to perform delegated services upon adequate cross-training as determined necessary by the hospital or inpatient facility.

2. Speech-language pathologists shall not accept delegation of a service for which the licensee does not possess the knowledge, skill or training to perform.

3. Speech-language pathologists shall not perform a delegated service for which the licensee does not possess the knowledge, skill or training to perform.

4. Delegated services shall not be re-delegated to another person or licensee by the delegatee.

5. Speech-language pathologists shall not prescribe or select medications, perform surgical or other invasive procedures or perform anesthesia services regardless of delegation.

…

1.24 EXPANDED SCOPE OF PRACTICE FOR SPEECH-LANGUAGE PATHOLOGISTS IN ORDER TO ADMINISTER VACCINATIONS PURSUANT TO THE GOVERNOR'S EXECUTIVE ORDER D 2022 040

A. Basis. Through Executive Order D 2022 040, amending and extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, Governor Jared Polis directed the Executive Director of DORA, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules consistent with the Executive Order. The basis for these emergency rules is Executive Order D 2022 040 issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order and Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq*., C.R.S.

B. Purpose. These Emergency Rules are adopted by the Executive Director of DORA, through the Division Director, to effectuate Executive Order D 2022 040, amending and extending Executive Orders D 2021 122, D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, and D 2022 038, and directing the immediate expansion of the workforce of trained medical personnel available to administer the coronavirus disease 2019 (COVID-19) vaccinations within inpatient facilities and outpatient settings due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

C. Expanded Scope of Practice In Order to Administer the COVID-19 Vaccination.

1. Speech-language pathologists may administer the COVID-19 vaccination while working in a hospital, inpatient facility or outpatient setting as delegated by physicians, physician assistants, advanced practice registered nurses, certified registered nurse anesthetists, or professional nurses.

    a. Speech-language pathologists are authorized to perform this delegated service upon adequate cross-training as determined necessary by the hospital, inpatient facility, or outpatient setting.

    b. Speech-language pathologists shall not accept delegation of this service if the licensee does not possess the knowledge, skill or training to perform.

    c. Speech-language pathologists shall not perform this delegated service if the licensee does not possess the knowledge, skill or training to perform.

    d. This delegated service shall not be re-delegated to another person or licensee by the delegatee.

    e. Speech-language pathologists shall not prescribe, order, or select the COVID-19 vaccination regardless of delegation.

COLORADO
Department of Regulatory Agencies
Division of Professions and Occupations

STATEMENT OF BASIS, PURPOSE and JUSTIFICATION for EMERGENCY RULES

Colorado Governor Jared Polis ("Governor") declared a state of disaster recovery on July 8, 2021, through Executive Order D 2021 122, to focus the State's efforts on recovery from the COVID-19 pandemic. Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, addresses the immediate need for trained medical personnel available to provide healthcare services during the recovery from the COVID-19 pandemic.

Basis

Through Executive Order D 2021 122, which was amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, Governor Jared Polis directed the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

The basis for these emergency rules is Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, issued by Governor Jared Polis pursuant to the Colorado COVID-19 Disaster Recovery Order issued on July 8, 2021, Article IV, Section 2 of the Colorado Constitution, and the Colorado Disaster Emergency Act, sections 24-33.5-701, *et. seq.*, C.R.S.

Purpose

The purpose of these emergency rules is to effectuate Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and directing the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Professions and Occupations (Division Director), to promulgate and issue temporary emergency rules to expand the workforce of trained medical personnel available to provide healthcare services within inpatient facilities due to the coronavirus disease 2019 (COVID-19) pandemic in Colorado.

Through this emergency rulemaking, the Executive Director of the Department of Regulatory Agencies, through the Director of the Division of Profession and Occupations (Division Director), is promulgating these emergency rules expanding scope of practice for physical therapists and physical therapist assistants in order to provide hospitals and inpatient

facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Justification

As set forth in Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, the need exists to immediately expand the available healthcare workforce in hospitals and inpatient facilities. The Executive Director of the Department of Regulatory Agencies, through the Division Director, is promulgating these emergency rules expanding scope of practice to provide hospitals and inpatient facilities with the flexibility to fill healthcare service gaps with readily available personnel through expanded delegation of services.

Pursuant to section 24-4-103(6)(a), C.R.S., a temporary or emergency rule may be adopted without compliance with section 24-4-103(4),C.R.S., which requires the agency to hold a public hearing "at which it shall afford interested persons an opportunity to submit written a data, views, or arguments and to present the same orally"; and with less than the twenty days' notice set forth in section 24-4-103(3), C.R.S., or without notice where circumstances imperatively require, only if the agency finds that "[i]mmediate adoption of the rule is imperatively necessary to comply with a state or federal law or federal regulation or for preservation of the public health, safety or welfare and compliance with the requirements of this section would be contrary to the public interest." Such findings must be made on the record.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, hereby finds the immediate adoption of these emergency rules is imperatively necessary to comply with Executive Order D 2021 122, as amended and extended by Executive Orders D 2021 124, D 2021 125, D 2021 129, D 2021 132, D 2021 136, D 2021 139, D 2021 141, D 2022 003, D 2022 010, , D 2022 013, D 2022 017, D 2022 020, D 2022 028, D 2022 035, D 2022 037, D 2022 038, and D 2022 040, and, that due to threat posed by the COVID-19 pandemic, the adoption of emergency rules to expand the available healthcare workforce in hospitals and inpatient facilities is imperatively necessary for the preservation of the public health, safety and welfare, and cannot wait the several months required for permanent rulemaking and therefore emergency rules are appropriate pursuant to the Administrative Procedure Act.

The Executive Director of the Department of Regulatory Agencies, through the Division Director, finds, as required by section 24-4-103(4)(b), C.R.S., that the need for the emergency rulemaking exists; the proper constitutional and/or statutory authority exists for the rules; to the extent practicable, the rules are clearly and simply stated so that their meaning will be understood by any required to comply with the rules; the rules do not conflict with other provisions of the law; and any duplication or overlapping of the rules, if any, has been explained.

These temporary/emergency rules take effect October 26, 2022, and remain in effect for the longer of (A) 30 days after adoption, or (B) the duration of the State of Disaster Emergency

declared by the Governor, up to a maximum of 120 days after adoption of these temporary/emergency rules.

Adopted this 26th day of October, 2022.

_____

Karen McGovern, Deputy Division Director of Legal Affairs, for Ronne Hines, Director Division of Professions and Occupations

PHILIP J. WEISER
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STATE OF COLORADO
DEPARTMENT OF LAW

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Office of the Attorney General

Tracking number: 2022-00680

Opinion of the Attorney General rendered in connection with the rules adopted by the

Division of Professions and Occupations - Office of Speech-Language Pathology Certification

on 10/26/2022

4 CCR 748-1

SPEECH-LANGUAGE PATHOLOGIST RULES AND REGULATIONS

The above-referenced rules were submitted to this office on 10/26/2022 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.

November 15, 2022 10:49:24

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-3

Rule title

10 CCR 2505-3 FINANCIAL MANAGEMENT OF THE CHILDREN'S BASIC HEALTH PLAN 1 - eff 10/14/2022

Effective date

10/14/2022

Expiration date

02/11/2023

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
Rule Number: CHP 22-10-06-G
Division / Contact / Phone:Office of Medicaid Operations / Ana Bordallo / 3558

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: CHP 22-10-06-G, Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 110,140, 310 and 320, Colorado Department of Health Care Policy and Financing, Child Health Plan *Plus* (10 CCR 2505-3).
5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 10/14/2022
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text with the proposed text beginning at Section 50 through the end of Section 610. This rule is effective October 14, 2022.

*to be completed by MSB Board Coordinator

Title of Rule: Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
Rule Number: CHP 22-10-06-G
Division / Contact / Phone:Office of Medicaid Operations / Ana Bordallo / 3558

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule change will amend 10 CCR 2505-3 sections 110,140,310 and 320 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act(ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during this Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories which includes the Child Health Plan Plus (CHP+) category. These policy changes will stay in place until the end of the Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Members who were evacuated from or unable to return to Colorado and are temporarily absent will maintain enrollment in the CHP+ program. Enrollment fees will be waived for members who are being redetermined and eligible for CHP+. required through the Federal CARES Act for the Maintenance of Effort(MOE), the Department will continue eligibility for all the CHP+ categories regardless of changes made for a redetermination or additional documentation for current CHP+ enrollee and allow them to continue eligibility through the end of the Public Health Emergency. At the end of emergency, the Department will process the redetermination and /or changes for all members whose eligibility was maintained during the emergency period.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   Due to the Coronavirus (COVIS-19) public health emergency rules need to be updated for the state to be in compliance with federal regulations.

3. Federal authority for the Rule, if any:

   Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 and Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-

136. The Affordable Care Act(ACA), which includes the Maintenance of Effort (MOE) provision.

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2022);
25.5-8-107.(b)

Title of Rule: Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320
Rule Number: CHP 22-10-06-G
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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 proposed rules will impact members enrolled in the CHP+ programs. The rule updates will benefit members enrolled in CHP+ by remaining eligible during this Coronavirus (COVIS-19) Public Health Emergency.

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

   The proposed rule will help to determine eligibility correctly by applying regulations appropriately to help members remain eligible for the CHP+ programs during this Coronavirus (COVID-19) Public Health Emergency.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.
   The Department expects that eligibility could potentially increase as members who are outside the state for the duration of the emergency will not be disenrolled. This will lead to an increase in expenditure for the Department as the member will be included in the monthly capitation payment. The Department also assumes that the waiving of enrollment fees for the CHP+ program will reduce revenues to the Department which will result in the increase of expenditures to the CHP+ Trust fund, Healthcare Affordability and Sustainability Fee (HAS) Cash Fund, and federal funds in order to fill the gap in revenue lost from the premiums. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

4. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.
The Department expects that inaction to the proposal to allow CHP+ member to retain eligibility outside the state will result in lack of care to those

members who are outside the state during the emergency period who will need those services. The Department sees no benefit to inaction.
In addition, the Department expects that inaction to the proposal to waive enrollment fees will cause potential members to not qualify because they are unable to pay the premiums due to the severity of the economic shock. The Department also sees no benefit to inaction.
5. Determine whether there are less costly methods or less intrusive methods for achieving the purpose of the proposed rule.
There are currently no less costly measures to the Department that will allow the Department to service members more effectively during the emergency period.

6.Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There are no alternative methods for the proposed rule that were considered

50 DEFINITIONS

50.1 “Applicant” shall mean a person applying or re-applying for benefits on behalf of a child and/or themselves.

50.2 “CBMS” shall mean Colorado Benefits Management System is the computer system that determines an applicant’s eligibility for public assistance in the state of Colorado.

50.3 “Child” means a person who is less than nineteen years of age.

50.4 “Cost sharing” shall mean payments, such as copayments that are due on behalf of the enrollee.

50.5 “Department” shall mean the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Children’s Basic Health Plan as well as other State-funded health care programs.

50.6 “Dependent child” shall mean a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 18, or, is age 18 and a full-time student, and expected to graduate by age 19

50.7 “Effective Date” shall mean the first day of eligibility which is the date the application is received and date-stamped by the Eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

50.8 “Eligibility Site” shall mean a location outside of the Department that has been deemed by the Department as eligible to accept applications and determine eligibility for applicants.

50.9 “Enrollee” shall mean an eligible person who is enrolled in the Children’s Basic Health Plan.

50.10 “Essential Community Provider” means a healthcare provider that:

A. Has historically served medically needy or medically indigent patients and demonstrates a commitment to serve low-income and medically indigent populations who make up a significant portion of its patient population, or in the case of a sole community provider, serves medically indigent patients within its medical capability; and

B. Waives charges or charges for services on a sliding scale based on income and does not restrict access or services because of a client's financial limitations.

50.11 “Evidence of Coverage” or “EOC” shall mean any certificate, agreement, or contract issued to an enrollee from time-to-time by a Managed Care Organization (MCO) setting out the coverage to which the enrollee is or was entitled under the Children’s Basic Health Plan.

50.12 “Grievance Committee” shall mean a conference with the Department or its Designee in which a contested decision regarding an applicant or enrollee is reexamined.

50.13 “Household” shall be determined by relationships to the tax filer as declared on the Single Streamlined Application and as required in 10 CCR 2505-10-8.100.4.E.

50.14 “Income” shall be any compensation from participation in a business, including wages, salary, tips, commissions and bonuses. The Modified Adjusted Gross Income is a methodology used to determine eligibility as required in 10 CCR 2505-10-8.100.4.C.

50.15 “Managed Care Organization” or “MCO” shall mean:

A. A carrier which meets the definition in §10-16-102 (8), C.R.S. with which the Department contracts to provide health care or dental services covered by the Children’s Basic Health Plan; or,

B. Essential community providers and other health care and dental service providers with whom the Department contracted to provide health care services under the Children’s Basic Health Plan using a managed care model.

50.16 “Presumptive Eligibility” shall mean children and pregnant women who have applied and appear to be eligible for the Children’s Basic Health Plan shall be presumed eligible and may receive immediate temporary medical coverage.

50.17 “Unearned Income” shall be the gross amount received in cash or kind that is not earned from employment or self-employment.

50.18 “Woman” shall mean a female who is 19 years in age or older.

100 ELIGIBILITY

110 INDIVIDUALS ASSISTED UNDER THE PROGRAM

110.1 To be eligible for the Children’s Basic Health Plan, an eligible person shall:

A.

1. Be less than 19 years of age; or

2. Be a pregnant woman

B. Fall into one of the following categories:

1. Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the United States Virgin Islands, the Northern Mariana Islands, American Samoa, or Swain's Island; or

2. Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

3. Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance who falls into one of the following categories:

a. Lawfully admitted for permanent residence under the U.S. Immigration and Nationality Act (hereafter referred to as the “INA”); or

b. Paroled into the United States for at least one year under 8 U.S.C § 1182(d)(5); or

c. Granted conditional entry under Section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

d. determined by the Eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C.

§1641(c), has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Children's Basic Health Plan); or

4. Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

   a. Lawfully residing in Colorado and is an honorably discharged military veteran; or

      1. A spouse of such military veteran; or

      2. An unremarried surviving spouse of such military veteran; or

      3. An unmarried dependent child of such military veteran.7

   b. Lawfully residing in Colorado and is on active duty in the United States Armed Forces, excluding military training; or

      1. A spouse of such individual; or

      2. An unremarried surviving spouse of such individual; or

      3. An unmarried dependent child of such individual.

   c. Granted asylum under Section 208 of the INA; or

   d. Refugee under Section 207 of the INA; or

   e. An individual with deportation withheld:

      1. Under Section 243(h) of the INA, as in effect prior to September 30, 1996; or

      2. Under Section 241(b)(3), as amended by P.L. 104-208 of the INA.

   f. A Cuban or Haitian entrant, as defined under Section 501(e) of the U.S. Refugee Education Assistance Act of 1980; or

   g. An individual who:

      1. Was born in Canada and possesses at least 50 percent American Indian blood; or

      2. Is a member of an Indian tribe, as defined in 25 U.S.C. Section 450(b)e.

   h. Admitted into the United States as an Amerasian immigrant under Section 584 of the U.S. Foreign Operations, Export Financing, and Related Programs Appropriation Act of 1988, as amended by P.L. 100-461; or

   i. A lawfully admitted, permanent resident, who is a Hmong or Highland Lao veteran of the Vietnam conflict; or

j. An alien who was admitted in the United States on or after December 26, 2007 who is an Iraqi Special Immigrant under section 101(a)(27) of the INA; or

k. An alien who was admitted in the United States on or after December 26,2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA; and

5. Be a lawfully admitted non-citizen in the United States who falls into one of the categories:

a. granted temporary resident status in accordance with section 8 U.S.C. 1160 or 1255a; or

b. granted Temporary Protected Status (TPS) in accordance with section 8 U.S.C 1254a and pending applicants for TPS granted employment authorization;

c. granted employment authorization under section 8 CFR 274a.12(c);or

d. Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.

e. Deferred Enforced Departure (DED), pursuant to a decision made by the President

f. Granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum;

g. Granted an administrative stay of removal under section 8 CFR 241; or

h. Beneficiary of approved visa petition who has a pending application for adjustment of status.

i. Pending an application for asylum under section 8 U.S.C. 1158, or for withholding of removal under section 8 U.S.C. 1231, or under the Convention Against Torture who-

1. as been granted employment authorization; or

2. Is under the age of 14 and has had an application pending for at least 180 days.

j. Granted withholding of removal under the Convention Against Torture;

k. Citizens of Micronesia, the Marshall Islands, and Palau; or

l. Is lawfully present American Samoa under the immigration of laws of American Samoa.

m. A non-citizen in a valid nonimmigrant status, as defined in section 8 U.S.C. 1101(a)(15) or under section 8 U.S.C. 1101(a)(17); or

n. A non-citizen who has been paroled into the United States for less than one year under section U.S.C. 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings; or

o. A child who has a pending application for Special Immigrant Juvenile status under 8 U.S.C 1101(a)(27)(J).

C. For determinations of eligibility for the Children's Basic Health Plan, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 110.1.B and has declared that he or she has a legal immigration status.

1. The Verify Lawful Presence (VLP) interface will be used to verify immigration status as required in 10 CCR 2505-10-8.100.3.G.2

2. If the state cannot verify immigration status the individual will receive a Reasonable Opportunity Period as required in 10 CCR 2505-10-8.100.3.H.9

D. Be a resident of Colorado; and residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. Temporarily absent means that at the time he/she leaves, the person intends to return.

E. Have a household income greater than 133% but not exceeding 250% of the Federal Poverty Level (MAGI-equivalent), adjusted for household size for children under the age of 19; or

F. Have a household income greater than 185% but not exceeding 250% of the Federal Poverty Level (MAGI-equivalent), adjusted for household size for pregnant women.

G. Failure to complete an application or to provide required documentation in Section 130 will result in the denial of the incomplete application or individual applicant (s).

120 INSUFFICIENT ACCESS TO OTHER HEALTH COVERAGE

120.1 To be eligible for the Children's Basic Health Plan, an eligible person shall not:

A. Be covered under a group health plan or under health insurance coverage excluding Consolidated Omnibus Budget Reconciliation Act (COBRA); or

B. Be eligible to receive assistance under Title XIX of the Social Security Act; or

C. Be an inmate of a public institution or a patient in an institution for mental diseases.

120.2 The Department shall not require that applicants be uninsured for any period of time prior to becoming eligible for the Children's Basic Health Plan.

130 VERIFICATION REQUIREMENTS

130.1 To be eligible for the Children's Basic Health Plan, an applicant shall provide minimal verification as required in 10 CCR 2505-10-8.100.4.B.

140 REDETERMINATION

140.1 A redetermination of eligibility shall mean a case review and necessary verification to determine whether the client continues to be eligible to receive Medical Assistance. Eligibility shall be redetermined twelve (12) months since the last eligibility determination. An Eligibility site may redetermine eligibility through telephone, mail, or electronic means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

A. A redetermination form is not required to be sent to the client if all current eligibility requirements can be verified by reviewing information from another assistance program or if this information can be verified through an electronic data source. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to redetermination month, no request shall be made of the client and a notice of the outcome will go to the client. If not all verification or information is available, the eligibility site shall only request the additional minimum verification from the client. This procedure is referenced as Ex Parte Review.

B. A redetermination form, approved by the Department, shall be mailed to the client at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed. The client shall not be required to return the form to the eligibility site. The only verification that may be required at redetermination is the minimum verification needed to complete a redetermination of eligibility.

The redetermination form shall direct clients to review current information and to take no action if there are no changes to report in the household. Eligibility sites and CBMS shall view the absence of reported changes from the client at this redetermination period as confirmation that there have been no changes in the household. This procedure is referenced as automatic reenrollment.

C. Due to the Coronavirus COVID-19 Public Health Emergency, required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories regardless of changes made for a redetermination or additional documentation for current CHP+ enrollee and allow them to continue eligibility through the emergency declaration. Once the emergency declaration has concluded, the Department will process the redetermination and /or changes for all members whose eligibility was maintained during the emergency declaration.

150 CALCULATION OF HOUSEHOLD INCOME

150.1 Calculation of income for the Children's Basic Health Plan shall be determined as required in 10 CCR 2505-10-8.100.4.C

150.2 Income disregards for the Children's Basic Health Plan shall be determined as required in 10 CCR 2505-10-8.100.4.D

160 [Repealed eff. 12/30/2012]

170 PRESUMPTIVE ELIGIBILITY

170.1 A pregnant applicant or a child under the age of 19 may apply for presumptive eligibility for immediate temporary medical services through designated presumptive eligibility sites.

A. To qualify for presumptive eligibility, a child under the age of 19 shall have a declared household income that shall be greater than 133% but not exceed 250% of Federal Poverty Level (MAGI-equivalent); or

B. To qualify for presumptive eligibility, a pregnant women shall have an attested pregnancy, declare that her household's income shall be greater than 185% but not exceed 250% of the Federal Poverty Level (MAGI-equivalent); and

C. He/she shall be a United States citizen or a documented immigrant as defined in Section 110.

170.2 Presumptive eligibility sites shall be certified by the Department of Health Care Policy and Financing to make presumptive eligibility determinations. Sites shall be re-certified by the Department of Health Care Policy and Financing every 2 years to remain approved presumptive eligibility sites.

A. The presumptive eligibility site shall forward the application to the county within five business days of the received date.

170.3 The presumptive eligibility period begins on the date the applicant is determined eligible and ends with the earlier of:

A. The day an eligibility determination for Medical Assistance is made for the applicant(s); or

B. The last day of the month following the month in which a determination for presumptive eligibility was made.

170.4 The county or Medical Assistance site shall make an eligibility determination within 45 days from the date of application.

A. Presumptively eligible clients may appeal the county or Medical Assistance site's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in Section 600.

B. A presumptively eligible client may not appeal the end of a presumptive eligibility period.

180 Express Lane Eligibility

Express Lane Eligibility shall allow for automatic initiation of Medical Assistance enrollment by using available data and findings from other programs as listed below.

180.1 Free/Reduced Lunch Program

A. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced Lunch application at a participating school district

1. Families will be given the option to opt into Medical Assistance coverage for their potentially eligible child.

2. Children who meet all necessary eligibility requirements as outlined in this volume will be automatically enrolled.

3. Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 90 days of eligibility while awaiting this verification.

4. Any additionally required verification will be requested from the client through CBMS prior to being automatically enrolled.

5. Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in section 150.

6. If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the application for Medical Assistance.

B. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district

1. Families who are automatically enrolled Free/Reduced Lunch recipient children will not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.

2. These families must apply for Medical Assistance in order to give consent for request of benefits.

180.2 Direct Certification

A. When an application for Food Stamps or Colorado Works has been submitted, families will be given the option to opt into Medical Assistance coverage for their potentially eligible children.

1. Children who meet all necessary eligibility requirements as outlined throughout sections 100 through 180 will be automatically enrolled,

2. Children who are only missing verification of U.S. citizenship and identity will receive 90 days of coverage while waiting for this verification.

3. Any additionally required verification will be requested from the client through CBMS prior to being automatically enrolled.

4. Eligibility is determined based on income declared on the Food Stamp or Colorado Works application as well as eligibility requirements outlined throughout this volume.

5. If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the Single Streamlined application for Medical Assistance.

6. Individuals whose eligibility is not determined through Express Lane Eligibility may also submit a separate Single Streamlined Application for Medical Assistance to determine eligibility.

200 BENEFITS PACKAGE

210 The following are covered benefits including any applicable limitations:

A. Emergency Care and Urgent/After Hours Care;

B. Emergency Transport/Ambulance Services;

C. Hospital/Other Facility Services Including:

1. Inpatient;

2. Physician;

3. Outpatient/Ambulatory;

D. Medical Office Visits Including:

1. Physician;

2. Mid-Level Practitioner;

3. Specialist;

E. Diagnostic Services;

F. Preventative, Routine and Family Planning Services Including:

1. Immunizations;

2. Well-child visits;

3. Health maintenance visits;

G. Maternity Care Including:

1. Prenatal;

2. Delivery and inpatient well-baby care;

3. Postpartum care

H. Mental Illness Treatments such as:

1. Neurobiologically-based mental illness including:

a. Schizophrenia;

b. Schizoaffective disorder;

c. Bipolar affective disorder;

d. Major depressive disorder;

e. Specific obsessive compulsive disorder;

f. Panic disorder;

2. Mental disorders including:

a. Post traumatic stress disorder

b. Drug and alcohol disorders

c. Dysthymia

d. Cyclothymia

e. Social phobia

f. Agoraphobia with panic disorder

g. General anxiety

h. Anorexia Nervosa exclusive of residential treatment

i. Bulimia exclusive of residential treatment

3. All other mental illness;

a. Inpatient coverage;

b. Outpatient coverage;

I. Physical Therapy, Speech Therapy and Occupational Therapy shall be limited to 30 visits per diagnosis per year. Effective November 1, 2007, Physical, Speech and Occupational Therapy services shall be unlimited for children from birth up to the child's third birthday.

J. Durable Medical Equipment shall be limited to the lesser of the purchase price or rental price for medically necessary durable medical equipment that shall not exceed two thousand dollars per year.

K. Transplants must be medically necessary and are limited to:

1. Liver;

2. Heart;

3. Heart/lung;

4. Cornea;

5. Kidney;

6. Bone marrow which shall be limited to the following conditions:

a. Aplastic anemia;

b. Leukemia;

c. Immunodeficiency disease;

d. Neuroblastoma;

e. Lymphoma;

f. High risk stage ii and iii breast cancer;

g. Wiskott aldrich syndrome;

7. Peripheral stem cell support which shall be limited to the following conditions:

a. Aplastic anemia;

b. Leukemia;

c. Immunodeficiency disease;

d. Neuroblastoma;

e. Lymphoma;

f. High risk stage II and III breast cancer;

g. Wiskott aldrich syndrome;

L. Home health care;

M. Hospice care;

N. Prescription medication;

O. Kidney dialysis shall be excluded only if the member is also eligible for Medicare;

P. Skilled nursing facility care must be provided only when there is a reasonable expectation of measurable improvement in the members' health status.

Q. Vision services shall be limited to:

1. Vision screenings for age appropriate preventative care;

2. Referral required for refraction services;

3. Minimum fifty dollar benefit for eyeglasses;

R. Audiology services shall be limited to:

1. Hearing screenings for age appropriate preventative care;

2. Hearing aids without financial limitation for enrollees age 18 and under no more than once every five years unless medically necessary including:

a. A new hearing aid when alterations to the existing hearing aid cannot adequately meet the needs of the child

b. Services and supplies including, but not limited to, the initial assessment, fitting, adjustments, and auditory training that is provided according to accepted professional standards.

S. Intractable pain;

T. Autism;

U. Case management is covered only when medically necessary;

V. Dietary counseling/nutritional services shall be limited to:

1. Formula for metabolic disorders;

2. Total parenteral nutrition;

3. Enterals and nutrition products;

4. Formulas for gastrostomy tubes;

W. Dental services are limited to:

1. Those dental services described in the Children's Basic Health Plan dental Evidence of Coverage booklet provided to enrollees, who are less than nineteen years of age. Beginning October 1, 2019, the dental services listed below are covered benefits for enrolled pregnant women of any age, excepting Limited Orthodontic services under Section 210.W.1.h for pregnant women age nineteen and above. Children's Basic Health Plan dental services are provided by the dental MCO (or its designee) with which the Department has contracted for the applicable plan year to provide the following dental services;

   a. Diagnostic

   b. Preventive

   c. Restorative

   d. Endodontic

   e. Periodontic

   f. Prosthodontic

   g. Oral and Maxillofacial Surgery

   h. Limited Orthodontic, excepting pregnant women age nineteen and above.

   i. Adjunctive General Services

2. Orthodontic and prosthodontic treatment for cleft lip or cleft palate in newborns (covered as a medical service in accordance with section 10-16-104, C.R.S.); and

3. Treatment of teeth or periodontium required due to accidental injury to naturally sound teeth (covered as a medical service in accordance with section 10-16-104, C.R.S.). A physician or legally licensed dentist must perform treatment within 72 hours of the accident.

X. Therapies covered shall include:

1. Chemotherapy;

2. Radiation;

Y. The following are not covered benefits:

1. Acupuncture;

2. Artificial conception;

3. Biofeedback;

4. Storage Costs for umbilical blood;

5. Chiropractic care;

6. Convalescent care or rest cures;

7. Cosmetic surgery;

8. Custodial care;

9. Domiciliary care;

10. Duplicate coverage;

11. Government institution or facility services;

12. Hair loss treatments;

13. Hypnosis;

14. Infertility services;

15. Maintenance therapy;

16. Nutritional therapy unless specified otherwise;

17. Elective termination of pregnancy, unless the elective termination is to save the life of the mother or if the pregnancy is the result of an act of rape or incest;

18. Personal comfort items;

19. Physical exams for employment or insurance;

20. Private duty nursing services;

21. Routine foot care;

22. Sex change operations;

23. Sexual disorder treatments;

24. Taxes;

25. Temporomandibular joint (TMJ) treatment, unless it has a medical basis;

26. Other therapies and treatments which are not medically necessary;

27. Vision services unless specified otherwise;

28. Vision therapy;

29. War-related conditions;

30. Weight-loss programs;

31. Work-related conditions;

300 ENROLLMENT FEES AND COPAYMENTS

320 COPAYMENTS

320.1 The following copayments shall be due for enrollees at the time of service:

A. For families with income, at the time of eligibility determination, less than 101% of the Federal Poverty Level (MAGI-equivalent), all copayments shall be waived, except for emergency and care, which shall be $3.00 per use and urgent/after hours care, which shall be $1.00 per use.

B. For families with income, at the time of eligibility determination, between 101% and 150% of the Federal Poverty Level (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 2012:

a. $2.00 per office visit;

b. $2.00 per outpatient mental health or substance abuse visit;

c. $1.00 per generic or brand name prescription;

d. $2.00 per physical therapy, occupational therapy or speech therapy visit;

e. $2.00 per vision visit;

f. $3.00 per use of emergency care and urgent/after hours care;

2. Effective July 1, 2012:

a. $2.00 per office visit;

b. $2.00 per outpatient mental health or substance abuse visit;

c. $1.00 per generic or brand name prescription;

d. $2.00 per physical therapy, occupational therapy or speech therapy visit;

e. $2.00 per vision visit;

f. $3.00 per use of emergency care (co-payment is waived if client is admitted to the hospital);

g. $1.00 per use of urgent/after hours care;

h. $2.00 per trip for emergency transport/ambulance services;

i. $2.00 per inpatient hospital visit;

j. $2.00 per inpatient hospital visit for physician services in the hospital;

k. $2.00 per outpatient hospital or ambulatory surgery center visit.

C. For families with income, at the time of eligibility determination, between 151% and 200% of Federal Poverty Level (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 2012:

a. $5.00 per office visit;

b. $5.00 per outpatient mental health or substance abuse visit;

c. $3.00 per generic prescription;

d. $5.00 per brand name prescription;

e. $5.00 per physical therapy, occupational therapy or speech therapy visit;

f. $5.00 per vision visit;

g. $15.00 per use of emergency care and urgent/after hours care

2. Effective July 1, 2012:

a. $5.00 per office visit;

b. $5.00 per outpatient mental health or substance abuse visit;

c. $3.00 per generic prescription;

d. $10.00 per brand name prescription;

e. $5.00 per physical therapy, occupational therapy or speech therapy visit;

f. $5.00 per vision visit;

g. $30.00 per use of emergency care ((co-payment is waived if client is admitted to the hospital)

h. $20.00 per use of urgent/after hours care;

i. $5.00 per date of service for laboratory and radiology/imaging services

j. $15.00 per trip for emergency transport/ambulance services;

k. $20.00 per inpatient hospital visit;

l. $5.00 per inpatient hospital visit for physician services;

m. $5.00 per outpatient hospital or ambulatory surgery center visit.

3. Due to the Coronavirus COVID-19 Public Health Emergency, members who are eligible for Children's Basic Health Plan will have waived laboratory copayments, specifically as it relates to laboratory copayments associated with COVID-19 testing.

D. For families with income, at the time of eligibility determination, between 201% and 250% of Federal Poverty Level (MAGI-equivalent), the copayment shall be:

1. Effective until June 30, 2012:

a. $10.00 per office visit;

b. $10.00 per outpatient mental health or substance abuse visit;

c. $5.00 per generic prescription;

d. $10.00 per brand name prescription;

e. $10.00 per physical therapy, occupational therapy or speech therapy visit;

f. $10.00 per vision visit;

g. $20.00 per use of emergency care and urgent/after hours care.

2. Effective July 1, 2012:

a. $10.00 per office visit;

b. $10.00 per outpatient mental health or substance abuse visit;

c. $5.00 per generic prescription;

d. $15.00 per brand name prescription;

e. $10.00 per physical therapy, occupational therapy or speech therapy visit;

f. $10.00 per vision visit;

g. $50.00 per use of emergency care (co-payment is waived if client is admitted to the hospital);

h. $30.00 per use of urgent/after hours care;

i. $10.00 per date of service for laboratory and radiology/imaging services

j. $25.00 per trip for emergency transport/ambulance services;

k. $50.00 per inpatient hospital visit;

l. $10.00 per inpatient hospital visit for physician services;

m. $10.00 per outpatient hospital or ambulatory surgery center visit.

3, Due to the Coronavirus COVID-19 Public Health Emergency, members who are eligible for Children's Basic Health Plan will have waived laboratory copayments, specifically as it relates to laboratory copayments associated with COVID-19 testing.330 COST SHARING LIMITATIONS

330.1 American Indians and Alaskan Natives shall be exempt from cost sharing requirements. American Indian shall mean a member of a federally recognized Indian tribe, band, or group, or a descendant in the first or second degree of any such member. Alaskan Native shall mean an Eskimo or Aleut or other Alaska Native enrolled by the Secretary of the Interior.

330.2 The maximum yearly cost sharing requirements for families of enrollees shall be 5% of income.

330.3 No copayments shall apply to preventive services. For the purpose of this section, preventive services shall mean:

A. All healthy newborn and newborn inpatient visits, including routine screening whether provided on an inpatient or outpatient basis;

B. Routine examinations;

C. Immunizations and related office visits; and

D. Routine preventive and diagnostic dental services.

330.4 Prenatal Care Program clients shall be exempt from cost sharing requirements.

400 ENROLLMENT

400.1 An applicant found eligible for Children's Basic Health Plan can elect to be enrolled the Children's Basic Health Plan.

410 SELECTION OF A MANAGED CARE ORGANIZATION

410.1

A. Once eligibility has been determined, an eligible person shall have the opportunity to select a participating MCO in the county of the eligible person's residence. If there is only one participating MCO available in the county of the eligible person's residence, the eligible person shall be enrolled in that MCO.

B. In the event the Department contracts with an MCO to provide dental services to Children's Basic Health Plan enrollees, an enrollee automatically will be enrolled with such MCO. No separate MCO election will be required.

410.2 MCO SELECTION

A. Upon determination of eligibility for the Children's Basic Health Plan program, if the eligible person has notified the Department or its designee of his/her chosen MCO prior to the last business day of the month in which eligibility was determined, the Department or its designee shall enroll the eligible person in that MCO.

B. Upon determination of eligibility for the Children's Basic Health Plan program, if the eligible person has not chosen an MCO, the Department or its designee shall enroll the eligible person in an MCO selected by the Department or its designee. In areas of the state where there is only one participating MCO available, the Department or its designee shall select that MCO and enroll the eligible person.

C. The Department or its designee shall notify the enrollee of the MCO selected. If the enrollee wants to change MCOs, the enrollee shall contact the Department or its

designee within 90 days from the effective date of the MCO enrollment. An enrollee may also change a pending MCO enrollment before the effective date.

D. For renewal applications, the Department or its designee shall reassign the eligible person to the participating MCO the applicant approved for the previous enrollment period. If the eligible person wishes to change MCO enrollment, he/she shall notify the Department or its designee within his/her re-enrollment period.

410.3 In counties in which a participating MCO as defined in section 50.14.A is not available, the eligible person shall be enrolled in an MCO as defined in section 50.14.B.

410.4 Once an enrollee has selected an MCO or upon expiration of the timeframe to change, the enrollee shall remain enrolled in that MCO for the remainder of his/her eligibility period, unless the eligible person meets any of the disenrollment criteria set forth in section 440.

410.5 An eligible person shall have an opportunity to change to a different MCO serving the eligible person's geographic region, if one is available, during the applicant's annual redetermination period.

420 ENROLLMENT OF ALL ELIGIBLE PERSONS IN A FAMILY

420.1 If one eligible child from a family is enrolled in the Children's Basic Health Plan, all eligible children in that family must be enrolled in the Children's Basic Health Plan.

420.2 All eligible children in a family must be enrolled in the same MCO.

430 ENROLLMENT DATE

430.1 Eligibility for the Children's Basic Health Plan shall be effective on the latter of:

A. The first day of the month of application for Medical Assistance; or

B. The first day of the month the person becomes eligible for the Children's Basic Health Plan program.

430.2 Upon being enrolled in the Children's Basic Health Plan, continuous eligibility applies to children under the age of 19, who through an eligibility determination, reassessment or redetermination are found eligible for the Children's Basic Health Plan program. The continuous eligibility period may last for up to 12 months and will begin on the month of application or from the authorization date.

A. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, updates or corrections may be made to the child's case. Any changes to the child's case made during the 14-day no fault period may impact his or her eligibility for Medical Assistance.

B. A child's continuous eligibility period will end effective the earliest possible month, if any of the following occur:

i) Child is deceased

ii) Becomes an inmate of a public institutio

iii) The child states that she/he has moved out of the household permanently

iv) Is no longer a Colorado resident

v) Is unable to be located based on evidence or reasonable assumption

vi) Requests to be withdrawn from continuous eligibility

vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.H.9

viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

ix) An eligible person shall not be enrolled in other health insurance coverage

430.3. If determined eligible, the enrollment date of a pregnant woman shall be effective as of the first of the month of the date of application or the first day of the month the pregnant woman becomes eligible. The enrollment span shall end at the end of the month following 60 days after the birth of the child or termination of the pregnancy. Once eligibility has been approved, coverage must be provided regardless of changes in the woman's financial circumstances, once the income verification requirements are met.

A. A pregnant women’s eligibility period will end effective the earliest possible month, if any of the following occur:

i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

430.4 An eligible person’s enrollment date in the selected MCO shall be no later than:

A. The first of the month following eligibility determination and MCO selection if eligibility is determined before the 17th of the month.

B. The first of the second month following eligibility determination and MCO selection if eligibility is determined on or after the 17th of the month.

430.5 A child born to a mother who is enrolled in the Children’s Basic Health Plan at the time of the child’s birth is guaranteed coverage for one year.

A. To receive Medical Assistance under the Children’s Basic Health Plan, the birth must be reported verbally or in writing to the County Department of Human Services or Eligibility site. Information provided shall include the baby’s name, date of birth, and mother’s name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother’s Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn’s agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn.

440 DISENROLLMENT

440.1 An enrollee shall be disenrolled from an MCO for the following reasons:

A. Administrative error on the part of the Department, the Department's designee, or the MCO, including but not limited to enrollment of a person who does not reside in the MCO's service area; or,

B. A change in the enrollee's residence to an area not in the MCO's service area; or,

C. When an enrollee's coverage is terminated as described in section 440.1A.

440.2 If an enrollee is disenrolled from an MCO for any of the reasons stated in section440.1 and there is another participating MCO available in the enrollee's county of residence, the enrollee shall be allowed to select a new MCO.

440.3 If the enrollee is enrolled in a MCO as defined in section 50.15B and a MCO as defined in section 50.15A becomes available in the child's county of residence, the enrollee will be disenrolled from the MCO as defined in section 50.15 B and enrolled in the MCO as defined in section 50.15A.

440.4 An enrollee may be disenrolled from both an MCO and/or the Children's Basic Health Plan for the following reasons:

A. Fraud or intentional misconduct, including but not limited to knowing misuse of covered services, knowing misrepresentation of membership status; or,

B. An enrollee's receipt of other health care coverage; or,

C. The admission of an enrollee into any federal, state, or county institution for the treatment of mental illness, narcoticism, or alcoholism, or into any correctional facility; or,

D. Ineligibility for the program, based on the guidelines set forth in the Children's Basic Health Plan eligibility rules; or,

E. Failure to comply with cost sharing requirements (copayments) set forth in the Children's Basic Health Plan cost sharing rules; or,

F. There is not another participating MCO as defined in section 50.14 available in the enrollee's county of residence.

440.5 If an eligible person or an eligible person's family displays an ongoing pattern of behavior that is abusive to provider(s), staff or other patients; or, disruptive to the extent that the provider's ability to furnish services to the child or other patients is impaired, the eligible person may be disenrolled from his/her managed care organization. If there is another participating MCO available in the eligible person's county of residence, the Department may allow the eligible person to select a new MCO. If there is not another MCO available in the eligible person's county, the eligible person may be disenrolled from the Children's Basic Health Plan.

500 FINANCIAL MANAGEMENT

The Children's Basic Health Plan, being a non-entitlement program, must manage to its legislative appropriation. The Department shall track expenditures, caseload, and other financial information to make informed decisions on spending its appropriation. Expenditures may exceed State appropriations with approval of the Governor, but any General Fund over expenditure shall be limited to $250,000.

510 The Department shall make quarterly assessments of projected expenditures. If it appears the program may overspend its appropriation due to changes in enrollment, health care costs, funding, legislation, or other factors, the Department shall consider if adjustments to the program are necessary. The program may use, but is not limited to, any of the following financial management tools: waiting lists, adjustments of eligibility criteria and/or levels, instituting open enrollment periods, or temporary closure of the program.

600 APPEALS PROCESS

600.1 Applicants shall be notified of any action regarding the eligibility and enrollment status and cost sharing requirements for the enrollees' participation in the Children's Basic Health Plan and appeal rights regarding those actions by the Department or its designee.

600.2 The Department or its designee shall notify the applicant within ten (10) business days of a decision regarding eligibility, enrollment and cost sharing. The notice shall:

A. Be in writing;

B. Be in his/her primary language, to the extent practicable;

C. Describe to the applicant the reasons for the decision;

D. Document the authority for the decision (e.g. rule citation); and

E. Inform the applicant of his/her rights and responsibilities regarding the decision.

600.3 An applicant who disagrees with a denial regarding eligibility, enrollment, or cost sharing requirements may appeal in writing to the Children's Basic Health Plan Eligibility Vendor within thirty (30) calendar days of the date of the notification of denial of eligibility, enrollment, or cost sharing. The appeal shall be reviewed and processed within thirty (30) calendar days of receipt and the results of the appeal shall be communicated to the applicant within ten (10) business days of the review. The following guidelines shall apply to the appeal process:

A. The Children's Basic Health Plan Eligibility Vendor will coordinate the appeals process with the county or Eligibility site that determined the initial eligibility, enrollment, or cost sharing decision within ten (10) business days after receipt of the appeal.

B. The county or Eligibility site that determined the initial eligibility, enrollment, or cost sharing decision shall:

1. Review the data entry of the application in the Department's eligibility system for accuracy and completeness within ten (10) business days after receipt of the appeal from the Children's Basic Health Plan Eligibility Vendor;

2. Correct or complete information in the Department's eligibility system if it is found to be incomplete or incorrect and re-run eligibility;

3. Maintain the original denial, if the information in the Department's eligibility system is complete and correct; and

4. Notify the applicant and the Children's Basic Health Plan Eligibility Vendor in writing once the review is complete with the results of the data entry review and the option of forwarding the appeal to the Grievance Committee.

600.4 If the applicant disagrees with the results of the appeal, the applicant may have their appeal reviewed by the Grievance Committee. The Grievance Committee's decision shall be final.

A. The Grievance Committee shall be conducted by an independent panel appointed by the Executive Director of the Department. The panel shall include at least three people from the Department or its designee not previously involved with the grievance. A person previously involved with the grievance may be present at the conference and appear before the panel to present information and answer questions, but shall not have a vote. The Department shall ensure that those appointed to the panel have sufficient experience to make an informed decision regarding the grievance under review.

B. The applicant may attend the Grievance Committee in person or by telephone.

C. The applicant may be represented by the person of the applicant's choice (i.e. legal counsel, friend, family member, etc.) during the Grievance Committee.

D. The applicant may have access to documents that were used by the Department or its designee in making the decision under appeal.

600.5 An enrollee who disagrees with a denial of benefits shall submit an appeal to the MCO he/she is enrolled in and shall follow the MCO's appeal process.

610 [Repealed eff.12/30/2012]

Editor's Notes

History

Entire rule eff. 07/30/2007.

Rule 210 emer. rule eff. 11/01/2007.

Rule 210 eff. 12/30/2007.

Rules 50.17-50.21, 100-110.1E, 150.3-150.3E, 170-170.2 emer. rules eff. 01/01/2008.

Rules 50.17-50.21; 100-110.1E; 150.3-150.3E; 170-170.2 eff. 03/30/2008.

Rules 500-510 eff. 11/30/2008.

Rule 210 eff. 12/30/2008.

Rule 110 eff. 03/30/2009.

Rule 150 emer. rule eff. 04/10/2009.

Rule 150 eff. 06/30/2009.

Rules 110.1 B 4-5, 150.1 Q-R eff. 11/30/2009.

Rule 130.1 B emer. rule eff. 01/01/2010; expired 03/11/2010.

Rule 130.1 B eff. 03/30/2010.

Rules 110.1 D, 150.3, 170.1, 310.1 B, 320.1 D emer. rules eff. 05/01/2010. Rule 110.1 D expired 08/07/2010.

Rule 140.1 emer. rule eff. 06/11/2010.

Rules 150.3, 170.1, 310.1 B, 320.1 D eff. 06/30/2010.

Rules 110.1 D, 140.1 eff. 08/30/2010.

Rules 110.1 B 4-5 eff. 10/30/2010.

Rules 130.1 A, 150.2 eff. 12/30/2010.

Rule 140.1 B emer. rule eff. 09/09/2011.

Rule 180 emer. rule eff. 10/14/2011.

Rule 140 1B eff. 11/30/2011.

Rules 180, 430 eff. 12/30/2011.

Rules 300-330 eff. 01/01/2012.

Rules 430.1-430.2 emer. rules eff. 01/13/2012.

Rules 170, 430 eff. 04/01/2012.

Rules 410.1 A, 410.2-410.4 eff. 11/30/2012.

Rules 50.9, 50.15-50.16, 120, 150.1 O-Q, 400.1 eff. 12/30/2012. Rules 160, 220, 340, 450, 610 repealed eff. 12/30/2012.

Rules 170.5, 330.4 eff. 01/30/2013.

Rules 180.1 A.1, 180.1 A.6, 180.2 eff. 04/30/2013.

Rule 120 emer. rule eff. 05/10/2013.

Rule 120 eff. 07/30/2013.

Rules 50, 110.1.D-110.1.F, 130, 150, 170.1, 430 eff. 10/01/2013.

Rules 430.2-430.5 eff. 04/30/2014.

Rules 110.1 B.2, 170.1 C eff. 07/01/2015.

Rules 50-600.5 eff. 03/02/2017.

Rule 110 eff. 09/30/2017.

Rule 430.4 eff. 10/30/2017.

Rules 430.2-430.3 eff. 10/30/2018.

Rule 210 W emer. rule eff. 10/01/2019.

Rule 210 W eff. 12/30/2019.

Annotations

Rule 170.5 (adopted 12/14/2012) was repealed by Senate Bill 13-079 effective 05/15/2013.

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

OCTOBER 2022 EMERGENCY JUSTIFICATION FOR MEDICAL ASSISTANCE RULES ADOPTED AT THE OCTOBER 14, 2022 MEDICAL SERVICES BOARD MEETING

CHP 22-10-06-G - Revision to the Medical Assistance Rule concerning Child Health Plan Plus program rule updates, Sections 110,140, 310 and 320

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. Due to the Coronavirus (COVIS-19) public health emergency this rule needs to be updated for the State to be in compliance with federal regulations and is imperatively necessary for the preservation of public health, safety, and welfare.

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Office of the Attorney General

Tracking number: 2022-00648

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 10/14/2022

10 CCR 2505-3

FINANCIAL MANAGEMENT OF THE CHILDREN'S BASIC HEALTH PLAN

The above-referenced rules were submitted to this office on 10/14/2022 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.

November 02, 2022 09:15:49

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Emergency Rules Adopted

Department

Department of Health Care Policy and Financing

Agency

Medical Services Board (Volume 8; Medical Assistance, Children's Health Plan)

CCR number

10 CCR 2505-10

Rule title

10 CCR 2505-10 MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY 1 - eff 10/14/2022

Effective date

10/14/2022

Expiration date

02/11/2023

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 22-10-06-A
Division / Contact / Phone:Office of Community Living / Candace Bailey / 303-866-2549

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 22-10-06-A, Novel Coronavirus Disease (COVID-19) Rules
3. This action is an adoption of:	new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.6000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	October 14, 2022
Is rule to be made permanent? (If yes, please attach notice of hearing).	No

PUBLICATION INSTRUCTIONS*

Insert the newly proposed text at 8.6000. This rule is effective October 14, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 22-10-06-A
Division / Contact / Phone:Office of Community Living / Candace Bailey / 303-866-2549

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of this emergency rule is to temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   The temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary fo the preservation of public health safety, and welfare.

3. Federal authority for the Rule, if any:

   Social Security Act Section 1135, Social Security Act 1115 (Pending), and Social Security Act 1915(c), Appendix K.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2021); 25.5 Article 6, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Novel Coronavirus Disease (COVID-19) Rules, Section 8.6000
Rule Number: MSB 22-10-06-A
Division / Contact / Phone:Office of Community Living / Candace Bailey / 303-866-2549

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Individual's receiving services in community-based settings, provider-owned community-based residential settings, provider-owned facility settings, and case management will all be benefitting from an increase in available funding to respond to the COVID-19 crisis.

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

   Those rendering services in facilities, the community, or even remotely from their office or home may receive additional payment to do so during this critical time. Those receiving services are likely to continue with more likely to experience uninterrupted services as direct care workers/direct support professionals will be incentivized to continue to provide these services.

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

   Many of the changes the Department is asking for are cost neutral. Additionally, the Department has sought, and in some cases, received approval from the Centers for Medicare and Medicaid to increase payments or rates. However, the Department also must work with its partners at the Office for State Planning and Budget as well as prioritize the many different areas of Medicaid that are impacted by COVID-19. Accordingly, the Department continues to estimate potential costs.

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

   The comparison between direct cost and cost of inaction is hard to quantify. However, it is highly likely that the cost of doing nothing could

be higher costs associated with more costly forms of care, significant impact to member's quality of life, and, in some cases – the loss of life or limb.

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

   At this time, the Department is also pursuing additional alternatives to ensure health, safety, and welfare but a key component of this effort is to ensure providers, agencies, and direct support professionals have the money they need to continue to go out in a time of crisis and provide services.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   As mentioned above, the Department is also partnering with community organizations, non-profits, advocacy organizations, other executive agencies, and the governor's office to work towards prioritizing Colorado's most vulnerable citizens receiving long-term care health, safety, and welfare.

MEDICAL ASSISTANCE – SECTION 8.6000 Novel Coronavirus Disease (COVID-19) Rules

10 CCR 2505-10 8.6000

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

8.6001.1 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Section 8.420

> Temporarily waive the requirement that payments for ICF-IID are only allowed for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) to allow for potential inclusion of existing HCBS Group Homes.

Sections 8.404.3; 8.404.1; 8.405.2.22; 8.405.2.23; 8.405.2.24; 8.405.2.25.

> Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

Sections 8.443.16.A; 8.443.1.C-D.

> Temporarily allow payment beyond current limitation not to exceed COVID-19 emergency supplement payments.

8.6001.2 Nursing Facilities

Sections 8.443.10.B; 8.443.10.a; 8.443.11.A

> Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

> COVID-19 Mitigation Emergency Supplemental Payment
>
> > Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.
> >
> > 1. In order to be eligible for this payment facilities must be:

a. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

b. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

c. Cooperative with State or National efforts to mitigate the emergency

2. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

3. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

Section 8.443.1.B Addition of the Following Language

In addition to the MMIS claims reimbursement and provider fee funded supplemental payments, the Department may issue additional supplemental payments necessary to protect the health, safety and welfare of nursing facility residents when additional state or federal funding is available.

Establishment of Section 8.430.6 – Temporary Medicaid Nursing Facility Expansion

1. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

2. Facilities seeking temporary enrollments must submit plans to discharge residents within 60 days of the emergency end date.

3. Facilities with temporary Medicaid beds will be reimbursed statewide average rate for nursing facilities.

4. The enrollment will be effective until 60 days after the COVID-19 emergency is lifted.

5. After the 60 days has expired, the facility will receive no further reimbursement.

8.6001.3 Case Management

Sections 8.763.C; 8.761.46

Authorize providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19.

8.6001.4 Level of Care Assessment

Sections 8.393.2.c.5.a; 8.393.2.D.3.a; 8.393.3.A.1.c.i.3; 8.401.183.B; 8.497; 8.401; 8.491.2.B.2; 8.500.1; 8.500.90; 8.503; 8.504.1; 8.504.5.D; 8.506.3; 8.506.4.e.ii; 8.508.20; 8.515.5.B.1; 8.517.5.A.2; 8.519.1;

Remove the Professional Medical Information Page (PMIP) from the level of care determination for HCBS waivers, Long-Term Care-Home Health, PACE, NF, and ICF/IID programs to enable additional capacity and expedite enrollment.

Sections 8.390.3.A.2; 8.393.1.M.1.C; 8.393.2.C.5.; 8.393.2.D.1-3; 8.401.11 through 8.401.15; 8.485.61.B; 8.485.71.C; 8.486.201; 8.603.5.D; 8.500.18.B.3; 8.500.108.B.1; 8.503.70.3; 8.503.80.A; 8.506.3;

8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

Modify the requirements for initial and continued stay review assessments. For initial assessments, the level of care assessment will be limited to the Activities of Daily living which determines the functional eligibility/LOC for the member. Members pursuing a Home and Community Based Services (HCBS) waiver enrollment will be issued a start date based on the date of referral to the Case Management Agency, with the Level of Care to be completed with the member thereafter via telephonic or virtual modality. Changes to transfers from nursing facility to nursing facility by not requiring an entirely new assessment be conducted. For yearly re-assessments, the members existing eligibility will continue through the duration of 1135. Then the yearly re-assessment set to occur within six (6) months following the conclusion of the Section 1135 Waiver.

8.6001.5 Termination from Waiver Eligibility - Adverse Action

Sections 8.393.3.A.1.a through 8.393.A.1.d; 8.485.61.A through 8.485.61.D.3.b; 8.500.16.A.1 through 8.500.16.A.4; 8.500.16.E.1 and E.2; 8.503.160.A.1 through 8.500.160.A.4; 8.503.160.E.1 through 8.503.160.E.9; 8.508.190.A.1-4; 8.508.190.E.1 and E.2 ; 8.508.190.H.1-4; 8.508.190.I.3 and I.4; 8.509.15.A.1 through 8.509.15.A.4.c.1; 8.555.5.D.2

Remove requirement to involuntarily terminate a member from their selected HCBS waiver program

8.6001.6 Preadmission Screening and Resident Review (PASRR)

Section 8.401.18.181.A

PASRR Level I Screening and Level II Evaluations will be suspended for 30 days in accordance with Section 1919(e)(7) for new admissions.

8.6001.7 Personal Care

Sections 8.485.61.D.2-3; 8.489.10.11; 8.510.4.A

Temporarily waive the restriction of personal care services provided in Hospital, Nursing Facility, or other acute-like setting.

Sections 8.510.18; 8.552.1.B

Temporarily allow legally responsible person to provide services using participant directed models (Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)).

8.6001.8 Guidelines for Institutions for Mental Diseases (IMDs)

Section 8.401.4

Temporarily waive the IMD requirements for nursing facilities that exceed 50% of patient-census with a primary diagnosis of major mental illness.

8.6001.9 Retainer Payments

Sections 8.515.80.F; 8.500.14.B.3

Temporarily allow specified Brain Injury waiver providers to bill retainer payments for services not rendered.

MEDICAL ASSISTANCE – SECTION 8.6000 Novel Coronavirus Disease (COVID-19) Rules

10 CCR 2505-10 8.6000

8.6000 COVID-19 EMERGENCY RULES

PURPOSE: To temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduced programmatic limitations, and alignment with existing federal guidance related to the COVID-19 pandemic.

8.6001 REGULATORY CHANGES

The following regulations require, as applicable, that funds be made available for payment, federal approval is received, and any conflicting state statutory requirements are suspended by Executive Order. Each regulation below is effective once the applicable prerequisites are satisfied and shall continue to be in effect as long as those prerequisites continue to be satisfied.

8.6001.1 Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

Section 8.420

> Temporarily waive the requirement that payments for ICF-IID are only allowed for facilities licensed by the Colorado Department of Public Health and Environment (CDPHE) to allow for potential inclusion of existing HCBS Group Homes.

Sections 8.404.3; 8.404.1; 8.405.2.22; 8.405.2.23; 8.405.2.24; 8.405.2.25.

> Temporarily allow emergency placement of eligible individuals into an ICF-IID. Individual would still need to be fully eligible in meeting placement requirements but would allow for Department to expedite process through existing layers of review.

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> Temporarily allow payment beyond current limitation not to exceed COVID-19 emergency supplement payments.

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Sections 8.443.10.B; 8.443.10.a; 8.443.11.A

> Temporarily allow Nursing Facilities to receive a supplemental payment for COVID-19 related activities, provided the Nursing Facility organization follows Departmental guidance and benchmarks for the assurance of the member's health, safety, and welfare and adherence to published guidelines for safety.

Section 8.443.12.B – Inclusion of the Following Language:

> COVID-19 Mitigation Emergency Supplemental Payment
>
> > Subject to available non-provider fee funding and Upper Payment Limit restrictions, the Department shall pay an additional supplemental payment to nursing facilities increasing measures to protect residents during the COVID-19 public health emergency.
> >
> > 4. In order to be eligible for this payment facilities must be:

d. Compliant with all emergency related reported measures required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

e. Implementing enhanced operational guidelines required by CMS, HCPF, CDPHE or the State Emergency Operations Center.

f. Cooperative with State or National efforts to mitigate the emergency

5. The Department will use historical Medicaid patient data to calculate and issue supplemental payments.

6. All payments issued as an emergency supplemental payment due to COVID-19 must be reported as a revenue in the cost reporting period in which it is received.

Section 8.443.1.B Addition of the Following Language

In addition to the MMIS claims reimbursement and provider fee funded supplemental payments, the Department may issue additional supplemental payments necessary to protect the health, safety and welfare of nursing facility residents when additional state or federal funding is available.

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6. 8.430.6.A The Department may issue temporary enrollments for the purposes of increasing bed capacity during a public health emergency.

7. Facilities seeking temporary enrollments must submit plans to discharge residents within 60 days of the emergency end date.

8. Facilities with temporary Medicaid beds will be reimbursed statewide average rate for nursing facilities.

9. The enrollment will be effective until 60 days after the COVID-19 emergency is lifted.

10. After the 60 days has expired, the facility will receive no further reimbursement.

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Sections 8.763.C; 8.761.46

Authorize providers of targeted case management services to increase, supplement, exceed, or provide additional authorization of units and correlating payments to all long-term care case management entities including transitional services for individuals needing community-placement due to COVID-19.

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Sections 8.393.2.c.5.a; 8.393.2.D.3.a; 8.393.3.A.1.c.i.3; 8.401.183.B; 8.497; 8.401; 8.491.2.B.2; 8.500.1; 8.500.90; 8.503; 8.504.1; 8.504.5.D; 8.506.3; 8.506.4.e.ii; 8.508.20; 8.515.5.B.1; 8.517.5.A.2; 8.519.1;

Remove the Professional Medical Information Page (PMIP) from the level of care determination for HCBS waivers, Long-Term Care-Home Health, PACE, NF, and ICF/IID programs to enable additional capacity and expedite enrollment.

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8.506.4.B; 8.509.14; 8.508.121; 8.503.70.A.1; 8.503.80.A.4; 8.506.4.B; 8.506.12.F; 8.508.20; 8.509.14; 8.509.31.A; 8.515.6.A.3; 8.517.7.A.3; 8.603.5.D; 8.503.30.A; 8.503.30.A.8; 8.508.121.A

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Remove requirement to involuntarily terminate a member from their selected HCBS waiver program

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Temporarily allow legally responsible person to provide services using participant directed models (Consumer Directed Attendant Support Services (CDASS) and In-Home Support Services (IHSS)).

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Sections 8.515.80.F; 8.500.14.B.3

Temporarily allow specified Brain Injury waiver providers to bill retainer payments for services not rendered.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13 and 8.126.1
Rule Number: MSB 22-10-06-B
Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-10-06-B, Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13 and 8.126.1

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.125.11, 8.125.12, 8.125.13 and 8.126.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 10/14/2022

   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Remove the current text beginning at 8.125.11 through the end of 8.125.13. Replace the current text at 8.126.1 with the proposed text beginning at 8.126.1 through the end of 8.126.1. This rule is effective October 14, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13 and 8.126.1
Rule Number: MSB 22-10-06-B
Division / Contact / Phone: Medicaid Operations Office / Clint Eatmon / 720-819-6409

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision will temporarily remove current requirements for providers to comply with: Fingerprint Criminal Background Checks (10 CCR 2505-10 8.125.12), Site-Visits (10 CCR 2505-10 8.125.11) and payment of Application Fee's (10 CCR 2505-10 8.125.13), during the provider enrollment process. Alleviating these requirements will expedite the processing of provider-enrollment applications.

   These proposed changes bring Colorado regulations into alignment with the approved 1135 waiver which was granted by CMS, temporarily waiving these requirements at the Federal Level. If passed, the rule will become effective on the date the board adopts it and it will expire after 120 days. However, the Department has the option to bring the rule to MSB a second time within the 120 days to reinstate or further extend the timeframe, depending on prevailing conditions and current guidance at that time.

   The rule revision at 8.126.1 (10 CCR 2505-10 8.126.1), will allow providers enrolled as a Mass Immunizer with Medicare to temporarily enroll in Colorado to provide administration of COVID-19 vaccinations.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Removing these requirements will expedite the processing of provider enrollment applications during the COVID-19 pandemic, thereby increasing the number of approved providers during this emergency period.

   Allowing Mass Immunizers to enroll and administer COVID-19 vaccinations will increase the availability and administration of these critical vaccines.

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

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3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

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Title of Rule: Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13 and 8.126.1
Rule Number: MSB 22-10-06-B
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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.

   Those seeking to be approved Medicaid providers and our member population will benefit from this proposed rule.

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

   Those seeking to become approved providers will benefit from a streamlined provider enrollment process. Members will benefit from increased access to care as more providers are enrolled and available to offer treatment and services, including COVID-19 vaccinations.

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

   There are no costs to the Department or to another agency to implement and enforce the proposed rule.

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

   There are no probable costs to providers.

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

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

DO NOT PUBLISH THIS PAGE

There are no alternative methods for achieving the purpose of the proposed rule.

8.125 PROVIDER SCREENING

8.126 COLORADO NPI RULE

8.126.1 Definitions

A. Billing Provider Field means the data field on a Claim that reflects the Health Care Provider to which the payer issues payment.

B. Campus means the physical area immediately adjacent to the Hospital's main buildings, other areas and structures that are not strictly contiguous to the main buildings but are located within 250 yards of the main buildings, and any other areas determined on an individual case basis by the Centers of Medicare and Medicaid Services to be part of the provider's campus.

C. Claim means a request for payment for the delivery of medical care, services, or goods authorized under the Medical Assistance Program, submitted to the Department through its fiscal agent by a Health Care Provider. Claim includes the transmission of encounter information for the purpose of reporting the delivery of medical care, services, or goods.

D. Health Care Provider means any person or organization that furnishes, bills for, or is paid for medical care, services, or goods to one or more Medical Assistance Program members.

1. A Health Care Provider includes an Organization Health Care Provider, Subpart of an Organization Health Care Provider, Off Campus Location, and a Site of an Organization Health Care Provider.

2. Unless specified otherwise in Subsection 8.126.1, a Health Care Provider may include a Health Care Provider located outside the state of Colorado (out-of-state provider) that is licensed and/or certified pursuant to their state laws.

E. Hospital means an Organization Health Care Provider that is enrolled in the Medical Assistance Program under the Provider Type of "Hospital - General" as defined in this Subsection 8.126.1.

F. Medical Assistance Program means the programs authorized under Articles 4, 5, 6, 8, and 10 of Title 25.5.

G. National Provider Identifier (NPI) means the standard, unique health identifier for Health Care Providers or Organization Health Care Providers that is used by the National Plan and Provider Enumeration System (NPPES) in accordance with 45 C.F.R. pt. 162.

H. Off-Campus Location means a facility that:

1. Has operations that are directly or indirectly owned or controlled by, in whole or in part, or affiliated with, a Hospital, regardless of whether the operations are under the same governing body as the Hospital;

2. Is not on the Hospital's Campus;

3. Provides services that are organizationally and functionally integrated with the Hospital;

4. Is an outpatient facility providing preventive, diagnostic, treatment, or emergency services; and

5. Is identified on the Hospital's State License Addendum issued by the Colorado Department of Public Health and Environment or, for Hospitals licensed outside of Colorado, documentation demonstrating direct or indirect ownership or control of the Off-Campus Location.

I. Organization Health Care Provider means a Health Care Provider that is not an individual.

J. Provider Type means a classification of Health Care Provider or Organization Health Care Provider to which the payer issues payment for services provided to individuals enrolled in the Medical Assistance Program, according to the Provider Type license, accreditation, certification, and/or service provided. The Provider Types recognized by the Department are as follows:

1. Administrative Services Organization (ASO) is an entity that has entered into a valid, active contract to provide ASO services with the Colorado Department of Health Care Policy and Financing.

2. Ambulatory Surgical Center (ASC) means a health care entity that is:

a. Licensed by the Colorado Department of Public Health and Environment as an Ambulatory Surgical Center; and

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as an Ambulatory Surgical Center.

3. Audiologist means an individual licensed as an audiologist by the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

4. Behavioral Therapy Clinic means any group practice that has at least one affiliated Behavioral Therapy Individual. The affiliated Behavioral Therapy Individual must be enrolled in the Colorado Medical Assistance Program.

5. Behavioral Therapy Individual means an individual that:

a. Is nationally certified as a Board-Certified Behavioral Analyst (BCBA); or

b. Meets one of the following:

(1) Has a doctoral degree with a specialty in psychiatry, medicine, or clinical psychology and is actively licensed by the State Board of Examiners; and has completed 400 hours of training; and/or has direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities; or

(2) Has a doctoral degree in one of the behavioral or health sciences; and has completed 800 hours of specific training; and/or has experience in behavioral therapies that are consistent with best practice and research

on effectiveness for people with autism or other developmental disabilities; or

(3) Is nationally certified as a BCBA; or

(4) Has a master's degree or higher in behavioral or health sciences; and is a licensed teacher with an endorsement of school psychologist; or is a licensed teacher with an endorsement of special education or early childhood special education; or is credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist); and has completed 1,000 hours of direct supervised training or has experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

6. Birthing Center means a health care entity licensed as a Birth Center by the Colorado Department of Public Health and Environment. Out-of-state providers are not eligible for enrollment.

7. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers.

8. Certified Registered Nurse Anesthetist (CRNA) means an individual who is:

   a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

   b. Included within the advanced practice registry as a CRNA.

9. Clinic – Dental means any group practice that has at least one affiliated, licensed dentist or dental hygienist.

   a. The affiliated dentist or dental hygienist must be enrolled in the Colorado Medical Assistance Program; and

   b. A dental practice or clinic must be owned by a licensed dentist except if the dental practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.); and

   c. A dental hygiene practice or clinic must be owned by a licensed dentist or licensed dental hygienist except if the dental hygiene practice or clinic is a non-profit organization defined as a community health center (also known as an FQHC) or having 50% or more patients determined as low income, or a political subdivision (i.e. city, county, state, etc.)

10. Clinic – Practitioner means any group practice that has at least one affiliated, licensed physician, osteopath, or podiatrist. The affiliated practitioner must be enrolled in the Colorado Medical Assistance Program.

11. Community Clinic means a health care entity that is:

a. Licensed as a Community Clinic or Community Clinic and Emergency Center (CCEC) by the Colorado Department of Public Health and Environment;

b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program; and

c. Owned by a Medicare participating hospital.

12. Community Mental Health Center (CMHC) means a health care entity that:

a. Is licensed as a Community Mental Health Center by the Colorado Department of Public Health and Environment;

b. Has program approval to operate as a CMHC from the Colorado Department of Human Services; and

c. If the CMHC delivers substance use disorder services, shall have Substance Use Disorder program approval from Colorado Department of Human Services.

13. Dental Hygienist means an individual who is licensed as a Dental Hygienist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

14. Dentist means an individual who is licensed as a Dentist by the Colorado Dental Board within the Colorado Department of Regulatory Agencies.

15. Dialysis Treatment Clinic [Formerly Known as Dialysis Center] means a health care entity that is:

a. Licensed as a Dialysis Treatment Clinic by the Colorado Department of Public Health and Environment; and

b. Certified by Centers for Medicare and Medicaid Services to participate in the Medicare program as an End-Stage Renal Dialysis Facility (ESRD).

16. Federally Qualified Health Center (FQHC) means a health care entity that has been awarded a Section 330 Grant from the Health Resources and Services Administration. A health care entity that has been designated as a “look-alike” is also eligible to be enrolled as an FQHC.

17. Foreign Teaching Physician means an individual who is licensed as a distinguished foreign teaching physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

18. Home and Community Based Services (HCBS) means Health First Colorado (Colorado’s Medicaid Program)’s community-based care alternatives to institutional, Long-Term care. Providers enrolling as an HCBS provider shall meet all applicable state and federal requirements to provide HCBS by waiver and specialty type.

19. Home Health Agency means a health care entity that:

a. Has a Class A Home Care Agency license from the Colorado Department of Public Health and Environment; and

b. Is certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as Home Health Agency.

20. Hospice means a health care entity that is:

    a. Licensed as a Hospice by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospice.

21. Hospital – General means a health care entity that is:

    a. Licensed as a General Hospital by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Hospital.

22. Hospital – Psychiatric [Formerly Known as Hospital - Mental] means a health care entity that is:

    a. Licensed as a Psychiatric Hospital by the Colorado Department of Public Health and Environment; and

    b. Certified by the Centers for Medicare and Medicaid Services to participate in the Medicare program as a Psychiatric Hospital.

23. Independent Laboratory means a laboratory that:

    a. Has a current and valid Clinical Laboratory Improvement Amendments (CLIA) certification; and

    b. Is certified through the Centers for Medicare and Medicaid Services as a laboratory.

24. Indian Health Service – Federally Qualified Health Center (FQHC) means a health care entity that:

    a. Is treated by the Centers for Medicare and Medicaid Services as a comprehensive Federally funded health center; and

    b. Includes an outpatient health program or facility operated by a tribe or tribal organization under the Indian Self-Determination Act or by an urban Indian organization receiving funds under Title V of the Indian Health Care Improvement Act for the provision of primary health services.

25. Indian Health Service – Pharmacy means a health care entity that has evidence of participation in the Indian Health Service.

26. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) [Formerly Known as Nursing Facility – ICF/IID] means a health care entity that is:

    a. Licensed as an Intermediate Care Facility for Individuals with Intellectual Disabilities through the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as an ICF/IID.

27. Licensed Behavioral Health Clinician means an individual that is licensed by the Colorado Department of Regulatory Agencies as either:

a. A Licensed Clinical Social Worker;

b. A Licensed Professional Counselor;

c. A Licensed Marriage and Family Therapist; or

d. A Licensed Addiction Counselor.

28. Licensed Psychologist means an individual who is licensed as a psychologist by the State Board of Psychologist Examiners within the Colorado Department of Regulatory Agencies.

29. Managed Care Entity [Formerly Known as Health Maintenance Organization (HMO)] means an entity that has a valid and comprehensive or all-inclusive risk contract with the Colorado Department of Health Care Policy and Financing.

30. Non-Physician Practitioner Group means any group practice consisting of any of the following:

a. Licensed Nurse Practitioners;

b. Licensed Audiologists;

c. Licensed Occupational Therapists;

d. Licensed Behavioral Health Clinicians;

e. Licensed Psychologists;

f. Licensed Speech Therapists; and/or

g. Licensed Physical Therapists.

h. Beginning on the effective date of this amended rule, and for the remainder of the COVID-19 Public Health Emergency (PHE), providers that have enrolled as a Mass Immunizer Roster Biller (provider specialty type 73) with Medicare may temporarily enroll in the medical assistance program as a Non-Physician Practitioner Group for the purpose of billing for the administration of COVID-19 vaccinations for medical assistance clients.

31. Non-Physician Practitioner Individual means a registered nurse, which means an individual licensed as a Registered Nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies.

32. Nurse Midwife means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Midwife.

33. Nurse Practitioner means an individual who is:

a. Licensed as a registered nurse by the State Board of Nursing within the Colorado Department of Regulatory Agencies; and

b. Included within the advanced practice registry as a Nurse Practitioner.

34. Nursing Facility means a health care entity that is:

a. Licensed as a Nursing Care Facility through the Colorado Department of Public Health and Environment; and

b. Certified by the Centers for Medicare and Medicaid Services or the Colorado Department of Health Care Policy and Financing to participate in the Medicaid program as a Skilled Nursing Care Facility.

35. Occupational Therapist means an individual who is licensed as an Occupational Therapist by the Director of the Division of Professions and Occupations within the Colorado Department of Regulatory Agencies.

36. Optical Outlet means a health care supplier that is qualified to make and supply eyeglasses and contact lenses for the correction of vision. If, in the performance of its duties, the Optical Outlet requires laboratory services, the laboratory is required to have a current and valid CLIA certification.

37. Optometrist means an individual who is licensed as an Optometrist by the State Board of Optometry within the Colorado Department of Regulatory Agencies.

38. Osteopath means an individual who holds a degree of “doctor of osteopathy,” and who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

39. Personal Care Agency means a health care entity that has a Class A or Class B Home Care Agency license from the Colorado Department of Public Health and Environment.

40. Pharmacist means an individual who is licensed as a Pharmacist by the State Board of Pharmacy within the Colorado Department of Regulatory Agencies.

41. Pharmacy means a pharmacy, pharmacy outlet, or prescription drug outlet registered by the Board of Pharmacy within the Colorado Department of Regulatory Agencies.

42. Physical Therapist means an individual who is licensed as a Physical Therapist by the Physical Therapy Board within the Colorado Department of Regulatory Agencies.

43. Physician means an individual who is licensed as a physician by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

44. Physician Assistant means an individual who is licensed as a physician assistant by the Colorado Medical Board within the Colorado Department of Regulatory Agencies.

45. Podiatrist means an individual licensed as a podiatrist by the Colorado Podiatry Board within the Colorado Department of Regulatory Agencies.

46. Psychiatric Residential Treatment Facility (PRTF) means a health care entity that:

    a. Is licensed by the Colorado Department of Human Services as a Residential Child Care Facility and a PRTF; and

    b. Is certified as a qualified residential provider by the Department of Public Health and Environment; and

    c. Is accredited by the Joint Commission, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children; and

    d. Has provided an attestation to the Department that the PRTF is in compliance with the conditions of participation as required by Colorado Department of Human Services and the Centers for Medicare and Medicaid Services.

47. Qualified Medicare Beneficiary (QMB) Benefits Only means the provider type designation used for Chiropractors who participate under the QMB Program. Chiropractor means an individual licensed as a chiropractor by the Board of Chiropractic Examiners within the Colorado Department of Regulatory Agencies. QMB Benefits Only providers must also be certified as QMB Benefits Only providers through the Centers for Medicare and Medicaid Services.

48. Regional Accountable Entity (RAE) means an entity that has entered into a valid, existing contract with the Colorado Department of Health Care Policy and Financing to be a Regional Accountable Entity.

49. Rehabilitation Agency means a group practice that requires at least one affiliated and licensed professional enrolled in the Colorado Medical Assistance Program.

50. Residential Child Care Facility (RCCF) means a health care entity that is:

    a. Designated by the Colorado Department of Human Services to provide Medicaid-reimbursable mental health services as an RCCF; and

    b. Licensed by Colorado Department of Human Services as an RCCF.

51. Rural Health Clinic (RHC) means a clinic that is certified by the Centers for Medicare and Medicaid Services as a Rural Health Clinic.

52. School Health Services means a school district or Board of Cooperative Educational Services that has a valid, active contract with the Colorado Department of Health Care Policy and Financing to participate in the Colorado School Health Services Program.

    a. The Site at which an Organization Health Care Provider delivers medical care, services, or goods authorized under the Medical Assistance Program enrolled under the Provider Type of School Health Services is a school district.

53. Speech Therapist is an individual certified as a Speech Language Pathologist by the Director of the Divisions of Professions and Occupations within the Colorado Department of Regulatory Agencies.

54. Substance Use Disorder (SUD) – Clinic means a health care entity that:

    a. Is licensed as a SUD Provider by the Colorado Department of Human Services;

b. Has program approval to operate as a SUD – Clinic from Colorado Department of Human Services; and

c. Has at least one affiliated advanced practice nurse, physician/psychiatrist, physician assistant, or behavioral health clinician who is certified in addiction medicine.

55. Supply means a Durable Medical Equipment, Prosthetic, Orthotic and Supplies (DMEPOS) provider that meets one or both of the following definitions:

a. Complex Rehabilitation Technology (CRT) Supplier means a health care supplier that meets all the requirements of Section 8.590.5.D, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate;

(2) Has CRT Professional Certification; and

(3) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS and CRT.

b. Durable Medical Equipment (DME) means a health care supplier that meets the requirements of Sections 8.590.5.A and B, and that:

(1) Has a Sales Tax Certificate or Tax-Exempt Certificate; and

(2) Is accredited by the Centers for Medicare and Medicaid Services to provide DMEPOS.

56. Transportation means a provider that meets one or both of the following definitions:

a. Emergency Medical Transportation (EMT) [Formerly Known as Emergency Medical Transportation and Air Ambulance] means providers that:

(1) Meet all provider screening requirements in Section 8.125.

(2) Comply with commercial liability insurance requirements.

(3) Maintain the appropriate licensure for:

(a) Ground ambulance license as required by Colorado Department of Public Health and Environment; and

(b) Air ambulance license as required by Colorado Department of Public Health and Environment.

(4) License, operate, and equip ground and air ambulances in accordance with federal and state regulations.

b. Non-Emergent Medical Transportation (NEMT) means a provider that:

(1) Has a Public Utilities Commission (PUC) common carrier certificate as a taxicab; or

(2) Has a PUC Medicaid Client Transport (MCT) Permit as required by the PUC; or

(3) Has a ground ambulance license as required by Department of Public Health and Environment; or

(4) Has an Air Ambulance license as required by Colorado Department of Public Health and Environment; or

(5) Is exempt from licensure requirements in accordance with the PUC.

57. X-Ray Facility means an imaging center that:

a. Has an X-Ray Facility and Machine Registration Report certified by the Colorado Department of Public Health and Environment; and

b. Is certified by the Centers for Medicare and Medicaid Services to participate in Medicare as an X-Ray facility.

K. Service Facility Location Field means the physical location specifically where services were rendered as identified on the Claim.

L. Site means the physical location by street address, including suite number, where goods and/or services are provided. The term Site when involving a Health Care Provider that voluntarily contracts with a RAE as a Primary Care Medical Provider (PCMP) to participate in the Department's Accountable Care Collaborative (ACC) as a medical home, also includes the following requirements:

1. PCMP services must be identifiable from other goods and/or services, including services provided by specialists provided by the Health Care Provider in the same physical location through a separate and unique NPI.

2. PCMP services provided at a Campus or Off-Campus Location must be identifiable from other goods and/or services, including services provided by specialists, provided by the Health Care Provider on the same Campus or Off-Campus Location through a separate and unique NPI.

M. Subpart means a component or separate physical location of an Organization Health Care Provider that may be separately licensed or certified. This definition is intended to be consistent with the use of the term "Subpart" as defined in 45 C.F.R. pt. 162.

N. The definitions in Subsection 8.126.1 apply only to Section 8.126.

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
Rule Number: MSB 22-10-06-C
Division / Contact / Phone: Health Programs Office / Courtney Sedon / 303-866-6163

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-10-06-C, Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.018.1.F and 8.018.4.D.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 10/14/2022

   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.018 with the proposed text beginning at 8.018.1 through the end of 8.018.4. This rule is effective October 14, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
Rule Number: MSB 22-10-06-C
Division / Contact / Phone:Health Programs Office / Courtney Sedon / 303-866-6163

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision expands the definition of Facility in the existing EMT rule. The expanded definition will allow for ambulance transports to a wider range of care locations during the COVID-19 public health emergency, including alternative hospital sites and temporary facilities. The rule also allows for transports between facilities without requiring basic or advanced life support services.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Under the Department's current rule, ambulance trips may only be taken to a limited set of medical facilities, the "closest, most appropriate Facility." CMS recently issued an expanded list of allowable destinations for ambulance trips that qualify for Medicare reimbursement during the COVID-19 public health emergency. This rule will align the Department with that new CMS Medicare guidance by expanding our definition of Facility. The goal is to allow EMT providers to take members to a wider range of medical facilities that are appropriate to the member's condition but that are not necessarily hospitals. This will help prevent hospital overcrowding while also getting members the most appropriate medical care, and will allow utilization of temporary and alternative care sites.

   The second change relates to interfacility transportation, which is ambulance transportation from one facility to another, provided the member requires basic or advanced life support en route. This revision suspends the life support requirement. This will allow for members to be moved from one facility to another if they need continued COVID-19-related care, but do not require life support en route.

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3. Federal authority for the Rule, if any:
4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   Title of Rule: Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1
   Rule Number: MSB 22-10-06-C
   Division / Contact / Phone: Health Programs Office / Courtney Sedon / 303-866-6163

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members utilizing or eligible for EMT services (nearly all members are eligible), EMT providers, and facilities treating COVID-19 patients will all benefit from the proposed revisions.

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

   Affected members will benefit from increased access to care, and transportation providers will benefit from greater flexibility in their ability to transport patients. Medical providers and facilities will benefit from an increased ability to transport patients to prevent any one facility from becoming overloaded.

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

   There are no costs to the Department or to any other agency to implement and enforce the proposed rule.

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

   The probable benefits of implementation are greater flexibility for EMT providers and the avoidance of overcrowding at hospitals. The benefit to members is that they can receive care in the most appropriate setting. The potential costs are an increase in EMT trips, however EMT trips occur as they are needed. The costs of inaction are potential overcrowding at hospitals and a reduction in willing EMT providers.

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

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose for the proposed rule.

8.018 EMERGENCY MEDICAL TRANSPORTATION

8.018.1. DEFINITIONS

8.018.1.A. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.018.1.B. Client means a person enrolled in the Medical Assistance Program.

8.018.1.C. Emergency Medical Services (EMS) Provider means an individual who has a current and valid emergency medical service provider certificate issued by the Department of Public Health and Environment (CDPHE) and includes Emergency Medical Technician (EMT), Advanced Emergency Medical Technician (AEMT), Emergency Medical Technician Intermediate (EMT-I), and Paramedic, in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.

8.018.1.D. Emergency Medical Technician (EMT) means an individual who has a current and valid EMT certificate issued by CDPHE and who is authorized to provide basic emergency medical care in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two.

8.018.1.E. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation during which Clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route.

8.018.1.F. Facility means a general hospital, hospital unit, psychiatric hospital, rehabilitation hospital, Acute Treatment Unit (ATU), or Crisis Stabilization Unit (CSU), as well as any location that is an alternative site determined to be part of a hospital, Critical Access Hospital (CAH) or Skilled Nursing Facility (SNF), community mental health centers, federally qualified health centers (FQHCs), physician's offices, urgent care facilities, ambulatory surgery centers (ASCs), any other location furnishing dialysis services outside of the End Stage Renal Disease (ESRD) facility, and the beneficiary's home..

8.018.1.G. Fixed-Wing Air Ambulance means a fixed-wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.018.1.H. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.018.1.I. Interfacility Transportation means transportation of a Client from one Facility to another Facility.

8.018.1.J. Life-Sustaining Supplies means oxygen and oxygen supplies required for life-sustaining treatment during transport via ambulance.

8.018.1.K. Mileage means the number of miles the Client is transported in the ambulance.

8.018.1.L. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment that is covered by the Colorado Medical Assistance Program under Section 8.014. Non-emergency care may be scheduled or unscheduled. This may include urgent care transportation and hospital discharge transportation.

8.018.1.M. Paramedic means an individual who has a current and valid Paramedic certificate issued by CDPHE and who is authorized to provide acts of advanced emergency medical care in

accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight at 6 CCR 1015-3, Chapter Two. For the purposes of these rules, Paramedic includes the historic Emergency Medical Service Provider level of EMT-Paramedic (EMT-P).

8.018.1.N. Paramedic with Critical Care Endorsement means an individual who has a current and valid Paramedic certificate issued by CDPHE and who has met the requirements in CDPHE rule to obtain a critical care endorsement from CDPHE and is authorized to provide acts in accordance with the Rules Pertaining to EMS Practice and Medical Director Oversight relating to critical care, as set forth in C.R.S. § 25-3.5-206.

8.018.1.O. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.018.1.P. Specialty Care Transport (SCT) means interfacility Ground Ambulance transportation of a critically injured or ill Client from a stabilizing hospital to a hospital with full capabilities to treat the Client's case. SCT is necessary when a Client's condition requires ongoing care during transport at a level of service beyond the scope of the EMT, that must be furnished by one or more health professionals in an appropriate specialty area including, but not limited to, nursing, emergency medicine, respiratory care, cardiovascular care, or a Paramedic with Critical Care Endorsement.

8.018.2. CLIENT ELIGIBILITY

8.018.2.A. Emergency Medical Transportation is a benefit for all Colorado Medical Assistance Program Clients who are ill, injured, or otherwise mentally or physically incapacitated and in need of immediate medical attention to prevent permanent injury or loss of life.

8.018.3. PROVIDER ELIGIBILITY

8.018.3.A. Providers must enroll with the Colorado Medical Assistance Program as an Emergency Medical Transportation provider to be eligible for reimbursement. Enrolled Emergency Medical Transportation providers must:

1. Meet all provider screening requirements in Section 8.125.

2. Comply with commercial liability insurance requirements.

3. Maintain and comply with the appropriate licensure:

    a. Ground Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-301 and 6 CCR 1015-3, Chapter Four.

    b. Air Ambulance license as required by CDPHE statute at C.R.S. § 25-3.5-307 and 6 CCR 1015-3, Chapter Five.

4. License, operate, and equip Ground and Air Ambulances in accordance with federal and state regulations.

8.018.4. COVERED SERVICES

8.018.4.A. Emergency Medical Transportation is a covered service when medically necessary, as defined in Section 8.076.1.8., and in accordance with this Section 8.018.4.

8.018.4.B. Ground Ambulance

1. The following Ground Ambulance Emergency Medical Transportation services are covered:

    a. Transportation to the closest, most appropriate Facility.

    b. Basic life support (BLS) or advanced life support (ALS) required to maintain life during transport from the Client's pickup point to the treating Facility.

        i. BLS includes:

            1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

            2. Suctioning en route (not deep suctioning); and

            3. Airway control/positioning.

        ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference. This incorporation by reference excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

            1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

            2. ALS Level 2 includes:

                a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

                b. The provision of at least one of the following ALS procedures:

                i. Manual defibrillation/cardioversion.

                ii. Endotracheal intubation.

                iii. Central venous line.

                iv. Cardiac pacing.

                v. Chest decompression.

                vi. Surgical airway.

                vii. Intraosseous line.

c. Specialty Care Transport when medically necessary to reach the closest, most appropriate Facility.

d. Department-approved supplies used during Emergency Medical Transportation, including Life-Sustaining Supplies, are separately reimbursable when medically necessary.

8.018.4.C. Air Ambulance

1. Air Ambulance Emergency Medical Transportation services are covered when:

a. They meet the criteria at Section 8.018.4.B.1.a.-b.; and

b. The point of pick up is inaccessible by a Ground Ambulance, or great distances or other obstacles prohibit transporting the Client by land to the nearest appropriate medical Facility.

8.018.4.D. Interfacility Transportation

1. Interfacility Transportation is covered when:

a. The Client requires a transfer from one Facility to another.

2. Interfacility Transportation can be provided via Ground or Air Ambulance.

8.018.5. NON-COVERED SERVICES AND GENERAL LIMITATIONS

8.018.5.A. The following services are not covered or reimbursable to Emergency Medical Transportation providers as part of an Emergency Medical Transportation service:

1. Waiting time and cancellations.

2. Transportation of additional passengers.

3. Response calls when determined no transportation is needed or approved.

4. Charges when the Client is not in the vehicle.

5. Non-benefit services (e.g., first aid) provided at the scene when transportation is not necessary.

6. Transportation which is covered by another entity.

7. Transportation to local treatment programs not enrolled in Colorado Medical Assistance Program.

8. Transportation of a Client who is deceased prior to transport.

9. Pick up or delivery of prescriptions or supplies.

10. Transportation arranged for a Client’s convenience when there is no reasonable risk of permanent injury or loss of life.

11. Transportation to non-emergency medical appointments or services. See Section 8.014 for NEMT services.

8.018.6. PRIOR AUTHORIZATION

8.018.6.A. Prior Authorization is not required for Emergency Medical Transportation.

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 22-10-06-D
Division / Contact / Phone:Health Programs Office / Courtney Sedon / 303-866-6163

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 10/14/2022

   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.014 with the proposed text beginning at 8.014 through the end of 8.014.8. This rule is effective October 14, 2022.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 22-10-06-D
Division / Contact / Phone: Health Programs Office / Courtney Sedon / 303-866-6163

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision permits NEMT services for covered Medicaid services to locations that are not enrolled with the Colorado Medical Assistance Program. The purpose of this rule is to expand the list of allowable NEMT destinations to include alternative care sites (e.g., the Colorado Convention Center) that are not covered places of service. By temporarily waiving the covered place of service requirement, members can receive treatment for COVID-19 at a wider range of locations. This will potentially increase hospital capacity by shifting patients to sites that are not enrolled with the Colorado Medical Assistance Program.

   In addition, the revision suspends the ability for NEMT providers to transport more than one member at a time, unless the additional passenger is an approved Escort.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Permitting NEMT trips to non-covered places of service will prevent hospital overcrowding while ensuring that members receive treatment for COVID-19. The change allows flexibility and takes advantage of newly established alternative care sites that may be temporary in nature and thus not enrolled in the Colorado Medical Assistance Program. If members with COVID-19 can only receive care at covered places of service, those sites may become overcrowded and may see a shortage of available beds.

   Suspending multi-loading will ensure compliance with social distancing guidelines by limiting a vehicle's occupants.

3. Federal authority for the Rule, if any:

   42 CFR 440.170 (2020)

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   25.5-5-324, C.R.S. (2019)

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3
Rule Number: MSB 22-10-06-D
Division / Contact / Phone:Health Programs Office / Courtney Sedon / 303-866-6163

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Members utilizing or eligible for NEMT services (nearly all members with State Plan/Title XIX are eligible), NEMT providers, and facilities treating COVID-19 patients will all benefit from the proposed revisions.

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

   Affected members will benefit from increased access to care, and transportation providers will benefit from a slight uptick in utilization when trip volumes have fallen. Medical providers and facilities will benefit from an increased ability to transport patients to prevent any one facility from becoming overloaded.

   For the multi-loading revision, members and drivers will benefit from a reduction in potential exposure to COVID-19. Drivers will not see a reduction in trip volume because the Department previously issued guidance that suspended multi-loading during the public health emergency. This rule simply formalizes that guidance.

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

   There are no costs to the Department or to any other agency to implement and enforce the proposed rule.

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

   For the covered place of service requirement, the probable cost of the proposed rule is a potential minimal increase in utilization, which is more

than offset by the reduction in NEMT utilization during the stay at home order. The benefits of the proposed rule are increased access to care and the ability to move members to different sites as they recover, which frees up hospital beds.

The cost of inaction is that members in a hospital for COVID-19 will continue to tie up beds if they cannot be moved to an alternate location as they recover. This will potentially strain hospital resources.

For multi-loading, the cost of the revision is a small increase in claims. One driver will have to take one patient at a time rather than multiple patients on the same route. As a result, the Department will need to dispatch more drivers. The cost will be offset by the substantial reduction in NEMT utilization for March and April. The benefit to implementation is that drivers and passengers will maintain social distancing standards and reduce the spread of COVID-19.

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

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose for the proposed rule.

8.014 NON-EMERGENT MEDICAL TRANSPORTATION

8.014.1. DEFINITIONS

8.014.1.A. Access means the ability to make use of.

8.014.1.B. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.C. Ambulatory Vehicle means a passenger-carrying vehicle available for those clients able to walk and who do not rely on wheelchairs or other mobility devices, during boarding or transportation, which would necessitate a vehicle with a lift or other accommodations.

8.014.1.D. Ancillary Services mean services incurred indirectly when a client authorized to receive NEMT also requires the assistance of an Escort or financial assistance for meals or lodging.

8.014.1.E. At-Risk Adult means an adult who is unable to make personal or medical determinations, provide necessary self-care, or travel independently.

8.014.1.F. Child means a minor under the age of 18.

8.014.1.G. Day Treatment means facility-based services designed for Children with complex medical needs. Services include educational or day care services when the school or day care system is unable to provide skilled care in a school setting, or when the Child's medical needs put them at risk when around other Children.

8.014.1.H. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation under Section 8.018 during which clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route

8.014.1.I. Escort means a person who accompanies an At-Risk Adult or minor client.

8.014.1.J. Fixed-Wing Air Ambulance means a fixed wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.014.1.K. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.L. Medicaid Client Transport (MCT) Permit means a permit issued by the Colorado Department of Regulatory Agencies Public Utilities Commission (PUC) in accordance with the PUC statute at Section 40-10.1-302, C.R.S.

8.014.1.M. Mode means the method of transportation.

8.014.1.N. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment. Non-emergency care may be scheduled or unscheduled. This may include Urgent Care transportation and hospital discharge transportation.

8.014.1.O. Program of All Inclusive Care for the Elderly (PACE) is a capitated rate benefit which provides all-inclusive long-term care to certain individuals as defined in Section 8.497.

8.014.1.P. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.014.1.Q. State Designated Entity (SDE) means the organization responsible for administering NEMT. For the purposes of this rule, the responsible SDE is determined by the client's county of residence.

8.014.1.R. Stretcher Van means a vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route. This may be by stretcher, board, gurney, or another appropriate device.

8.014.1.S. Taxicab means a motor vehicle operating in Taxicab Service, as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.T. Taxicab Service has the same meaning as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.U. Trip means one-way transportation from the point of origin to the point of destination.

8.014.1.V. Urgent Care means an appointment for a covered medical service with verification from an attending physician or facility that the client must be seen or picked up from a discharged appointment within 48 hours.

8.014.1.W. Wheelchair Vehicle means a motor vehicle designed and used for the non-emergent transportation of individuals with disabilities who use a wheelchair. These vehicles include vans modified for wheelchair Access or wheelchair accessible minivans.

8.014.2. CLIENT ELIGIBILITY AND RESPONSIBILITIES

8.014.2.A. All Colorado Medical Assistance Program clients are eligible for NEMT services unless the client falls within the following eligibility groups on the date of the Trip:

1. Qualified Medicaid Beneficiary (QMB) Only

2. Special Low Income Medicare Beneficiary (SLMB) Only

3. Medicare Qualifying Individual-1 (QI-1) Only

4. Old Age Pension- State Only (OAP-state only)

8.014.2.B. Child Health Plan Plus clients are not eligible for NEMT.

8.014.2.C. PACE clients receive transportation provided by their PACE organization and are not eligible for NEMT.

8.014.2.D. NEMT services may be denied if clients do not observe the following responsibilities:

1. Comply with applicable state, local, and federal laws during transport.

2. Comply with the rules, procedures and policies of the SDE.

3. Obtain authorization from their SDE.

4. Clients must not engage in violent or illegal conduct while utilizing NEMT services.

5. Clients must not pose a direct threat to the health or safety of themselves or others, including drivers.

6. Clients must cancel their previously scheduled NEMT Trip if the ride is no longer needed, except in emergency situations or when the client is otherwise unable to cancel.

8.014.3. PROVIDER ELIGIBILITY AND RESPONSIBILITIES

8.014.3.A. Providers must enroll with the Colorado Medical Assistance Program as an NEMT provider.

8.014.3.B. Enrolled NEMT providers must:

1. Meet all provider screening requirements in Section 8.125;

2. Comply with commercial liability insurance requirements and, if applicable, PUC financial responsibility requirements established in the PUC statute at C.R.S. § 40-10.1-107;

3. Refrain from attempting to solicit clients known to have already established NEMT service with another provider;

4. Maintain and comply with the following appropriate licensure, or exemption from licensure, requirements:

   a. PUC common carrier certificate as a Taxicab;

   b. PUC MCT Permit as required by the PUC statute at C.R.S. § 40-10.1-302;

   c. Ground Ambulance license as required by Department of Public Health and Environment (CDPHE) rule at 6 CCR 1015-3, Chapter Four;

   d. Air Ambulance license as required by CDPHE rule at 6 CCR 1015-3, Chapter Five; or

   e. Exemption from licensure requirements in accordance with PUC statute at C.R.S. § 40-10.1-105.

5. Only provide NEMT services appropriate to their current licensure(s) and within the geographic limitations applicable to the licensure; and

6. Ensure that all vehicles and auxiliary equipment used to transport clients meet federal, state, and local safety inspection and maintenance requirements.

PUC statute at C.R.S. §§ 40-10.1-105, 40-10.1-107 and 40-10.1-302 (2019) and CDPHE rule at 6 CCR 1015-3, Chapters Four and Five (2019), are hereby incorporated by reference.

8.014.3.C. NEMT transportation providers must maintain a Trip report for each NEMT Trip provided and must, at a minimum, include:

1. The pick-up address;

2. The destination address;

3. Date and time of the Trip;

4. Client’s name or identifier;

5. Confirmation that the driver verified the client’s identity;

6. Confirmation by the client, Escort, or medical facility that the Trip occurred;

7. The actual pick-up and drop off time;

8. The driver's name; and

9. Identification of the vehicle in which the Trip was provided.

8.014.3.D. Multiple Loading

1. NEMT providers may not transport more than one client at the same time, unless the additional passenger is an Escort.

8.014.3.E. The Section 8.014.3 requirements do not apply to client reimbursement or bus or rail systems.

8.014.4. COVERED PLACES OF SERVICE

8.014.4.A. NEMT must be provided to the closest provider available qualified to provide the service the client is traveling to receive. The closest provider is defined as a provider within a 25-mile radius of the client's residence, or the nearest provider if one is not practicing within a 25-mile radius of the client's residence. Exceptions may be made by the SDE in the following circumstances:

1. If the closest provider is not willing to accept the client, the client may use NEMT to access the next closest qualified provider.

2. If the client has complex medical conditions that restrict the closest medical provider from accepting the patient, the SDE may authorize NEMT to be used to travel to the next closest qualified provider. The treating medical provider must send the SDE written documentation indicating why the client cannot be treated by the closest provider.

3. If a client has moved within the three (3) months preceding an NEMT transport, the client may use NEMT to their established medical provider seen in their previous locale. During these three (3) months, the client and medical provider must transfer care to the closest provider as defined at Section 8.014.4.B. or determine transportation options other than NEMT.

8.014.5. COVERED SERVICES

8.014.5.A. Transportation Modes

1. Covered Modes of transportation include:

a. Bus and public rail systems

i. Transit passes may be issued by the SDE when the cumulative cost of bus tickets exceeds the cost of a pass.

b. Personal vehicle mileage reimbursement

c. Ambulatory Vehicles

d. Wheelchair Vehicles

e. Taxicab Service

f. Stretcher Van

g. Ground Ambulance

h. Air Ambulance

i. Commercial plane

j. Train

8.014.5.B. NEMT Services

1. NEMT is a covered service when:

a. The client does not have Access to other means of transportation, including free transportation;

b. Transportation is required to obtain a non-emergency service(s) that is medically necessary, as defined in Section 8.076.1.8.; and

c. The client is receiving a service covered by the Colorado Medical Assistance Program.

2. NEMT services may be covered for clients even if the medical procedure is paid for by an entity other than the Colorado Medical Assistance Program.

3. Non-emergent ambulance service (Ground and Air Ambulance), from the client's pickup point to the treating facility, is covered when:

a. Transportation by any other means would endanger the client's life; or

b. The client requires basic life support (BLS) or advanced life support (ALS) to maintain life and to be transported safely.

i. BLS includes:

1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

2. Suctioning en route (not deep suctioning); and

3. Airway control/positioning.

ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference.

1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

2. ALS Level 2 includes:

a. Administration of at least three medications by intravenous push/bolus or by continuous infusion,

excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

b. The provision of at least one of the following ALS procedures:

i. Manual defibrillation/cardioversion.

ii. Endotracheal intubation.

iii. Central venous line.

iv. Cardiac pacing.

v. Chest decompression.

vi. Surgical airway.

vii. Intraosseous line.

4. NEMT may be provided to an Urgent Care appointment under the following circumstances:

a. A provider is available;

b. The appointment is for a covered medical service with verification from an attending physician that the client must be seen within 48 hours; and

c. The client is transported to an Urgent Care facility, which may include a trauma center if it is the nearest and most appropriate facility.

8.014.5.C. Personal Vehicle Mileage Reimbursement

1. Personal vehicle mileage reimbursement is covered for a privately owned, non-commercial vehicle when used to provide NEMT services in accordance with Section 8.014.5.B and owned by:

a. A client, a client’s relative, or an acquaintance; or

b. A volunteer or organization with no vested interest in the client.

2. Personal vehicle mileage reimbursement will only be made for the shortest Trip length in miles as determined by an internet-based map, Trip planner, or other Global Positioning System (GPS).

a. Exceptions can be made by the SDE if the shortest distance is impassable due to:

i. Severe weather;

ii. Road closure; or

iii. Other unforeseen circumstances outside of the client’s control that severely limit using the shortest route.

b. If an exception is made under Section 8.014.5.C.2.a., the SDE must document the reason and pay mileage for the actual route traveled.

3. To be reimbursed for personal vehicle mileage, the client must provide the following information to the SDE within forty-five (45) calendar days of the final leg of the Trip:

a. Name and address of vehicle owner and driver (if different from owner);

b. Name of the insurance company and policy number for the vehicle; and

c. Driver's license number and expiration date.

8.014.5.D. Ancillary Services

1. Escort

a. The Colorado Medical Assistance Program may cover the cost of transporting one Escort when the client is:

i. A Child.

1. An Escort is required to accompany a client if the client is under thirteen (13) years old, unless the Child:

a. Is traveling to a Day Treatment program (Children are not eligible for NEMT travel to and from school-funded day treatment programs);

b. The parent or guardian signs a written release;

c. An adult will be present to receive the Child at the destination and return location; and

d. The Day Treatment program and the parents approve of the NEMT provider used.

2. Clients who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel without an Escort if:

a. The parent or guardian signs a written release; andAn adult will be present to receive the Child at the destination and return location.

ii. An At-Risk Adult unable to make personal or medical determinations, or to provide necessary self-care, as certified in writing by the client's attending Colorado Medical Assistance Program enrolled NEMT provider.

b. The Escort must be physically and cognitively capable of providing the needed services for the client.

i. If a client's primary caregiver has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay, a second Escort may be covered under Section 8.014.5.D.1.c.ii.

c. The Colorado Medical Assistance Program may cover the cost of transporting a second Escort for the client, if prior authorized under Section 8.014.7. A second Escort will only be approved if:

i. The client has a behavioral or medical condition which may cause the client to be a threat to self or to others if only one Escort is provided; or

ii. The client's primary caregiver Escort has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay.

2. Meals and Lodging

a. Meals and lodging for in-state treatment may be reimbursed when:

i. Travel cannot be completed in one calendar day; or

ii. The client requires ongoing, continuous treatment and:

1. The cost of meals and lodging is less than or equal to the cost of traveling to and from the treatment facility and the client's residence; or

2. The client's treating medical professional determines that traveling to and from the client's residence would put the client's health at risk.

b. Meals and lodging may be covered for the Escort(s) when the client is a Child or an At-Risk Adult who requires the Escort's continued stay under Section 8.014.5.D.1.

c. Reimbursement will only be made for meals and lodging for which clients and Escorts are actually charged, up to the per diem rate established by the Colorado Medical Assistance Program.

d. Meals and lodging will not be paid or reimbursed when those services are included as part of an inpatient stay.

8.014.6. NON-COVERED NEMT SERVICES AND GENERAL LIMITATIONS

8.014.6.A. The following services are not covered or reimbursable to NEMT providers as part of a NEMT service:

1. Services provided only as a convenience to the client.

2. Charges incurred while client is not in the vehicle, except for lodging and meals in accordance with Section 8.014.5.D.2.

3. Transportation to or from non-covered medical services, including services that do not qualify due to coverage limitations..

4. Waiting time.

5. Cancellations.

6. Transportation which is covered by another entity.

7. Metered taxi services.

8. Charges for additional passengers, including siblings or Children, not receiving a medical service, except when acting as an Escort under Section 8.014.5.D.1.

9. Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle.

10. Transportation to emergency departments to receive emergency services. See Section 8.018 for Emergency Medical Transportation services.

11. Providing Escorts or the Escort's wages.

12. Trips to receive Home and Community Based Services

a. Non-medical transportation should be utilized if other transportation options are not available to the client.

8.014.6.B. General Limitations

1. The SDE is responsible for ensuring that the client utilizes the least costly Mode of transportation available that is suitable to the client's condition.

8.014.7. AUTHORIZATION

8.014.7.A. All NEMT services must be authorized as required by the SDE.

1. Authorization requests submitted more than three months after an NEMT service is rendered will be denied.

2. NEMT services may be denied if proper documentation is not provided to the SDE.

8.014.7.B. If a client requests transportation via Wheelchair Vehicle, Stretcher Van, or ambulance, the SDE must verify the service is medically necessary with the client's medical provider

1. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

8.014.7.C. Out-of-State NEMT

1. NEMT to receive out of state treatment is permissible only if treatment is not available in the state of Colorado.

2. The following border towns are not considered out of state for the purposes of NEMT prior authorization:

a. Arizona: Flagstaff and Teec Nos Pos.

b. Kansas: Elkhart, Goodland, Johnson, Sharon Springs, St. Francis, Syracuse, Tribune.

c. Nebraska: Benkelman, Cambridge, Chappell, Grant, Imperial, Kimball, Ogallala, and Sidney.

d. New Mexico: Aztec, Chama, Farmington, Raton, and Shiprock.

e. Oklahoma: Boise City.

f. Utah: Monticello and Vernal.

g. Wyoming: Cheyenne and Laramie.

8.014.7.D. Prior Authorization

1. The following services require prior authorization by Colorado Medical Assistance Program:

a. Out-of-state travel, except to the border towns identified at section 8.014.7.C.2.

b. Air travel, both commercial air and Air Ambulance.

c. Train travel via commercial railway.

d. Second Escort.

2. Prior authorization requests require the following information:

a. NEMT prior authorization request form completed by SDE and member's physician and submitted to Colorado Medical Assistance Program according to form instructions.

i. The Colorado Medical Assistance Program will return requests completed by non-physicians and incomplete requests to the SDE.

ii. The Colorado Medical Assistance Program's determination will be communicated to the SDE. If additional information is requested, the SDE must obtain the information and submit to the Colorado Medical Assistance Program. If the request is denied, the SDE must send the client a denial notice.

8.014.8. INCORPORATIONS BY REFERENCE

The incorporation by reference of materials throughout section 8.014 excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
Rule Number: MSB 22-10-06-F
Division / Contact / Phone: Eligibility / Ana Bordallo / 3558

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

a

2. Title of Rule: MSB 22-10-06-F, Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 10/14/2022

   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100 with the proposed text beginning at 8.100.3.D through the end of 8.100.3.D. Replace the current text at 8.100.3.F with the proposed text beginning at 8.100.3.F through the end of 8.100.3.F. Replace the current text at 8.100.3.I with the proposed text beginning at 8.100.3.I through the end of 8.100.3.I. Replace the current text at 8.100.3.K with the proposed text beginning at 8.100.3.K through the end of 8.100.3.K. Replace the current text at 8.100.3.L with the proposed text beginning at

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

8.100.3.L. Replace the current text at 8.100.3.P with the proposed text beginning at 8.100.3.P through the end of 8.100.3.P. Replace the current text at 8.100.4.B with the proposed beginning at 8.100.4.B through the end of 8.100.4.B. Replace the current text at 8.100.4.C with the proposed text beginning at 8.100.4.C through the end of 8.100.4.C. 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. Replace the current text at 8.100.5.A with the proposed text beginning at 8.100.5.A through the end of 8.100.5.A. Replace the current text at 8.100.5.B with the proposed text beginning at 8.100.5.B through the end of 8.100.5.B. Replace the current text at 8.100.6.P with the proposed text beginning at 8.100.6.P through the end of 8.100.6.P. Replace the current text at 8.100.6.Q with the proposed text beginning at 8.100.6.Q through the end of 8.100.6.Q. This rule is effective October 14, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
Rule Number: MSB 22-10-06-F
Division / Contact / Phone: Eligibility / Ana Bordallo / 3558

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule change will amend 10 CCR 2505-10 sections 8.100.1,8.100.3, 8.100.4, 8.100.5 and 8.100.6 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act(ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during the federal Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories and these policy changes will stay in place until the end of the federal Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Self-attestation for most verifications will be acceptable to be in compliance with the Maintenance of Effort (MOE) provision to ensure the continuance of health coverage for all eligible members. When a member is not reasonable compatible based off income a member self-attests, documentation will not be required, and the member will remain eligible for Medical Assistance. Self-attestation of resources will be acceptable for Non-MAGI programs. Premiums for the Buy-In program will be waived. Required through the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program. Newly enrolled members will still need to meet the work requirements. For applicants who are not eligible for Medical Assistance but have been exposed or who are potentially infected by the COVID-19, will be eligible for Medical Assistance for related COVID testing. The economic stimulus relief package designed to provide direct assistance to individuals to help offset the financial impacts of the COVID-19 Public Health Emergency will be exempt for MAGI and Non-MAGI eligibility determinations. The economic stimulus will *not* be a countable resource for 12 months for any Non-MAGI financial eligibility determinations that include a resource test. Lastly, the Federal Pandemic Unemployment Compensation (FPUC) program which provides an extra $600.00 a week is not countable unearned income for Medical Assistance categories

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

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Explain:

Due to the Coronavirus (COVID-19) Public Health Emergency the state rules need to be updated to comply with federal regulations.

3. Federal authority for the Rule, if any:

   Families First Coronavirus Response Act (FFCRA), Public Law No. 116-127 and Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law No. 116-136 and the Affordable Care Act (ACA), which includes the Maintenance of Effort (MOE) provision.

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   25.5-4-205(3)(II)(b)(A), 25.5-5-105, 25.5-5-206(1)(II)(B), 25.5-6-1404(1)(b) and(3)(a)(b), 25.5-6-1405(1),25.5.-6-1405(2)

Title of Rule: Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
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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 proposed rules will impact applicants and members who are applying or enrolled in a MAGI and Non-MAGI Medical Assistance program. The rule updates will benefit both an applicant and member who becomes eligible for Medical Assistance by remaining eligible during this Coronavirus (COVID-19) Public Health Emergency.

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

   The proposed rule will help to determine eligibility correctly by applying regulations based on the CARES Act to help applicants and members remain eligible for MAGI and Non-MAGI Medical Assistance programs during this Coronavirus (COVID-19) Public Health Emergency.

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

   Self-attestation of all eligibility requirements, including resources, is likely to increase the number of individuals who will be eligible to enroll in Medicaid, therefore the Department expects its expenditures to increase as a result of this policy change. The Department expects that the waiving of premiums for the Disabled Buy-In program will reduce the revenues to the Department, which will result in an increase in expenditures from the Healthcare Affordability and Sustainability Fee (HAS) Cash Fund and federal funds, in order to fill the gap in revenue lost from the premiums.

   The Department expects that the provision of COVID testing to applicants will increase expenditures to the Department, but these expenditures will

be covered with 100% federal funds and will not impact expenditures from state fund sources.

The exemptions to counting the economic relief provided to individuals from the federal government towards eligibility for Medical Assistance is likely to not affect eligibility, and therefore not impact costs to the Department.

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

   The allowance of self-attestation of eligibility criteria is mandated by the Families First Coronavirus Response Act in order for states to qualify for an enhanced FMAP of 6.2%. If the Department does not act in accordance with this policy, the costs to the Department will increase beyond what is necessary. The benefit of implementing this policy will allow the Department to secure a higher FMAP, which will allow the Department to operate with less administrative burden and serve more members during the emergency period. With respect to the proposal to waive the premiums for the Disabled Buy-In program, the Department expects that inaction will cause potential members to not qualify for buy-in because they will be unable to pay the premiums due to the severity of the economic shock. Therefore, the Department sees no benefit to inaction of the rule changes.

   In addition, the Families First Coronavirus Response Act allows state Medicaid and CHP+ programs to fund the cost of COVID-19 diagnostic testing for residents who do not qualify for Medical Assistance through 100% federal funds. Thus, inaction will lead to less testing of individual during the emergency and more uncertainty of the status of the emergency in Colorado. Again, the Department sees no benefit to inaction as the costs will be covered by federal funds.

   The exemptions to counting the economic relief provided to individuals from the federal government towards eligibility for Medical Assistance are mandated by the Coronavirus Aid, Relief, and Economic Security (CARES) Act. If the Department does not act it will be in violation of the law.

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

   There are no less costly methods available to the Department to comply with the Families First Coronavirus Response Act and the CARES Act. The purposes of the proposed rule changes are to allow the Department to better serve Medicaid members and the people of Colorado during this

emergency period and the Department sees no other method to accomplish this goal.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

There are no alternative methods for the proposed rule that were considered.

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

300% Institutionalized Special Income Group is a Medical Assistance category that provides Long-Term Care Services to aged or disabled individuals.

1619b is section 1619b of the Social Security Act which allows individuals who are eligible for Supplemental Security Income (SSI) to continue to be eligible for Medical Assistance coverage after they return to work.

AB - Aid to the Blind is a program which provides financial assistance to low-income blind persons.

ABD - Aged, Blind and Disabled Medical Assistance is a group of Medical Assistance categories for individuals that have been deemed to be aged, blind, or disabled by the Social Security Administration or the Department.

Achieving a Better Life Experience (ABLE) accounts – Special savings accounts that are set up by (or for) certain individuals with disabilities in a qualified ABLE program that are exempt for eligibility. They can be established by any state's qualified ABLE Program. Colorado's ABLE program is administered by the Department of Higher Education.

Adjusted Gross Income (AGI)-means" gross income", as defined in federal tax rules, minus certain adjustments prescribed in the federal tax rules to derive the "Adjusted Gross Income" line on the tax return. These adjustments from gross income are taken before the taxpayer takes his or her Schedule A deductions or Standard Deduction.

Adult MAGI Medical Assistance Group provides Medical Assistance to eligible adults from the age of 19 through the end of the month that the individual turns 65, who do not receive or who are ineligible for Medicare.

AND - Aid to Needy Disabled is a program which provides financial assistance to low-income persons over age 18 who have a total disability which is expected to last six months or longer and prevents them from working.

AFDC - Aid to Families with Dependent Children is the Title IV federal assistance program in effect from 1935 to 1997 which was administered by the United States Department of Health and Human Services. This program provided financial assistance to children whose families had low or no income.

AP-5615 is the form used to determine the patient payment for clients in nursing facilities receiving Long Term Care.

Alien is a person who was not born in the United States and who is not a naturalized citizen.

Ambulatory Services is any medical care delivered on an outpatient basis.

Annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years.

Applicant is an individual who is seeking an eligibility determination for Medical Assistance through the submission of an application.

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility

site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

Application for Public Assistance is the designated application used to determine eligibility for financial assistance. It can also be used to determine eligibility for Medical Assistance.

Blindness is defined in this volume as the total lack of vision or vision in the better eye of 20/200 or less with the use of a correcting lens and/or tunnel vision to the extent that the field of vision is no greater than 20 degrees.

Burial Spaces are burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use, including necessary and reasonable improvements or additions to or upon such burial spaces such as: vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

Burial Trusts are irrevocable pre-need funeral agreements with a funeral director or other entity to meet the expenses associated with burial for Medical Assistance applicants/recipients. The agreement can include burial spaces as well as the services of the funeral director.

Caretaker Relative is a person who is related to the dependent child or any adult with whom the dependent child is living and who assumes responsibility for the dependent child’s care.

Case Management Services are services provided by community mental health centers, clinics, community centered boards, and EPSDT case managers to assist in providing services to Medical Assistance clients in gaining access to needed medical, social, educational and other services.

Cash Surrender Value is the amount the insurer will pay to the owner upon cancellation of the policy before the death of the insured or before maturity of the policy.

Categorically Eligible means persons who are eligible for Medical Assistance due to their eligibility for one or more Federal categories of public assistance.

CBMS - Colorado Benefits Management System is the computer system that determines an applicant’s eligibility for public assistance in the state of Colorado.

CDHS -Colorado Department of Human Services is the state department responsible for administering the social service and financial assistance programs for Colorado.

Children MAGI Medical Assistance group provides Medical Assistance coverage to tax dependents or otherwise eligible applicants through the end of the month that the individual turns 19 years old.

Child Support Services is a CDHS program that assures that all children receive financial and medical support from each parent. This is accomplished by locating each parent, establishing paternity and support obligations, and enforcing those obligations.

Citizen is a person who was born in the United States or who has been naturalized.

Client is a person who is eligible for the Medical Assistance Program. “Client” is used interchangeably with “recipient” when the person is eligible for the program.

CMS - Centers for Medicare and Medicaid Services is the Federal agency within the US Department of Health and Human Services that partners with the states to administer Medicaid and CHP+ via State Plans in effect for each State. Colorado is in Region VIII.

CHP+ - Child Health Plan Plus is low-cost health insurance for Colorado's uninsured children and pregnant women. CHP+ is public health insurance for children and pregnant women who earn too much to qualify for The Medical Assistance Program, but cannot afford private health insurance.

COLA - Cost of Living Adjustment is an annual increase in the dollar value of benefits made automatically by the United States Department of Health and Human Services or the state in OASDI, SSI and OAP cases to account for rises in the cost of living due to inflation.

Colorado State Plan is a written statement which describes the purpose, nature, and scope of the Colorado's Medical Assistance Program. The Plan is submitted to the CMS and assures that the program is administered consistently within specific requirements set forth in both the Social Security Act and the Code of Federal Regulations (CFR) in order for a state to be eligible for Federal Financial Participation (FFP).

Common Law Marriage is legally recognized as a marriage in the State of Colorado under certain circumstances even though no legally recognized marriage ceremony is performed or civil marriage contract is executed. Individuals declaring or publicly holding themselves out as a married couple through verbal or written methods may be recognized as legally married under state law. C.R.S. § 14-2-104(3).

Community Centered Boards are private non-profit organizations designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities.

Community Spouse is the spouse of an institutionalized spouse.

Community Spouse Resource Allowance is the amount of resources that the Medical Assistance regulations permit the spouse staying at home to retain.

Complete Application means an application in which all questions have been answered, which is signed, and for which all required verifications have been submitted.

The Department is defined in this volume as the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Child Health Plan Plus programs as well as other State-funded health care programs.

Dependent Child is a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 18, or, is age 18 and a full-time student, and expected to graduate by age 19.

Dependent Relative for purposes of this rule is defined as one who is claimed as a dependent by an applicant for federal income tax purposes.

Difficulty of Care Payments is a payment to an applicant or member as compensation for providing live-in home care to an individual who qualifies for foster care or Home and Community Based Services (HCBS) waiver program and lives in the home of the care recipient. This additional care must be required due to a physical, mental, or emotional handicap.

Disability means the inability to do any substantial gainful activity (or, in the case of a child, having marked and severe functional limitations) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of l2 months or more.

Dual Eligible clients are Medicare beneficiaries who are also eligible for Medical Assistance.

Earned Income is defined for purposes of this volume as any compensation from participation in a business, including wages, salary, tips, commissions and bonuses.

Earned Income Disregards are the allowable deductions and exclusions subtracted from the gross earnings. Income disregards vary in amount and type, depending on the category of assistance.

Electronic Data Source is an interface established with a federal or state agency, commercial entity, or other data sources obtained through data sharing agreements to verify data used in determining eligibility. The active interfaces are identified in the Department's verification plan submitted to CMS.

Eligibility Site is defined in this volume as a location outside of the Department that has been deemed by the Department as eligible to accept applications and determine eligibility for applicants.

Employed means that an individual has earned income and is working part time, full time or is self-employed, and has proof of employment. Volunteer or in-kind work is not considered employment.

EPSDT- Early Periodic Screening, Diagnosis and Treatment is the child health component of the Medical Assistance Program. It is required in every state and is designed to improve the health of low-income children by financing appropriate, medically necessary services and providing outreach and case management services for all eligible individuals.

Equity Value is the fair market value of land or other asset less any encumbrances.

Ex Parte Review is an administrative review of eligibility during a redetermination period in lieu of performing a redetermination from the client. This administrative review is performed by verifying current information obtained from another current aid program.

Face Value of a Life Insurance Policy is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or other special provisions.

Fair Market Value is the average price a similar property will sell for on the open market to a private individual in the particular geographic area involved. Also, the price at which the property would change hands between a willing buyer and a willing seller, neither being under any pressure to buy or to sell and both having reasonable knowledge of relevant facts.

FBR - The Federal Benefit Rate is the monthly Supplemental Security Income payment amount for a single individual or a couple. The FBR is used by the Aged, Blind and Disabled Medical Assistance Programs as the eligibility income limits.

FFP - Federal Financial Participation as defined in this volume is the amount or percentage of funds provided by the Federal Government to administer the Colorado Medical Assistance Program.

FPL - Federal Poverty Level is a simplified version of the federal poverty thresholds used to determine financial eligibility for assistance programs. The thresholds are issued each year in the Federal Register by the Department of Health and Human Services (HHS).

Good Cause is the client's justification for needing additional time due to extenuating circumstances, usually used when extending deadlines for submittal of required documentation.

Good Cause for Child Support is the specific process and criteria that can be applied when a client is refusing to cooperate in the establishment of paternity or establishment and enforcement of a child support order due to extenuating circumstances.

HCBS are Home and Community Based Services are also referred to as "waiver programs". HCBS provides services beyond those covered by the Medical Assistance Program that enable individuals to remain in a community setting rather than being admitted to a Long-Term Care institution.

In-Kind Income is income a person receives in a form other than money. It may be received in exchange for work or service (earned income) or a non-cash gift or contribution (unearned income).

Inpatient is an individual who has been admitted to a medical institution on recommendation of a physician or dentist and who receives room, board and professional services for 24 hours or longer, or is expected to receive these services for 24 hours or longer.

Institution is an establishment that furnishes, in single or multiple facilities, food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

Institutionalization is the commitment of a patient to a health care facility for treatment.

Institutionalized Individual is a person who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

Institutionalized Spouse is a Medicaid eligible client who begins a stay in a medical institution or nursing facility on or after September 30, 1989, or is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or receives Home and Community Based Services (HCBS) on or after July 1, 1999; and is married to a spouse who is not in a medical institution or nursing facility. An institutionalized spouse does not include any such individual who is not likely to be in a medical institution or nursing facility or to receive HCBS or PACE for at least 30 consecutive days. Irrevocable means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than outlined in the document.

Insurance Affordability Program (IAP) refers to Medicaid, Child Health Plan *Plus* (CHP+), and premium and cost-sharing assistance for purchasing private health insurance through state insurance marketplace.

Legal Immigrant is an individual who is not a citizen or national and has been permitted to remain in the United States by the United States Citizenship and Immigration Services (USCIS) either temporarily or as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by USCIS.

Legal Immigrant Prenatal is a medical program that provides medical coverage for pregnant legal immigrants who have been legal immigrants for less than five years.

Limited Disability for the Medicaid Buy-In Program for Working Adults with Disabilities means that an individual has a disability that would meet the definition of disability under SSA without regard to Substantial Gainful Activity (SGA).

Long-Term Care is Medical Assistance services that provides nursing-home care, home-health care, personal or adult day care for individuals aged at least 65 years or with a chronic or disabling condition.

Long-Term Care Institution means class I nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR) and swing bed facilities. Long-Term Care institutions can include hospitals.

Managed care system is a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care.

Medical Assistance is defined as all medical programs administered by the Department of Health Care Policy and Financing. Medical Assistance/Medicaid is the joint state/federal health benefits program for individuals and families with low income and resources. It is an entitlement program that is jointly funded by the states and federal government and administered by the state. This program provides for payment of all or part of the cost of care for medical services.

Medical Assistance Required Household is defined for purposes of this volume as all parents or caretaker relatives, spouses, and dependent children residing in the same home.

Minimal Verification is defined in this volume as the minimum amount of information needed to process an application for benefits. No other verification can be requested from clients unless the information provided is questionable or inconsistent.

Minimum Essential Coverage is the type of coverage one must maintain to be in compliance with the Affordable Care Act in order to avoid paying a penalty for being uninsured. Minimum essential coverage may include but not limited to: Medicaid; CHP+; private health plans through Connect for Health Colorado; Medicare; job-based insurance, and certain other coverage.

MMMNA - Minimum Monthly Maintenance Needs Allowance is the calculation used to determine the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MAGI - Modified Adjusted Gross Income refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act. These MAGI groups include Parents and Caretaker Relatives, Pregnant Women, Children, and Adults. For a more complete description of the MAGI categories and pursuant rules, please refer to section 8.100.4.

MAGI-Equivalent is the resulting standard identified through a process that converts a state's net-income standard to equivalent MAGI standards.

MIA - Monthly Income Allowance is the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MSP - Medicare Savings Program is a Medical Assistance Program to assist in the payment of Medicare premium, coinsurance and deductible amounts. There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLIMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals – 1 (QI-1s).

Non-Filer is an individual who neither files a tax return nor is claimed as a tax dependent. For a more complete description of how household composition is determined for the MAGI Medical Assistance groups, please refer to the MAGI household composition section at 8.100.4.E.

Nursing Facility is a facility or distinct part of a facility which is maintained primarily for the care and treatment of inpatients under the direction of a physician. The patients in such a facility require supportive, therapeutic, or compensating services and the availability of a licensed nurse for observation or treatment on a twenty-four-hour basis.

OAP - Old Age Pension is a financial assistance program for low income adults age 60 or older.

OASDI - Old Age, Survivors and Disability Insurance is the official term Social Security uses for Social Security Act Title II benefits including retirement, survivors, and disability. This does not include SSI payments.

Outpatient is a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment. Is a patient who does not require admittance to a facility to receive medical services.

PACE - Program of All-inclusive Care for the Elderly is a unique, capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive

medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Parent and Caretaker Relative is a MAGI Medical Assistance group that provides Medical Assistance to adults who are parents or Caretaker Relatives of dependent children.

Patient is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

PEAK – the Colorado Program Eligibility and Application Kit is a web-based portal used to apply for public assistance benefits in the State of Colorado, including Medical Assistance.

PNA - Personal Needs Allowance means moneys received by any person admitted to a nursing care facility or Long-Term Care Institution which are received by said person to purchase necessary clothing, incidentals, or other personal needs items which are not reimbursed by a Federal or state program.

Pregnant Women is a MAGI Medical Assistance group that provides Medical Assistance coverage to pregnant women whose MAGI-based income calculation is less than 185% FPL, including women who are 60 days post-partum.

Premium means the monthly amount an individual pays to participate in a Medicaid Buy-In Program.

Provider is any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding a current valid license or certificate to provide such services or to dispense such goods.

Psychiatric Facility is a facility that is licensed as a residential care facility or hospital and that provides inpatient psychiatric services for individuals under the direction of a licensed physician.

Public Institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

Questionable is defined as inconsistent or contradictory tangible information, statements, documents, or file records.

Reasonable Compatibility refers to an allowable difference or discrepancy between the income an applicant self attests and the amount of income reported by an electronic data source. For a more complete description of how reasonable compatibility is used to determine an applicant’s financial eligibility for Medical Assistance, please refer to the MAGI Income section at 8.100.4.C

Reasonable Explanation refers to the opportunity afforded an applicant to explain a discrepancy between self-attested income and income as reported by an electronic data source, when the difference is above the threshold percentage for reasonable compatibility.

Recipient is any person who has been determined eligible to receive benefits.

Resident is any individual who is living within the state and considers the state as their place of residence. Residents include any unemancipated child whose parent or other person exercising custody lives within the state.

RRB - Railroad Retirement Benefits is a benefit program under Federal law 45 U.S.C. § 231 et seq that became effective in 1935. It provides retirement benefits to retired railroad workers and families from a special fund, which is separate from the Social Security fund.

Secondary School is a school or educational program that provides instruction or training towards a high school diploma or an equivalent degree such as a High School Equivalency Diploma (HSED).

SGA – Substantial Gainful Activity is defined by the Social Security Administration. SGA is the term used to describe a level of work activity and earnings. Work is “substantial” if it involves performance of significant physical or mental activities or a combination of both, which are productive in nature. For work activity to be substantial, it does not need to be performed on a full-time basis. Work activity performed on a part-time basis may also be substantial gainful activity. “Gainful” work activity is work performed for pay or profit; or work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

Single Entry Point Agency means the organization selected to provide case management functions for persons in need of Long-Term Care services within a Single Entry Point District.

Single Streamlined Application or “SSAp” is the general application for health assistance benefits through which applicants will be screened for Medical Assistance programs including Medicaid, CHP+, or premium and cost-sharing assistance for purchasing private health insurance through a state insurance marketplace.

SISC- Supplemental Income Status Codes are system codes used to distinguish the different types of state supplementary benefits (such as OAP) a recipient may receive. Supplemental Income Status Codes determine the FFP for benefits paid on behalf of groups covered under the Medical Assistance program.

SSA - Social Security Administration is an agency of the United States federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' benefits.

SSI - Supplemental Security Income is a Federal income supplement program funded by general tax revenues (not Social Security taxes) that provides income to aged, blind or disabled individuals with little or no income and resources.

SSI Eligible means an individual who is eligible to receive Supplemental Security Income under Title XVI of the Social Security Act, and may or may not be receiving the monetary payment.

TANF - Temporary Assistance to Needy Families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

Tax Dependent is anyone expected to be claimed as a dependent by a Tax-Filer.

Tax-Filer is an individual, head of household or married couple who is required to and who files a personal income tax return.

Third Party is an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of Medical Assistance.

Title XIX is the portion of the federal Social Security Act which authorizes a joint federal/state Medicaid program. Title XIX contains federal regulations governing the Medicaid program.

TMA - Transitional Medical Assistance is a Medical Assistance category for families that lost Medical Assistance coverage due to increased earned income or loss of earned income disregards.

ULTC 100.2 is an assessment tool used to determine level of functional limitation and eligibility for Long-Term Care services in Colorado.

Unearned Income is the gross amount received in cash or kind that is not earned from employment or self-employment.

VA - Veterans Affairs is The Department of Veterans Affairs which provides patient care and Federal benefits to veterans and their dependents.

8.100.2 Legal Basis

Constitution of Colorado, Article XXIV, Old Age Pensions, section 7, established a health and medical care fund for persons who qualify to receive old age pensions.

Colorado Revised Statutes, Title 25.5, Article 4, Colorado Medical Assistance Act, section 102, provides for a program of Medical Assistance for individuals and families, whose income and resources are insufficient to meet the costs of necessary medical care and services, to be administered in cooperation with the federal government.

The Social Security Act, Title XIX, Grants to States for Medical Assistance Programs, and the consequent Federal regulations, Title 42, CFR (Code of Federal Regulations), Chapter IV, Subchapter C, set forth the conditions for states to obtain Federal Financial Participation in Medical Assistance expenditures.

Under the Colorado Medical Assistance Program, the Medicaid program provides coverage of certain groups specified in Title XIX of the Social Security Act. The OAP State Only Medical Assistance Program provides coverage to certain old age pension clients entitled to health and medical care under the Colorado Constitution.

The Department of Health Care Policy and Financing is the single State agency designated to administer the Colorado Medical Assistance Program under Title XIX of the Social Security Act and Colorado statutes. The Office of Medical Assistance of the Department is delegated the duties and responsibilities for administration of the Colorado Medical Assistance Program.

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.A. Application Requirements

1. The eligibility site shall advise individuals concerning the benefits of the Medical Assistance Program and determine or redetermine eligibility for Medical Assistance in accordance with rules and regulations of the Department. A person who is applying for the Medical Assistance Program or a client who is determined ineligible for the Medical Assistance Program in one category shall be evaluated under all other categories of eligibility. There is no time limit for Medical Assistance coverage as long as the client remains categorically eligible.

2. If the applicant applied for Medical Assistance on the Single Streamlined Application and was found ineligible, this application shall be reviewed for all other Medical Assistance eligibility programs, the Child Health Plan Plus (CHP+) program and premium and cost-sharing assistance for purchasing private health insurance through the state insurance marketplace.

    a. The application data and verifications shall be automatically transferred to the state insurance marketplace through a system interface when applicants are found ineligible for Medical Assistance eligibility programs. If an individual is pending for a Non-MAGI Medical Assistance eligibility program but has been found financially ineligible for MAGI

Medical Assistance eligibility programs, the application data and verifications shall be transferred to the state insurance marketplace.

3. Persons applying for assistance need complete only one application form to apply for both Medical Assistance and Financial Assistance under the Federal or State Financial Assistance Programs administered in the county. The application will be the Application for Public Assistance.

4. If an applicant is found to be ineligible for a particular program, the Application for Public Assistance shall be reviewed and processed for other financial programs the household has requested on the Application for Public Assistance and all other Medical Assistance Programs. Referrals to other community agencies and organizations shall be made for the applicant whenever available or requested.

5. The applicant must sign the application form, give declaration in lieu of a signature by telephone, or may opt to use an electronic signature in order to receive Medical Assistance.

6. A family member, adult in the applicant's Medical Assistance Required Household or authorized representative may submit an application and request assistance on behalf of an applicant.

7. If the applicant is not able to participate in the completion of the application forms because they are a minor (as defined in C.R.S. § 13-22-101) or due to physical or mental incapacity, the spouse, other relative, friend, or representative acting responsibly on behalf of the applicant may complete the forms. When no such person is available to assist in these situations, the eligibility site shall assist the applicant in the completion of the necessary forms. This type of situation should be identified clearly in the case record.

8. For the purpose of Medical Assistance, when an applicant is incompetent or incapacitated and unable to sign an application, or in case of death of the applicant, the application shall be signed, under penalty of perjury, by someone acting responsibly on behalf of the applicant either:

   a. A parent, or other specified relative, or legally appointed guardian or conservator, or

   b. For a person in a medical institution for whom none of the above in 8.a. are available, an authorized official of the institution may sign the application.

9. Application interviews or requested visits to the eligibility site for Medical Assistance shall not be required. All correspondence may occur by mail, email or telephone.

10. During normal business hours, eligibility sites shall not restrict the hours in which applicants may file an application. The eligibility site must afford any individual wishing to do so the opportunity to apply for Medical Assistance without delay.

11. The applicant has the right to withdraw his or her application at any time.

8.100.3.B. Residency Requirements

1. Individuals shall make application in the county in which they live. Individuals who reside in a county but who do not reside in a permanent dwelling nor have a fixed mailing address shall be considered eligible for the Medical Assistance Program, provided all other eligibility requirements are met. In no instance shall there be a durational residency requirement imposed upon the applicant, nor shall there be a requirement for the applicant to reside in a permanent dwelling or have a fixed mailing address. If an individual without a permanent dwelling or fixed mailing address is hospitalized, the county where the hospital is located shall be responsible for processing the application to completion. If the individual moves prior to completion of the

eligibility determination the origination eligibility site completes the determination and transfers the case as applicable.

a. For applicants in Long Term Care institutions - The county of domicile for all Long Term Care clients is the county in which they are physically located and receiving services.

2. A resident of Colorado is defined as a person that is living within the state of Colorado and considers Colorado to be their place of residence at the time of application. For institutionalized individuals who are incapable of indicating intent as to their state of residence, the state of residence shall be where the institution is located unless that state determines that the individual is a resident of another state, by applying the following criteria:

a. for any institutionalized individual who is under age 21 or who is age 21 or older and incapable of indicating intent before age 21, the state of residence is that of the individual's parent(s) or legally appointed guardian at the time of placement;

b. for any institutionalized individual who became incapable of indicating intent at or after age 21, (1) the state of residence is the state in which the person was living when he or she became incapable of indicating intent, or (2) if this cannot be determined, the state of residence is the state in which the person was living when he or she was first determined to be incapable of indicating intent;

c. upon placement in another state, the new state is the state of residence unless the current state of residence is involved in the placement. If a current state arranged for an individual to be placed in an institution located in another state, the current state shall be the individual's state of residence, irrespective of the individual's indicated intent or ability to indicate intent;

d. in the case of conflicting opinions between states, the state of residence is the state where the individual is physically located.

3. For purposes of this section on establishing an individual's state of residence, an individual is considered incapable of indicating intent if:

a. the person has an I.Q. of 49 or less or has a mental age of 7 or less, based on standardized tests as specified in the persons in medical facilities section of this volume;

b. the person is judged legally incompetent; or

c. medical documentation, or other documentation acceptable to the eligibility site, supports a finding that the person is incapable of indicating intent.

4. Residence shall be retained until abandoned. A person temporarily absent from the state, inside or outside the United States, retains Colorado residence. Temporarily absent means that at the time he/she leaves, the person intends to return.

5. A non-resident shall mean a person who considers his/her place of residence to be other than Colorado. Any person who enters the state to receive Medical Assistance or for any other reason is a non-resident, so long as they consider their permanent place of residence to be outside of the state of Colorado.

8.100.3.C. Transferring Requirements

1. When a family or individual moves from one county to another within Colorado, the client shall report the change of address to the eligibility site responsible for the current active Medical

Assistance Program case(s). If a household applies in the county in which they live and then moves out of that county during the application determination process, the originating eligibility site shall complete the processing of that application before transferring the case. The originating eligibility site shall electronically transfer the case to the new county of residence in CBMS.

2. The originating eligibility site must notify the receiving eligibility site of the client's transfer of Medical Assistance. The originating eligibility site may notify the receiving eligibility site by telephone that a client has moved to the receiving county. If the family or individual wishes to apply for other types of assistance, they shall submit a new application to the receiving eligibility site.

3. If the household is transferring the current Medical Assistance case, the receiving eligibility site cannot mandate a new application, verification, or an office visit to authorize the transfer. The receiving eligibility site can request copies of specific case documents to be forwarded from the originating eligibility site to verify the data contained in CBMS.

4. If the originating eligibility site closes a case for the discontinuation reason of “unable to locate,” the applicant shall reapply at the receiving eligibility site for the Medical Assistance Program.

5. If a case is closed for any other discontinuation reason than “unable to locate” and the client provides appropriate information to overturn the discontinuation with the originating eligibility site, then, upon transfer, the receiving eligibility site shall reopen the case with case comments in CBMS. These actions shall be performed according to timeframes defined by the Department.

6. When a recipient moves from his/her home to a nursing facility in another county or when a recipient moves from one nursing facility to another in a different county:

    a. the initiating eligibility site will transfer the case electronically in the eligibility system to the eligibility site in which the nursing facility is located when the individual is determined eligible; and

    b. The following items shall be furnished by the initiating eligibility site to the new eligibility site in hard copy format:

        i) 5615 that was sent to the nursing facility indicating the case transfer; and

        ii) Identification and citizenship documents; and

        iii) The ULTC 100.2.

7. When transferring a case, the initiating eligibility site will send an AP-5615 form to the nursing facility administrator of the new nursing facility showing the date of case closure and the current patient payment at the time of transfer. Should the Medical Assistance Program reimbursement be interrupted, the receiving eligibility site will have the responsibility to process the application and back date the Medical Assistance eligibility date to cover the period of ineligibility.

8.100.3.D. Processing Requirements

1. The eligibility site shall process a Single Streamlined Application for Medical Assistance Program benefits within the following deadlines:

    a. 90 days for persons who apply for the Medical Assistance Program and a disability determination is required.

    b. 45 days for all other Medical Assistance Program applicants.

c. The above deadlines cover the period from the date of receipt of a complete application to the date the eligibility site mails a notice of its decision to the applicant.

d. In unusual circumstances, documented in the case record and in CBMS case comments, the eligibility site may delay its decision on the application beyond the applicable deadline at its discretion. Examples of such unusual circumstances are a delay or failure by the applicant or an examining physician to take a required action such as submitting required documentation, or an administrative or other emergency beyond the agency's control.

e. Due to the Coronavirus COVID-19 Public Health Emergency, required through the Federal CARES Act for the Maintenance of Effort (MOE), the Department will continue eligibility for all Medical Assistance categories, regardless of changes made for a redetermination or additional documentation for current Medicaid enrollees. The Department will allow these individuals to continue eligibility through the period of the COVID-19 pandemic federal emergency declaration. Once the federal emergency declaration has concluded, the Department will process eligibility redeterminations and /or changes for all members whose eligibility was maintained during the emergency declaration.

2. Upon request, applicants will be given an extension of time within the application processing timeframe to submit requested verification. Applicants may request an extension of time beyond the application processing timeframe to obtain necessary verification. The extension may be granted at the eligibility site's discretion. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

3. The eligibility site shall not use the above timeframes as a waiting period before determining eligibility or as a reason for denying eligibility.

4. For clients who apply for the Medical Assistance Program and a disability determination is required, the eligibility site shall send a notice informing the applicant of the reason for a delay beyond the applicable deadline, and of the applicant's right to appeal if dissatisfied with the delay. The eligibility site shall send this notice no later than 91 days following the application for the Medical Assistance Program.

5. For information regarding continuation of benefits during the pendency of an appeal to the Social Security Administration (SSA) based upon termination of disability benefits see section 8.057.5.C.

6. Effective July 1, 1997, as a condition of eligibility for the Medical Assistance Program, any legal immigrant who is applying for or receiving Medical Assistance shall agree in writing that, during the time period the client is receiving Medical Assistance, he or she will not sign an affidavit of support for the purpose of sponsoring an alien who is seeking permission from the United States Immigration and Citizenship Services to enter or remain in the United States. A legal immigrant's eligibility for Medical Assistance shall not be affected by the fact that he or she has signed an affidavit of support for an alien before July 1, 1997.

7. Eligibility sites at which an individual is able to apply for Medical Assistance benefits shall also provide the applicant the opportunity to register to vote.

a. The eligibility site shall provide to the applicant the prescribed voter registration application.

b. The eligibility site shall not:

i) Seek to influence the applicant's political preference or party registration;

ii) Display any political preference or party allegiance;

iii) Make any statement to the applicant or take any action, the purpose or effect of which is to discourage the applicant from registering to vote; and

iv) Make any statement to an applicant which is to lead the applicant to believe that a decision to register or not to register has any bearing on the availability of services or benefits.

c. The eligibility site shall ensure the confidentiality of individuals registering and declining to register to vote.

d. Records concerning registration and declination to register to vote shall be maintained for two years by the eligibility site. These records shall not be part of the public assistance case record.

e. A completed voter registration application shall be transmitted to the county clerk and recorder for the county in which the eligibility site is located not later than ten (10) days after the date of acceptance; except that if a registration application is accepted within five (5) days before the last day for registration to vote in an election, the application shall be transmitted to the county clerk and recorder for the county not later than five (5) days after the date of acceptance.

8. Individuals who transfer from one Colorado county to another shall be provided the same opportunity to register to vote in the new county of residence. The new county of residence shall follow the above procedure. The new county of residence shall notify its county clerk and recorder of the client's change in address within five (5) days of receiving the information from the client.

8.100.3.E. Retroactive Medical Assistance Coverage

1. An applicant for Medical Assistance shall be provided such assistance any time during the three months preceding the date of application, or as of the date the person became eligible for Medical Assistance, whichever is later. That person shall have received medical services at any time during that period and met all applicable eligibility requirements.

2. An explanation of the conditions for retroactive Medical Assistance shall be given to all applicants. Those applicants who within the three months period prior to the date of application or as of the date the person became eligible for Medical Assistance, whichever is later, have received medical services which would be a benefit under the Colorado State Plan, can request retroactive coverage on the application form. The determination of eligibility for retroactive Medical Assistance shall be made as part of the application process. An applicant does not have to be eligible in the month of application to be eligible for retroactive Medical Assistance. The applicant or client may verbally request retroactive coverage at any time following the completion of an application. Verification required to determine Medical Assistance Program eligibility for the retroactive period shall be secured by the eligibility site to determine retroactive eligibility. Proof of the declared medical service shall not be required.

8.100.3.F. Groups Assisted Under the Program

1. The Medical Assistance Program provides benefits to the following persons who meet the federal definition of categorically needy at the time they apply for benefits:

a. Parents and Caretaker Relatives, Pregnant Women, Children, and Adults as defined under the Modified Adjusted Gross Income (MAGI)Medical Assistance section 8.100.4.

b. Persons who meet legal immigrant requirements as outlined in this volume, who were or would have been eligible for SSI but for their alien status, if such persons meet the resource, income and disability requirements for SSI eligibility.

c. Persons who are receiving financial assistance; and who are eligible for a SISC Code of A or B. See section 8.100.3.M for more information on SISC Codes.

d. Persons who are eligible for financial assistance under Old Age Pension (OAP) and SSI, but are not receiving the money payment.

e. Persons who would be eligible for financial assistance from OAP or SSI, except for the receipt of Social Security Cost of Living Adjustment (COLA) increases, or other retirement, survivors, or disability benefit increases to their own or a spouse's income. This group also includes persons who lost OAP or SSI due to the receipt of Social Security Benefits and who would still be eligible for the Medical Assistance Program except for the cost of living adjustments (COLA's) received. These populations are referenced as Pickle and Disabled Widow(er)s.

f. Persons who are blind, disabled, or aged individuals residing in the medical institution or Long Term Care Institution whose income does not exceed 300% of SSI.

g. Persons who are blind, disabled or aged receiving HCBS whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment.

h. A disabled adult child who is at least 18 years of age and who was receiving SSI as a disabled child prior to the age of 22, and for whom SSI was discontinued on or after May 1, 1987, due to having received of OASDI drawn from a parent(s) Social Security Number, and who would continue to be eligible for SSI if the above OASDI and all subsequent cost of living adjustments were disregarded. This population is referenced as Disabled Adult Child (DAC).

i. Children age 18 and under who would otherwise require institutionalization in an Long Term Care Institution, Nursing Facility (NF), or a hospital but for which it is appropriate to provide care outside of an institution as described in 1902(e)(3) of the Act Public Law No. 97-248 (Section 134).

j. Persons receiving OAP-A, OAP-B, and OAP Refugees who do not meet SSI eligibility criteria but do meet the state eligibility criteria for the OAP State Only Medical Assistance Program. These persons qualify for a SISC Code C.

k. Persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but do not meet the criteria of citizenship shall receive Medical Assistance benefits for emergencies only.

l. Persons with a disability or limited disability who are at least 16 but less than 65 years of age, with income less than or equal to 450% of FPL after income disregards, regardless of resources, and who are employed.

m. Children with a disability who are age 18 and under, with household income less than or equal to 300% of FPL after income disregards, regardless of resources.

n. Due to the Coronavirus COVID-19 Public Health Emergency, an applicant who is not eligible for Medical Assistance but has been impacted through exposure to or potential infection of COVID-19 may be eligible to receive services for COVID-19 testing,

treatment, or care for complications related to COVID-19. To qualify for this limited benefit, the applicant must satisfy residency and immigration-or citizenship and not be enrolled in other health insurance.

8.100.3.G. General and Citizenship Eligibility Requirements

1. To be eligible to receive Medical Assistance, an eligible person shall:

a. Be a resident of Colorado;

b. Meet the following requirements while being an inmate, in-patient or resident of a public institution:

i). The following individuals, if eligible, may be enrolled for Medical Assistance

1. Patients in a public medical institution

2. Residents of a Long-Term Care Institution

3. Prior inmates who have been paroled

4. Resident of a publicly operated community residence which serves no more than 16 residents

5. Individuals participating in community corrections programs or residents in community corrections facilities (“halfway houses”) who have freedom of movement and association which includes individuals who:

a) are not precluded from working outside the facility in employment available to individuals who are not under justice system supervision;

b) can use community resources (e.g., libraries, grocery stores, recreation, and education) at will;

c) can seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state; and/or

d) are residing at their home, such as house arrest, or another location

ii). Inmates who are incarcerated in a correctional institution such as a city, county, state or federal prison may be enrolled, if eligible, with benefits limited to an in-patient stay of 24 hours or longer in a medical institution.

c. Not be a patient in an institution for tuberculosis or mental disease, unless the person is under 21 years of age or has attained 65 years of age and is eligible for the Medical Assistance Program and is receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement. See section 8.100.4.H for special provisions extending Medical Assistance coverage for certain patients who attain age 21 while receiving such inpatient psychiatric services;

d. Meet all financial eligibility requirements of the Medical Assistance Program for which application is being made;

e. Meet the definition of disability or blindness, when applicable. Those definitions appear in this volume at 8.100.1 under Definitions;

f. Meet all other requirements of the Medical Assistance Program for which application is being made; and

g. Fall into one of the following categories:

i) Be a citizen or national of the United States, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa or Swain's Island; or

ii) Be a lawfully admitted non-citizen who entered the United States prior to August 22, 1996, or

iii) Be a non-citizen who entered the United States on or after August 22, 1996 and is applying for Medical Assistance benefits to begin no earlier than five years after the non-citizen's date of entry into the United States who falls into one of the following categories:

1) lawfully admitted for permanent residence under the Immigration and Nationality Act (hereafter referred to as the "INA");

2) paroled into the United States for at least one year under 8 U.S.C. § 1182(d)(5); or

3) granted conditional entry under section 203(a)(7) of the INA, as in effect prior to April 1, 1980; or

4) determined by the eligibility site, in accordance with guidelines issued by the U.S. Attorney General, to be a spouse, child, parent of a child, or child of a parent who, in circumstances specifically described in 8 U.S.C. §1641(c), has been battered or subjected to extreme cruelty which necessitates the provision of Medical Assistance (Medicaid); or

iv) Be a non-citizen who arrived in the United States on any date, who falls into one of the following categories:

1) lawfully residing in Colorado and is an honorably discharged military veteran (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or

2) lawfully residing in Colorado and is on active duty (excluding training) in the U.S. Armed Forces (also includes spouse, unremarried surviving spouse and unmarried, dependent children), or

3) granted asylum under section 208 of the INA, or

4) refugee under section 207 of the INA, or

5) deportation withheld under section 243(h) (as in effect prior to September 30, 1996) or section 241(b)(3) (as amended by P.L. 104-208) of the INA, or

6) Cuban or Haitian entrant, as defined in section 501(e) of the Refugee Education Assistance Act of 1980, or

7) an individual who (1) was born in Canada and possesses at least 50 percent American Indian blood, or is a member of an Indian tribe as defined in 25 U.S.C. sec. 5304(e)(2016), or

8) admitted to the U.S. as an Amerasian immigrant pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act of 1988 (as amended by P.L. 100-461), or

9) lawfully admitted permanent resident who is a Hmong or Highland Lao veteran of the Vietnam conflict, or

10) a victim of a severe form of trafficking in persons, as defined in section 103 of the Victims of Trafficking and Violence Protection Act of 2000, Pub. L.106-386, as amended (22 U.S.C. § 7105(b) (2016)), or

11) An alien who arrived in the United States on or after December 26, 2007 who is an Iraqi special immigrant under section 101(a)(27) of the INA, or

12) An alien who arrived in the United States on or after December 26, 2007 who is an Afghan Special Immigrant under section 101(a)(27) of the INA.

v) The statutes listed at sections 8.100.3.G.1.g.iii.1-5 and at 8.100.3.G.1.g.iv.3-11 are incorporated herein by reference. No amendments or later editions are incorporated. These regulations are available for public inspection at the Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Pursuant to C.R.S. 24-4-103(12.5)(b)(2016), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

vi) Be a lawfully admitted non-citizen who is a pregnant women or a child under the age of 19 years in the United States who falls into one of the categories listed in 8.100.3.G.1.g.iii or into one of the following categories listed below. These individuals are exempt from the 5-year waiting period:

1) granted temporary resident status in accordance with 8 U.S.C. 1160 or 1255a,or

2) granted Temporary Protected Status (TPS) in accordance with 8 U.S.C 1254a and pending applicants for TPS granted employment authorization,

3) granted employment authorization under 8 CFR 274a.12(c),or

4) Family Unity beneficiary in accordance with section 301 of Pub. L. 101-649, as amended.

5) Deferred Enforced Departure (DED), pursuant to a decision made by the President,

6) granted Deferred Action status (excluding Deferred Action for Childhood Arrivals (DACA)) as described in the Secretary of Homeland Security's June 15,2012 memorandum,

7) granted an administrative stay of removal under 8 CFR 241.6(2016), or

8) Beneficiary of approved visa petition who has a pending application for adjustment of status.

9) Pending an application for asylum under 8 U.S.C. 1158, or for withholding of removal under 8 U.S.C. 1231, or under the Convention Against Torture who-

a) as been granted employment authorization; or

b) Is under the age of 14 and has had an application pending for at least 180 days.

10) granted withholding of removal under the Convention Against Torture,

11) A child who has a pending application for Special Immigrant Juvenile status under 8 U.S.C. 1101(a)(27)(J), or

12) Citizens of Micronesia, the Marshall Islands, and Palau, or

13) is lawfully present American Samoa under the immigration of laws of American Samoa.

14) A non-citizen in a valid nonimmigrant status, as defined in 8 U.S.C. 1101(a)(15) or under 8 U.S.C. 1101(a)(17), or

15) A non-citizen who has been paroled into the United States for less than one year under 8 U.S.C. § 1182(d)(5), except for an individual paroled for prosecution, for deferred inspection or pending removal proceedings.

vii) Exception: The exception to these requirements is that persons who apply for and meet the criteria for one of the categorical Medical Assistance programs, but who are not citizens, and are not eligible non-citizens, according to the criteria set forth in 8.100.3.G.1.g, shall receive Medical Assistance benefits for emergency medical care only. The rules on confidentiality prevent the Department or eligibility site from reporting to the United States Citizenship and Immigration Services persons who have applied for or are receiving assistance. These persons need not select a primary care physician as they are eligible only for emergency medical services.

For non-qualified aliens receiving Medical Assistance emergency only benefits, the following medical conditions will be covered:

An emergency medical condition (including labor and delivery) which manifests itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

1) placing the patient's health in serious jeopardy;

2) serious impairment of bodily function; or

3) serious dysfunction of any bodily organ or part.

A physician shall make a written statement certifying the presence of an emergency medical condition when services are provided and shall indicate that services were for a medical emergency on the claim form. Coverage is limited to care and services that are necessary to treat immediate emergency medical conditions. Coverage does not include prenatal care or follow-up care.

2. For determinations of eligibility for Medical Assistance, legal immigration status must be verified. This requirement applies to a non-citizen individual who meets the criteria of any category defined at 8.100.3.G(1)(g)(ii) (iii) (iv) or (vi) and has declared that he or she has a legal immigration status.

a. The Verify Lawful Presence (VLP) interface will be used to verify immigration status. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) Program to verify legal immigration status.

i) If an automated response from VLP confirms that the information submitted is consistent with VLP data for immigration status verification requirements, no further action is required for the individual and no additional documentation of immigration status is required.

ii) If the VLP cannot automatically confirm the information submitted, the individual will be contacted with a request for additional documents and/or information needed to verify their legal immigration status through the VLP interface. If a response from the VLP interface confirms that the additional documents and/or information received from the individual verifies their legal immigration status, no further action is required for the individual and no additional documentation of immigration status is required.

3. Reasonable Opportunity Period

a. If the verification through the electronic interface is unsuccessful then the applicant will be provided a reasonable opportunity period, of 90 days, to submit documents indicating a legal immigration status, as listed in 8.100.3.G.1.g. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period.

b If the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

c. The reasonable opportunity period applies to MAGI, Adult and Buy-In Programs.

i) For the purpose of this section only, MAGI Programs for persons covered pursuant to 8.100.4.G or 8.100.4.I. include the following:

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical Assistance	8.100.4.G.3

Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Legal Immigrant Prenatal Medical Assistance	8.100.4.G.6
Transitional Medical Assistance	8.100.4.I.1-5

ii) For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715. include the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.P
Medicaid Buy-In Program for Children with Disabilities	8.100.6.Q
Breast and Cervical Cancer Program (BCCP)	8.715

8.100.3.H. Citizenship and Identity Documentation Requirements

1. For determinations of initial eligibility and redeterminations of eligibility for Medical Assistance made on or after July 1, 2006, citizenship or nationality and identity status must be verified unless such satisfactory documentary evidence has already been provided, as described in 8.100.3.H.4.b. This requirement applies to an individual who declares or who has previously declared that he or she is a citizen or national of the United States.

   a. The following electronic interfaces shall be accepted as proof of citizenship and/or identity as listed and should be used prior to requesting documentary evidence from applicants/clients:

      i) SSA Interface is an acceptable interface to verify citizenship and identity. An automated response from SSA that confirms that the data submitted is consistent with SSA data, including citizenship or nationality, meets citizenship and identity verification requirements. No further action is required for the individual and no additional documentation of either citizenship or identity is required.

ii) Department of Motor Vehicles (DMV) Interface is an acceptable interface to verify identity. An automated response from DMV confirms that the data submitted is consistent with DMV data for identity verification requirements. No further action is required for the individual and no additional documentation of identity is required.

b. This requirement does not apply to the following groups:

i) Individuals who are entitled to or who are enrolled in any part of Medicare.

ii) Individuals who receive Supplemental Security Income (SSI).

iii) Individuals who receive child welfare services under Title IV-B of the Social Security Act on the basis of being a child in foster care.

iv) Individuals who receive adoption or foster care assistance under Title IV-E of the Social Security Act.

v) Individuals who receive Social Security Disability Insurance (SSDI).

vi) Children born to a woman who has applied for, has been determined eligible, and is receiving Medical Assistance on the date of the child's birth, as described in 8.100.4.G.5. This includes instances where the labor and delivery services were provided before the date of application and were covered by the Medical Assistance Program as an emergency service based on retroactive eligibility.

1) A child meeting the criteria described in 8.100.3.H.1.b.vi shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence at any time in the future, regardless of any subsequent changes in the child’s eligibility for Medical Assistance.

2) Special Provisions for Retroactive Reversal of a Previous Denial

a) If a child described at 8.100.3.H.1.b.vi was previously determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial shall be reversed. Eligibility shall be effective retroactively to the date of the child’s birth provided all of the following criteria are met:

(1) The child was determined to be ineligible for Medical Assistance during the period between July 1, 2006 and October 1, 2009 solely for failure to meet the citizenship and identity documentation requirements as they existed during that period;

(2) The child would have been determined to be eligible for Medical Assistance had 8.100.3.H.1.b.vi and/or 8.100.3.H.1.b.vi.2.a been in effect during the period from July 1, 2006 through October 1, 2009; and

(3) The child’s parent, caretaker relative, or legally appointed guardian or conservator requests that the

denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) A child for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.P.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed pursuant to this subsection 1.

c) A child granted retroactive eligibility for Medical Assistance shall be subject to the requirements described at 8.100.4.G.2. for continued eligibility.

vii) Individuals receiving Medical Assistance during a period of presumptive eligibility.

2. Satisfactory documentary evidence of citizenship or nationality includes the following:

a. Stand-alone documents for evidence of citizenship and identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and citizenship:

i) A U.S. passport issued by the U.S. Department of State that:

1) includes the applicant or recipient, and

2) was issued without limitation. A passport issued with a limitation may be used as proof of identity, as outlined in 8.100.3.H.3.

ii) A Certificate of Naturalization (DHS Forms N-550 or N-570) issued by the Department of Homeland Security (DHS) for naturalized citizens.

iii) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) issued by the Department of Homeland Security for individuals who derive citizenship through a parent.

iv) A document issued by a federally recognized Indian tribe, evidencing membership or enrollment in, or affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

1) Special Provisions for Retroactive Reversal of a Previous Denial

a) For a member of a federally recognized Indian tribe who was determined to be ineligible for Medical Assistance solely for failure to meet the citizenship and identity documentation requirements, the denial of eligibility shall be reversed and eligibility shall be effective as of the date on which the individual was determined to be ineligible provided all of the following criteria are met:

(1) The individual was determined to be ineligible for Medical Assistance on or after July 1, 2006 solely on the basis of not meeting the citizenship and identity documentation requirements as they existed during that period;

(2) The individual would have been determined to be eligible for Medical Assistance had 8.100.3.H.2.a.iv) been in effect on or after July 1, 2006; and

(3) The individual or a legally appointed guardian or conservator of the individual requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) A member of a federally recognized Indian tribe for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.P.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed as provided in this subsection 2.

b. Evidence of citizenship. If evidence from the list in 8.100.3.H.2.a. is not provided, an applicant or recipient shall provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship AND satisfactory documentary evidence from the documents listed in section 8.100.3.H. 3. to establish identity. Evidence of citizenship includes:

i) A U.S. public birth certificate.

1) The birth certificate shall show birth in any one of the following:

a) One of the 50 States,

b) The District of Columbia,

c) Puerto Rico (if born on or after January 13, 1941),

d) Guam (if born on or after April 10, 1899),

e) The Virgin Islands of the U.S. (if born on or after January 17, 1917),

f) American Samoa,

g) Swain's Island, or

h) The Northern Mariana Islands (NMI) (if born after November 4, 1986 (NMI local time)).

2) The birth record document shall have been issued by the State, Commonwealth, Territory or local jurisdiction.

3) The birth record document shall have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship, as described in 8.100.3.H.2.d.

ii) A Certification of Report of Birth (DS-1350) issued by the U.S. Department of State to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth.

iii) A Report of Birth Abroad of a U.S. Citizen (Form FS-240) issued by the U.S. Department of State consular office overseas for children under age 18 at the time of issuance. Children born outside the U.S. to U.S. military personnel usually have one of these.

iv) A Certification of birth issued by the U.S. Department of State (Form FS-545 or DS-1350) before November 1,1990.

v) A U.S. Citizen I.D. card issued by the U.S. Immigration and Naturalization Services (INS):

1) Form I-179 issued from 1960 until 1973, or

2) Form I-197 issued from 1973 until April 7, 1983.

vi) A Northern Mariana Identification Card (I-873) issued by INS to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986.

vii) An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code “KIC.”

viii) A final adoption decree that:

1) shows the child's name and U.S. place of birth, or

2) a statement from a State approved adoption agency that shows the child's name and U.S. place of birth. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

ix) Evidence of U.S. Civil Service employment before June 1, 1976. The document shall show employment by the U.S. government before June 1, 1976.

x) U.S. Military Record that shows a U.S. place of birth such as a DD-214 or similar official document showing a U.S. place of birth.

xi) Data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens.

xii) Child Citizenship Act. Adopted or biological children born outside the United States may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any

material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Documentary evidence must be provided at any time on or after February 27, 2001, if the following conditions have been met:

1) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this part);

2) The child is under the age of 18;

3) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;

4) The child was admitted to the United States for lawful permanent residence (as verified through the Systematic Alien Verification for Entitlements (SAVE) Program); and

5) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

xiii) Extract of a hospital record on hospital letterhead.

1) The record shall have been established at the time of the person's birth;

2) The record shall have been created at least 5 years before the initial application date; and

3) The record shall indicate a U.S. place of birth;

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

5) Souvenir “birth certificates” issued by a hospital are not acceptable.

xiv) Life, health, or other insurance record.

1) The record shall show a U.S. place of birth; and

2) The record shall have been created at least 5 years before the initial application date.

3) For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

xv) Religious record.

1) The record shall have been recorded in the U.S. within 3 months of the date of the individual's birth;

2) The record shall show that the birth occurred in the U.S.;

3) The record shall show either the date of birth or the individual's age at the time the record was made; and

4) The record shall be an official record recorded with the religious organization.

xvi) Early school record that meets the following criteria:

1) The school record shows the name of the child;

2) The school record shows the child's date of admission to the school;

3) The school record shows the child's date of birth;

4) The school record shows a U.S. place of birth for the child; and

5) The school record shows the name(s) and place(s) of birth of the applicant's parents.

xvii) Federal or State census record showing U.S. citizenship or a U.S. place of birth and the applicant's age.

xviii) One of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for The Medical Assistance Program. For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

1) Seneca Indian tribal census record;

2) Bureau of Indian Affairs tribal census records of the Navajo Indians;

3) U.S. State Vital Statistics official notification of birth registration;

4) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth;

5) Statement signed by the physician or midwife who was in attendance at the time of birth; or

6) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

xix) Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicate a U.S. place of birth.

xx) Medical (clinic, doctor, or hospital) record.

1) The record shall have been created at least 5 years before the initial application date; and

2) The record shall indicate a U.S. place of birth.

3) An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

xxi) Written affidavit. Affidavits shall only be used in rare circumstances. They may be used by U.S. citizens or nationals born inside or outside the U.S. If documentation is by affidavit, the following rules apply:

1) There shall be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit);

2) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient;

3) In order for the affidavit to be acceptable the persons making them shall provide proof of their own U.S. citizenship and identity.

4) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit shall contain this information as well;

5) The applicant/recipient or other knowledgeable individual (guardian or representative) shall provide a separate affidavit explaining why the evidence does not exist or cannot be obtained; and

6) The affidavits shall be signed under penalty of perjury pursuant to 18 U.S.C. §1641 and Title 18 of the Criminal Code article 8 part 5 and need not be notarized.

c. Evidence of citizenship for collectively naturalized individuals. If a document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. A second document from 8.100.3.H.3. to establish identity shall also be presented.

i) Puerto Rico:

1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; OR

2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on

March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

ii) US Virgin Islands:

1) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; OR

2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; OR

3) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

iii) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time).

4) If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile, and the individual is not a U.S. citizen.

d) Referrals for Colorado Birth Certificates

i) An applicant or client who was born in the State of Colorado who does not possess a Colorado birth certificate shall receive a referral to the Department of Public Health and Environment by the county department to obtain a birth certificate at no charge, pursuant to C.R.S. § 25-2-117(2)(a)(I)(C).

ii) The referral shall be provided on county department letterhead and shall include the following:

1) The name and address of the applicant or client;

2) A statement that the county department requests that the Department of Public Health and Environment waive the birth certificate fee, pursuant to C.R.S. § 25-2-117(2)(a)(I)(C); and

3) The name and contact telephone number for the county caseworker responsible for the referral.

iii) An applicant or client who has been referred to the Department of Public Health and Environment to obtain a birth certificate shall not be required to present a birth certificate to satisfy the citizenship documentation requirement at 8.100.3.H.2. The applicant or client shall have the right to use any of the documents listed under 8.100.3.H.2. to satisfy the citizenship documentation requirement.

3. The following documents shall be accepted as proof of identity and shall accompany a document establishing citizenship from the groups of documentary evidence outlined in 8.100.3.H.2.b. through d.

a) A driver's license issued by a State or Territory either with a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color;

b) School identification card with a photograph of the individual;

c) U.S. military card or draft record;

d) Identification card issued by the Federal, State, or local government with the same information included on driver's licenses;

e) Military dependent's identification card;

f) U.S. Coast Guard Merchant Mariner card;

g) Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document with a photograph or other personal identifying information relating to the individual. The document is acceptable if it carries a photograph of the individual or has other personal identifying information relating to the individual such as age, weight, height, race, sex, and eye color; or

h) Three or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted evidence of citizenship listed under 8.100.3.H.2.b. or 8.100.3.H.2.c. The following requirements must be met:

i) No other evidence of identity is available to the individual;

ii) The documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity; and

iii) All documents used must contain consistent identifying information.

iv) These documents include, but are not limited to, employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees, and property deeds/titles.

i) Special identity rules for children. For children under 16, the following records are acceptable:

i) Clinic, doctor, or hospital records; or

ii) School records.

1) The school record may include nursery or daycare records and report cards; and

2) The school, nursery, or daycare record must be verified with the issuing school, nursery, or daycare.

3) If clinic, doctor, hospital, or school records are not available, an affidavit may be used if it meets the following requirements:

a) It shall be signed under penalty of perjury by a parent or guardian;

b) It shall state the date and place of birth of the child; and

c) It cannot be used if an affidavit for citizenship was provided.

d) The affidavit is not required to be notarized.

e) An affidavit may be accepted on behalf of a child under the age of 18 in instances when school ID cards and drivers' licenses are not available to the individual until that age.

j) Special identity rules for disabled individuals in institutional care facilities.

i) An affidavit may be used for disabled individuals in institutional care facilities if the following requirements are met:

1) It shall be signed under penalty of perjury by a residential care facility director or administrator on behalf of an institutionalized individual in the facility; and

2) No other evidence of identity is available to the individual.

3) The affidavit is not required to be notarized.

k) Expired identity documents.

i) Identity documents do not need to be current to be acceptable. An expired identity document shall be accepted as long as there is no reason to believe that the document does not match the individual.

l) Referrals for Colorado Identification Cards

i) An applicant or client who does not possess a Colorado driver’s license or identification card shall be referred to the Department of Revenue Division of Motor Vehicles by the county department to obtain an identification card at no charge, pursuant to C.R.S. § 42-2-306(1)(a)(II).

ii) The referral shall be provided on county department letterhead and shall include the following:

1) The name and address of the applicant or client;

2) A statement that the county department requests that the Department of Revenue Division of Motor Vehicles waive the identification card fee, pursuant to C.R.S § 42-2-306(1)(a)(II).; and

3) The name and contact telephone number for the county caseworker responsible for the referral.

iii) An applicant or client who has been referred to the Division of Motor Vehicles to obtain an identification card shall not be required to present a Colorado identification card to satisfy the identity documentation requirement at 8.100.3.H.3. The applicant or client shall have the right to use any of the documents listed under 8.100.3.H.3. to satisfy the identity documentation requirement.

4. Documentation Requirements

a. Citizenship and identity documents may be submitted as originals, certified copies, photocopies, facsimiles, scans or other copies.

b. Individuals who submitted notarized copies of citizenship and identity documents as part of an application or redetermination before January 1, 2008 shall not be required to submit originals or copies certified by the issuing agency for any application or redetermination processed on or after January 1, 2008.

c. All citizenship and identity documents shall be presumed to be genuine unless the authenticity of the document is questionable.

d. Individuals shall not be required to submit citizenship and identity documentation in person. Documents shall be accepted from a Medical Assistance applicant or client or from his or her guardian or authorized representative in person or by mail.

i) Individuals are strongly encouraged to use alternatives to mailing original documents to counties, such as those described in 8.100.3.H.4.e.

e. Individuals may present original citizenship and identity documents or copies certified by the issuing agency to Medical Assistance (MA) sites, School-based Medical Assistance sites, Presumptive Eligibility (PE) sites, Federally Qualified Health Centers (FQHCs), Disproportionate Share Hospitals (DSHs), or any other location designated by the Department by published agency letter.

i) Staff at these locations shall make a copy of the original documents and shall complete a “Citizenship and Identity Documentation Received” form, stamp the copy, or provide other verification that identifies that the documents presented were originals. The verification shall include the name, telephone number, organization name and address, and signature of the individual who reviewed the document(s). This form, stamp, or other verification shall be attached to or directly applied to the copy.

ii) Upon request by the client or eligibility site, the copy of the original document with the “Citizenship and Identity Documentation Received” form, stamp, or other verification as described in 8.100.3.H.4.e. i) shall be mailed or delivered directly to the eligibility site within five business days.

f. Counties shall accept photocopies of citizenship and identity documents from any location described in 8.100.3.H.4.e provided the photocopies include the form, stamp, or verification described in 8.100.3.H.4.e.i).

g. Counties shall develop procedures for handling original citizenship and identity documents to ensure that these documents are not lost, damaged, or destroyed.

i) Upon receiving the original documents, eligibility site staff shall make a copy of the original documents and shall complete a “Citizenship and Identity Documentation Received” form, stamp the copy, or provide other verification that identifies that the documents presented were originals, as described in 8.100.3.H.4.e. i). This form, stamp, or other verification shall be attached to or directly applied to the copy.

ii) The original documents shall be sent by mail or returned to the individual in person within five business days of the date on which they were received.

iii) To limit the risk of original documents being lost, damaged, or destroyed, counties are strongly encouraged to make copies of documents immediately upon receipt and to return original documents to the individual while he or she is present.

h. Once an individual has provided the required citizenship and identity documentation, he or she shall not be required to submit the documentation again unless:

i) Later evidence raises a question about the individual's citizenship or identity; or

ii) There is a gap of more than five years between the ending date of the individual's last period of eligibility and a subsequent application for The Medical Assistance Program and the eligibility site has not retained the citizenship and identity documentation the individual previously provided.

5. Record Retention Requirements

a. The eligibility site shall retain a paper or electronically scanned copy of an individual's citizenship and identity documentation, including any verification described in 8.100.3.H.4.e.i), for at least five years from the ending date of the individual's last period of Medical Assistance eligibility.

6. Name Change Provisions

a. An individual who has changed his or her last name for reasons including, but not limited to, marriage, divorce, or court order shall not be required to produce any additional documentation concerning the name change unless:

i) With the exception of the last name, the personal information in the citizenship and identity documentation provided by the individual does not match in every way;

ii) In addition to changing his or her last name, the individual also changed his or her first name and/or middle name; or

iii) There is a reasonable basis for questioning whether the citizenship and identity documents belong to the same individual.

7. Reasonable Level of Assistance

a. The eligibility site shall provide a reasonable level of assistance to applicants and clients in obtaining the required citizenship and identity documentation.

b. Examples of a reasonable level of assistance include, but are not limited to:

i) Providing contact information for the appropriate agencies that issue the required documents;

ii) Explaining the documentation requirements and how the client or applicant may provide the documentation; or

iii) Referring the applicant or client to other agencies or organizations which may be able to provide further assistance.

c. The eligibility site shall not be required to pay for the cost of obtaining required documentation.

8. Individuals Requiring Additional Assistance

a. The eligibility site shall provide additional assistance beyond the level described in 8.100.3.H.7 to applicants and clients in obtaining the required citizenship and identity documentation if the client or applicant:

i) Is unable to comply with the requirements due to physical or mental impairments or homelessness; and

ii) The individual lacks a guardian or representative who can provide assistance.

b. Examples of additional assistance include, but are not limited to:

i) Contacting any known family members who may have the required documentation;

ii) Contacting any known current or past health care providers who may have the required documentation; or

iii) Contacting other social services agencies that are known to have provided assistance to the individual.

c. The eligibility site shall document its efforts to provide additional assistance to the client or applicant. Such documentation shall be subject to the record retention requirements described in 8.100.3.H.5.a.

9. Reasonable Opportunity Period

a. If a Medical Assistance applicant does not have the required documentation, he or she must be given a reasonable opportunity period to provide the required documentation. The reasonable opportunity period will begin as of the date of the Notice of Action. The required documentation must be received within the reasonable opportunity period. If the applicant does not provide the required documentation within the reasonable opportunity period, then the applicant's Medical Assistance benefits shall not be terminated during the

federal Coronavirus COVID-19 Public Health Emergency. Required documentation will be requested during the federal Coronavirus COVID-19 Public Health Emergency. When the federal COVID-19 Public Health Emergency has ended, a reasonable opportunity period will be given to request proper documentation from the member.

i) During the federal Coronavirus COVID-19 Public Health Emergency the Department will continue eligibility for all Medical Assistance categories, regardless of requested documentation and/or reported change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.

b. The reasonable opportunity period is 90 calendar days and applies to MAGI, Adult, and Buy-In Programs:

i) For the purpose of this section only, MAGI Programs for persons covered pursuant to 8.100.4.G or 8.100.4.I, include the following:

Commonly Used Program Name	Rule Citation
Children's Medical Assistance	8.100.4.G.2
Parent and Caretaker Relative Medical Assistance	8.100.4.G.3
Adult Medical Assistance	8.100.4.G.4
Pregnant Women Medical Assistance	8.100.4.G.5
Transitional Medical Assistance	8.100.4.I.1-5

ii) For the purpose of this section only, Adult and Buy-In Programs for persons covered pursuant to 8.100.3.F, 8.100.6.P, 8.100.6.Q, or 8.715 include the following:

Commonly Used Program Name	Rule Citation
Old Age Pension A (OAP-A)	8.100.3.F.1.c
Old Age Pension B (OAP-B)	8.100.3.F.1.c
Qualified Disabled Widow/Widower	8.100.3.F.1.e
Pickle	8.100.3.F.1.e
Long-Term Care	8.100.3.F.1.f-h
Medicaid Buy-In Program for Working Adults with Disabilities	8.100.6.P
Medicaid Buy-In Program for Children	8.100.6.Q

with Disabilities	
Breast and Cervical Cancer Program (BCCP)	8.715

10. Good Faith Effort

a. In some cases, a Medical Assistance client or applicant may not be able to obtain the required documentation within the applicable reasonable opportunity period. If the client or applicant is making a good faith effort to obtain the required documentation, then the reasonable opportunity period should be extended. The amount of time given should be determined on a case-by-case basis and should be based on the amount of time the individual needs to obtain the required documentation.

Examples of good faith effort include, but are not limited to:

i) Providing verbal or written statements describing the individual's effort at obtaining the required documentation;

ii) Providing copies of emails, letters, applications, checks, receipts, or other materials sent or received in connection with a request for documentation; or

iii) Providing verbal or written statements of the individuals' efforts at identifying people who could attest to the individual's citizenship or identity, if citizenship and/or identity are included in missing documentation.

An individual's verbal statement describing his or her efforts at securing the required documentation should be accepted without further verification unless the accuracy or truthfulness of the statement is questionable. The individual's good faith efforts should be documented in the case file and are subject to all record retention requirements.

8.100.3.I. Additional General Eligibility Requirements

1. Each person for whom Medical Assistance is being requested shall furnish a Social Security Number (SSN); or, if one has not been issued or is unknown, shall apply for the number and submit verification of the application, unless an exception below applies. The application for an SSN shall be documented in the case record by the eligibility site. Upon receipt of the assigned SSN, the client shall provide the number to the eligibility site. This requirement does not apply to those individuals who are not requesting Medical Assistance yet appear on the application, nor does it apply to individuals applying for emergency medical services or eligible newborns born to a Medical Assistance eligible mother.

a. An applicant's or client's refusal to furnish or apply for a Social Security Number affects the family's eligibility for assistance as follows:

i) that person cannot be determined eligible for the Medical Assistance Program; and/or

ii) if the person with no SSN or proof of application for SSN is the only dependent child on whose behalf assistance is requested or received, assistance shall be denied or terminated.

b. Exception: An individual who qualifies for any of the following exceptions must not be required to provide an SSN:

i.) The individual is not eligible to receive an SSN; or

ii) The individual does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

iii) The individual refuses to obtain an SSN because of a well-established religious objection.

c. Due to the COVID-19 Public Health Emergency, the Department will accept self-attestations for SSN verification. At the end of the COVID-19 Public Health Emergency, verification for eligibility criteria will be required as specified prior to the public health emergency.

2. A person who is applying for or receiving Medical Assistance shall assign to the State all rights against any other person (including but not limited to the sponsor of an alien) for medical support or payments for medical expenses paid on the applicant's or client's behalf or on the behalf of any other person for whom application is made or assistance is received.

All appropriate clients of the Medical Assistance Program shall have the option to be referred for child support enforcement services using the form as specified by the Department.

3. A person who is applying for or receiving Medical Assistance shall provide information regarding any third party resources available to any member of the assistance unit. Third party resources are any health coverage or insurance other than the Medical Assistance Program. A client's refusal to supply information regarding third party resources may result in loss of Medical Assistance Program eligibility.

4. A person who is eligible for Medical Assistance shall be free to choose any qualified and approved participating institution, agency, or person offering care and services which are benefits of the program unless that person is enrolled in a managed care program operating under Federal waiver authority.

8.100.3.J. Supplemental Security Income (SSI) And Aid To The Needy Disabled (AND) Recipients

1. Persons who may be eligible for benefits under either MAGI Medical Assistance or SSI:

a. shall be advised of the benefits available under each program;

b. may apply for a determination of eligibility under either or both programs;

c. have the option to receive benefits under the program of their choice, but may not receive benefits under both programs at the same time; and

d. may change their selection if their circumstances change or if they decide later that it would be more advantageous to receive benefits from the other program.

2. Any family member who is receiving financial assistance from SSI or OAP-A is not considered a member of the Medical Assistance required household, is not counted as a member of the household, and the individual's income and resources are disregarded in making the determination of need for Medical Assistance.

a. Exception: For MAGI Medical Assistance a family member who is receiving SSI, when appropriate can be counted as a member of the household and their income when appropriate can be considered in making the determination of eligibility for MAGI Medical

Assistance. For treatment of income and household construction for MAGI Medical Assistance cases, see section 8.100.4.

3. An individual receiving Aid to the Needy Disabled (AND) may also receive MAGI Medical Assistance, if the recipient meets the eligibility requirements for MAGI Medical Assistance. For these individuals, eligibility sites shall not include the applicant's AND payment when calculating income to determine the household's financial eligibility for MAGI Medical Assistance.

8.100.3.K. Consideration of Income

1. Income or resources of an alien sponsor or an alien sponsor's spouse shall be countable to the sponsored alien effective December 19, 1997. Forms used prior to December 19, 1997, including but not limited to forms I-134 or I-136 are legally unenforceable affidavits of support. The attribution of the income and resources of the sponsor and the sponsor's spouse to the alien will continue until the alien becomes a U.S. citizen or has worked or can be credited with 40 qualifying quarters of work, provided that an alien crediting the quarters to the applicant/client has not received any public benefit during any creditable quarter for any period after December 31, 1996.

    a. Exception: When the sponsored alien is a pregnant woman or a child the income or resources of an alien sponsor or an alien sponsor's spouse will not be countable to the sponsored alien.

2. Income, in general, is the receipt by an individual of a gain or benefit in cash or in kind during a calendar month. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, interest, etc., that are received by an individual or family.

3. Earned income is payment in cash or in kind for services performed as an employee or from self-employment.

4. Earned in kind income shall be income produced as a result of the performance of services by the applicant/client, for which he/she is compensated in shelter or other items in lieu of wages.

5. Received means "actually" received or legally becomes available, whichever occurs first; the point at which the income first is available to the individual for use. For example, interest income on a savings account is counted when it is credited to the account.

6. All Home Care Allowance (HCA) income paid to a Medical Assistance applicant or member by the HCA recipient to provide home care services is countable earned income.

7. An applicant or member who is a live-In home care provider to a care recipient receiving a Difficulty of Care Payment and who is being determined for a MAGI Medical Assistance program, must meet the following requirements for Difficulty of Care payments to be excluded as countable income:

    a. The care provider receiving payments for personal care or supportive services provided to a care recipient must live full-time in the same home with the care recipient; and

    b. The care recipient must either

        i) receiving personal care or supportive services must be enrolled in Long Term Service Supports (LTSS), with additional services through a Home-Based Services (HCBS) waiver program; or

ii) The care recipient must be enrolled in the Buy-In Program for Working Adults with Disabilities, and receive additional services through the Home and Community Based Services (HCBS) waiver program.

c. Exception: Difficulty of Care Payments are not excluded if the payments are for more than 10 qualified foster individuals under the age of 19 or 5 qualified foster individuals who are over the age of 19

8. Participation in the Workforce Investment Act (WIA) affects eligibility for Medical Assistance as follows:

a. Wages derived from participation in a program carried out under WIA (work experience or on-the-job training) and paid to a caretaker relative is considered countable earned income.

b. Training allowances granted by WIA to a dependent child or a caretaker relative of a dependent child to participate in a training program is exempt.

c. Wages derived from participation in a program carried out the under Workforce Investment Act (WIA) and paid to any dependent child who is applying for or receiving Medical Assistance are exempt in determining eligibility for a period not to exceed six months in each calendar year.

9. An individual involved in a profit-making activity as a sole proprietor, partner in a partnership, independent contractor, or consultant shall be classified as self-employed.

a. To determine the net profit of a self-employed applicant/client deduct the cost of doing business from the gross income. These business expenses include, but are not limited to:

i) the rent of business premises,

ii) wholesale cost of merchandise,

iii) utilities,

iv) taxes,

v) labor, and

vi) upkeep of necessary equipment.

b. The following are not allowed as business expenses:

i) Depreciation of equipment;

1) Exception: For the purpose of calculating MAGI-based income, depreciation of equipment is an allowable business expense if the equipment is not used for capital improvements.

ii) The cost of and payment on the principal of loans for capital asset or durable goods;

iii) Personal expenses such as personal income tax payments, lunches, and transportation to and from work.

c. Appropriate allowances for cost of doing business for Medical Assistance clients who are licensed, certified or approved day care providers are (1) $ 55 for the first child for whom day care is provided, and (2) $ 22 for each additional child. If the client can document a cost of doing business which is greater than the amounts above set forth, the procedure described in A, shall be used.

d. When determining self-employment expenses and distinguishing personal expenses from business expenses it is a requirement to only allow the percentage of the expense that is business related.

10. Self-employment income includes, but is not limited to, the following:

a. Farm income - shall be considered as income in the month it is received. When an individual ceases to farm the land, the self-employment deductions are no longer allowable.

b. Rental income - shall be considered as self-employment income only if the Medical Assistance client actively manages the property at least an average of 20 hours per week.

c. Board (to provide a person with regular meals only) payment shall be considered earned income in the month received to the extent that the board payment exceeds the maximum food stamp allotment for one-person household per boarder and other documentable expenses directly related to the provision of board.

d. Room (to provide a person with lodging only) payments shall be considered earned income in the month received to the extent that the room payment exceeds documentable expenses directly related to the provision of the room.

e. Room and board payments shall be considered earned income in the month received to the extent that the payment for room and board exceeds the food stamp allotment for a one-person household per room and boarder and documentable expenses directly related to the provision of room and board.

11. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment. Unearned income includes, but is not limited to, the following:

a. Pensions and other period payments, such as:

i) Private pensions or disability benefits

1) Exception: Refer to section 8.100.4 for treatment of private disability benefits for MAGI Medical Assistance.

ii) Social Security benefits (Retirement, survivors, and disability)

iii) Workers' Compensation payments

iv) Railroad retirement annuities

v) Unemployment insurance payments

vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME).

vii) Alimony and support payments

viii) Interest, dividends and certain royalties on countable resources

12. For all Medical Assistance categories, the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan (ARP) Act Recovery Rebate, known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.

13. Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra $600.00 a week for qualifying individuals, is exempt as countable unearned income for all Medical Assistance categories.

8.100.3.L Consideration of Resources

Consideration of Resources

1. Resources are counted in determining eligibility for the Aged, Blind and Disabled, and Long-Term Care institutionalized and Home and Community Based Services categories of Medical Assistance. Resources are not counted in determining eligibility for the MAGI Medical Assistance programs, the Medicaid Buy-in Program for Working Adults with Disabilities, or the Medicaid Buy-In Program for Children with Disabilities, See section 8.100.5 for rules regarding consideration of resources.

2. The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and American Rescue Plan (ARP) Act Recovery Rebate known as COVID-19 Economic Stimulus, shall be an exempt resource for the first 12 months following the receipt of the Recovery Rebate, after which the remaining balance will be considered a countable resource for all Medical Assistance categories which include an asset test.

8.100.3.M. Federal Financial Participation (FFP)

1. The state is entitled to claim federal financial participation (FFP) for benefits paid on behalf of groups covered under the Colorado Medical Assistance Program and also for the Medicare supplementary medical insurance benefits (SMIB) premium payments made on behalf of certain groups of categorically needy persons.

2. The SISC codes are as follows:

   a. Code A - for institutionalized persons whose income is under 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; and non-institutionalized persons receiving Home and Community Based Services, whose income does not exceed 300% of the SSI benefit level and who, except for the level of their income, would be eligible for an SSI payment; code A signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments;

   b. Code B - for persons eligible to receive financial assistance under SSI; persons eligible to receive financial assistance under OAP “A” who, except for the level of their income, would be eligible for an SSI payment; persons who are receiving mandatory State supplementary payments; and persons who continue to be eligible for Medical Assistance after disregarding certain Social Security increases; code B signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program and also for SMIB premium payments;

c. Code C - for persons eligible to receive assistance under OAP “A”, OAP “B”, or OAP Refugee Assistance for financial assistance only; who do not receive SSI payment and do not otherwise qualify under SISC code B as described in item B. above; code C signifies that no FFP is available in Medical Assistance program expenditures.

d. Code D1 – for persons eligible to receive assistance under AwDC from program implementation through 12/31/2013; Code D1 signifies 50% FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program.

e. Code E1 - for persons eligible to receive assistance under the Medicaid Buy-In Program for Working Adults with Disabilities and whose annual adjusted gross income, as defined under IRS statute, is less than or equal to 450% of FPL – after SSI earned income deductions; as well as for children eligible to receive assistance under the Medicaid Buy-In Program for Children with Disabilities and whose household income is less than or equal to 300% of FPL after income disregards. Code E1 signifies that FFP is available in expenditures for medical care and services which are benefits of the Medical Assistance program but not for SMIB premium payments.

3. Recipients of financial assistance under State AND, State AB, or OAP “C” are not automatically eligible for Medical Assistance and the SISC code which shall be entered on the eligibility reporting form is C.

8.100.3.N. Confidentiality

1. All information obtained by the eligibility site concerning an applicant for or a recipient of Medical Assistance is confidential information.

2. A signature on the Single Streamlined Application and the Application for Public Assistance allows an eligibility site worker to consult banks, employers, or any other agency or person to obtain information or verification to determine eligibility. The identification of the worker as an eligibility site employee will, in itself, disclose that an application for the Medical Assistance Program has been made by an individual. In this type of contact, as well as other community contacts, the eligibility site should strive to maintain confidentiality. The signature on the Single Streamlined Application and the Application for Public Assistance also provides permission for the release of the client's medical information to be provided by health care providers to the State and its agents for purpose of administration of the Medical Assistance Program.

3. Eligibility site staff may release a client's Medical Assistance state identification number and approval eligibility spans to a Medical Assistance provider for billing purposes.

   Eligibility site staff may inform a Medical Assistance provider that an application has been denied but may not inform them of the reason why.

4. Access to information concerning applicants or recipients must be restricted to persons or agency representatives who are subject to standards of confidentiality that are comparable to those of the State and the eligibility site.

5. The eligibility site must obtain permission from a family, individual, or authorized representative, whenever possible, before responding to a request for information from an outside source, unless the information is to be used to verify income, eligibility and the amount of Medical Assistance payment. This permission must be obtained unless the request is from State authorities, federal authorities, or State contractors acting within the scope of their contract. If, because of an emergency situation, time does not permit obtaining consent before release, the eligibility site must notify the family or individual immediately after supplying the information.

6. The eligibility site policies must apply to all requests for information from outside sources, including government bodies, the courts, or law enforcement officials. If a court issues a subpoena for a case record or for any eligibility site representative to testify concerning an applicant or recipient, the eligibility site must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

7. The following types of information are confidential and shall be safeguarded:

    a. Names and addresses of applicants for and recipients of the Medical Assistance Program;

    b. Medical services provided;

    c. Social and economic conditions or circumstances;

    d. Agency evaluation of personal information;

    e. Medical data, including diagnosis and past history of disease or disability;

    f. All information obtained through the Income and Eligibility Verification System (IEVS), Colorado Department of Labor and Employment, SSA or Internal Revenue Service;

    g. Any information received in connection with identification of legally liable third party resources;

    h. Any information received for verifying income and resources if applicable, or other eligibility and the amount of Medical Assistance payments;

    i. Social Security Numbers.

8. The confidential information listed above may be released to persons outside the eligibility site only as follows:

    a. In response to a valid subpoena or court order;

    b. To State or Federal auditors, investigators or others designated by the Federal or State departments on a need-to-know basis;

    c. To individuals executing Income and Eligibility Verification System;

    d. Child Support enforcement officials;

    e. To a recipient or applicant themselves or their designated representative.

    f. To a Long Term Care institution on the AP-5615 form.

9. The applicant/recipient may give a formal written release for disclosure of information to other agencies, such as hospitals, or the permission may be implied by the action of the other agency in rendering service to the client. Before information is released, the eligibility site should be reasonably certain the confidential nature of information will be preserved, the information will be used only for purposes related to the function of the inquiring agency, and the standards of protection established by the inquiring agency are equal to those established by the State Department. If the standards for protection of information are unknown, a written consent from the recipient shall be obtained.

8.100.3.O. Protection Against Discrimination

1. Eligibility sites are to administer the Medical Assistance Program in such a manner that no person will, on the basis of race, color, sex, age, religion, political belief, national origin, or handicap, be excluded from participation, be denied any aid, care, services, or other benefits of, or be otherwise subjected to discrimination in such program.

2. The eligibility site shall not, directly or through contractual or other arrangements, on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap:

    a. Provide aid, care, services, or other benefits to an individual which is different, or provided in a different manner, from that of others;

    b. Subject an individual to segregation barriers or separate treatment in any manner related to access to or receipt of assistance, care services, or other benefits;

    c. Restrict an individual in any way in the enjoyment or any advantage or privilege enjoyed by others receiving aid, care, services, or other benefits provided under the Medical Assistance Program;

    d. Treat an individual differently from others in determining whether he/she satisfies any eligibility or other requirements or conditions which individuals shall meet in order to receive aid, care, services, or other benefits provided under the Medical Assistance Programs;

    e. Deny an individual an opportunity to participate in programs of assistance through the provision of services or otherwise, or afford him/her an opportunity to do so which is different from that afforded others under the Medical Assistance Program.

3. No distinction on the grounds of race, color, sex, age, religion, political belief, national origin, or handicap is permitted in relation to the use of physical facilities, intake and application procedures, caseload assignments, determination of eligibility, and the amount and type of benefits extended by the eligibility site to Medical Assistance recipients.

4. An individual who believes he/she is being discriminated against may file a complaint with the eligibility site, the Department, or directly with the Federal government. When a complaint is filed with the eligibility site, the county director is responsible for an immediate investigation of the matter and taking necessary corrective action to eliminate any discriminatory activities found. If such activities are not found, the individual is given an explanation. If the person is not satisfied, he/she is requested to direct his/her complaint, in writing, to the State Department, Complaint Section, which will be responsible for further investigation and other necessary action consistent with the provisions of Title VI of the 1963 Civil Rights Act, as amended 42 U.S.C. §2000e et seq. and section 504 of the Rehabilitation Act of 1973, as amended 29 U.S.C. §791.

8.100.3.P. Redetermination of Eligibility

1. A redetermination of eligibility shall mean a case review and necessary verification to determine whether the Medical Assistance Program client continues to be eligible to receive Medical Assistance. Beginning as of the case approval date, a redetermination shall be accomplished each 12 months for Title XIX Medical Assistance only cases. An eligibility site may redetermine eligibility through telephone, mail, or electronic means. The use of telephone or electronic redeterminations should be noted in the case record and in CBMS case comments.

2. The eligibility site shall promptly redetermine eligibility when:

a. it receives and verifies information which indicates a change in a client's circumstances which may affect continued eligibility for Medical Assistance; or

b. it receives direction to do so from the Department.

The eligibility site shall redetermine eligibility according to timelines defined by the Department.

3. A redetermination form is not required to be sent to the client if all current eligibility requirements can be verified by reviewing information from another assistance program, verification system, and/or CBMS. When applicable, the eligibility site shall redetermine eligibility based solely on information already available. If verification or information is available for any of the three months prior to redetermination month, no request shall be made of the client and a notice of the findings of the review will go to the client. If not all verification or information is available, the eligibility site shall only request the additional minimum verification from the client. This procedure is referenced as Ex Parte Review.

4. A redetermination form, approved by the Department, shall be mailed to the person at least 30 days prior to the first of the month in which completion of eligibility redetermination is due. The redetermination form shall be used to inform the client of the redetermination and verification needed, but the form itself cannot be required to be returned. The only verification that can be required at redetermination is the minimum verification needed to complete a redetermination of eligibility.

   The redetermination form shall direct clients to review current information and to take no action if there are no changes to report in the household. Eligibility sites and CBMS shall view the absence of reported changes from the client at this redetermination period as confirmation that there have been no changes in the household. This procedure is referenced as automatic reenrollment.

   The following procedures relate to mail-out redetermination:

   a. A Redetermination Form shall be mailed to the client together with any other forms to be completed;

   b. Required verification shall be returned by the client to the eligibility site no later than ten working days after receipt of request;

   c. When the individual is unable to complete the forms due to physical, mental or emotional disabilities, or other good cause, and has no one to help him/her, the eligibility site shall either assist the client or refer him/her to a legal or other resource. When initial arrangements or a change in arrangements are being made, an extension of up to thirty days shall be allowed. The action of the eligibility site in assistance or referral shall be recorded in the case record and CBMS case comments.

   d. The redetermination form shall require that a recipient and community spouse of a recipient of HCBS, PACE or institutional services disclose a description of any interest the individual or community spouse has in an annuity or similar financial instrument regardless of whether the annuity is irrevocable or treated as an asset. The redetermination form shall include a statement that the Department shall be a remainder beneficiary for any annuity or similar financial instrument purchased on or after February 8, 2006 for the total amount of Medical Assistance provided to the individual.

   e. The eligibility site shall notify in writing the issuer of any annuity or financial instrument that the Department is a preferred remainder beneficiary in the annuity or similar financial instrument for the total amount of Medical Assistance provided to the individual. This

notice shall require the issuer to notify the eligibility site when there is a change in the amount of income or principal that is being withdrawn from the annuity.

5. When the redetermination verification information is received by the eligibility site, it shall be date stamped. Within ten working days, the verification information shall be thoroughly reviewed for completeness, accuracy, and consistency. All factors shall be evaluated as to their effect on eligibility at that time. Verifications shall be documented in the case file and CBMS case comments. The case file shall be used as a checklist in the redetermination process, and shall be used to keep track of matters requiring further action. When additional information is needed:

   a. due to incomplete information, the request form shall be mailed back to the client with a letter specifying the items that require completion;

   b. due to incomplete, inaccurate or inconsistent data, the Medical Assistance client shall be contacted by telephone or in writing so that the worker may secure the proper information according to timelines defined by the Department.

6. Due to the federal Coronavirus COVID-19 Public Health Emergency, the Department will continue eligibility for all Medical Assistance categories, regardless of a redetermination and/or reported change for these individuals to ensure continuity of eligibility for Medical Assistance coverage.

8.100.3.Q. Continuous Eligibility (CE) for Medical Assistance programs

1. Continuous eligibility applies to children under age 19, who through an eligibility determination, reassessment or redetermination, are found eligible for a Medical Assistance program. The continuous eligibility period may last for up to 12 months.

   a. The continuous eligibility period applies without regard to changes in income or other factors that would otherwise cause the child to be ineligible.

      i) A 14-day no fault period shall begin on the date the child is determined eligible for Medical Assistance. During the 14-day period, any changes to income or other factors made to the child's case during the 14-day no fault period may change his or her eligibility for Medical Assistance.

   b. Exception: A child's continuous eligibility period will end effective the earliest possible month if any of the following occur:

      i) Child is deceased

      ii) Becomes an inmate of a public institution

      iii) The child is no longer part of the Medical Assistance required household

      iv) Is no longer a Colorado resident

      v) Is unable to be located based on evidence or reasonable assumption

      vi) Requests to be withdrawn from continuous eligibility

      vii) Fails to provide documentation during a reasonable opportunity period as specified in section 8.100.3.H.9

      viii) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an

electronic data source, by the end of the 90-day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

2. The continuous eligibility period will begin on the first day of the month the application is received or from the date all criteria is met. Continuous eligibility is applicable to children enrolled in the following Medical Assistance programs:

   a. MAGI-Medical Assistance, program as specified in section 8.100.4.G.2

   b. SSI Mandatory, as specified in section 8.100.6.C

      i.) When a child is no longer eligible for SSI Mandatory they will be categorized as eligible within the MAGI-Child category for the remainder of the eligibility period.

   c. Long- Term Care services

      i.) When a child is no longer eligible for Long-Term Care services they will be categorized as eligible within the MAGI- Child category for the remainder of the eligibility period.

   d. Medicaid Buy-In program specified in section 8.100.6.Q

      i) Exception: Enrollment will be discontinued if there is a failure to pay premiums

   e. Pickle

   f. Disabled Adult Child DAC)

3. Children, under the age of 19, no longer enrolled in Foster Care Medicaid will be eligible for the MAGI-Medical Assistance program. The continuous eligibility period will begin the month the child is no longer enrolled in Foster Care Medicaid as long as they meet one of the following conditions:

   a. Begin living with other Relatives

   b. Are reunited with Parents

   c. Have received guardianship

8.100.4 MAGI Medical Assistance Eligibility [Eff. 01/01/2014]

8.100.4.A. MAGI Application Requirements

1. Persons requesting a MAGI Medical Assistance category need only to complete the Single Streamlined Application.

2. Parents and Caretaker Relatives, Pregnant Women, Children, and Adults may apply for Medical Assistance at sites other than the County Department of Social Services, including eligibility sites and Certified Application Assistance Sites (CAAS). The Department shall approve these sites to receive and initially process these applications. The application used shall be the Single Streamlined Application. The eligibility site shall determine eligibility.

3. The eligibility sites shall refer Medical Assistance clients who are pregnant and/or age 20 and under to EPSDT offices (designated by the Department) by:

a. Copying the page of the Single Streamlined Application that includes the EPSDT benefit questions. The eligibility site will then forward this page to the EPSDT office within five working days from the date of application approval; or by:

b. Means of secure, electronic data transfer approved by the Department

8.100.4.B. MAGI Category Verification Requirements

1. Minimal Verification – At minimum, applicants seeking Medical Assistance shall provide all of the following:

a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

i) Due to the COVID-19 Public Health Emergency, at the time of application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the federally declared COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.

1)Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet federal and state citizenship and immigration status requirements, are only eligible to receive emergency medical services.

b. Verification of citizenship and identity as outlined in section 8.100.3.H under Citizenship and Identity Documentation Requirements.

c. Earned Income: Income shall be self-attested by an applicant and verified through an electronic data source. Individuals who provide self-attestation of income must also provide a Social Security Number for wage verification purposes.

If earned income is not or cannot be self-attested, it shall be verified by wage stubs, tax documents, written documentation from the employer stating the employee's gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

Estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify that the individual's income has changed for all Medical Assistance programs in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded.

d. Unearned income: Unearned income can be self-attested by an applicant. Certain types of unearned income, such as unemployment and survivor benefits may be verified through electronic data sources. Due to the Coronavirus COVID -19 Public Health Emergency, the Department will not take action on any electronic interfaces that notify that the individual's income has changed for all Medical Assistance programs in which the individual is currently enrolled. The Department will take action and require documentation from the individual once the federal emergency declaration has concluded, for all people whose eligibility was maintained during the emergency declaration, for these individuals to maintain eligibility.

e. Verification of Legal Immigrant Status: Immigration status can be self-declared by an applicant applying for Medical Assistance, to determine eligibility for full Medical Assistance benefits. This declaration of legal immigration status will be verified through the Verify Lawful Presence (VLP) interface. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) program to verify legal immigration status. See section 8.100.3.G for a description of the VLP interface. If status cannot be verified, or if the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

2. Additional Verification: No other verification shall be required of the client unless information is found to be questionable on the basis of fact.

3. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

4. Information that exists in another case record or in CBMS shall be used by the eligibility site to verify those factors that are not subject to change, if the information is reasonably accessible.

5. The criteria of age and relationship can be declared by the client unless questionable. If questionable, these criteria can be established with information provided from:

   a. official papers such as: a birth certificate, order of adoption, marriage license, immigration or naturalization papers; or

   b. records or statements from sources such as: a court, school, government agency, hospital, or physician.

6. Establishing that a dependent child meets the eligibility criteria of:

   a. age, if questionable requires (1) viewing the birth certificate or comparably reliable document at eligibility site discretion, and (2) documenting the source of verification in the case file and CBMS case comments;

   b. living in the home of the caretaker relative, if questionable requires (1) viewing the appropriate documents which identify the relationship, (2) documenting these sources of verification in the case file and CBMS case comments.

8.100.4.C. MAGI Methodology for Income Calculation

1. For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated by reference. The incorporation of 26 U.S.C. § 61 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant

Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request. Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all income from all derived sources, The Modified Adjusted Gross Income calculation for the purposes of determining a household's financial eligibility for Medical Assistance shall consist of, but is not limited to, the following:

a. Earned Income:

   i) Wages, salaries, tips;

   ii) Gross income derived from business;

   iii) Gains derived from dealings in property;

   iv) Distributive share of partnership gross income (not a limited partner);

   v) Compensation for services, including fees, commissions, fringe benefits and similar items; and

   vi) Taxable private disability income.

b. Unearned Income:

   i) Interest (includes tax exempt interest);

   ii) Rents;

   iii) Royalties;

   iv) Dividends;

   v) Alimony received counts as unearned income if the divorce or legal separation is executed on or before December 31, 2018. Alimony received will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019;

   vi) Pensions and annuities;

   vii) Income from life insurance and endowment contracts;

   viii) Income from discharge of indebtedness;

   ix) Income in respect of a decedent;

   x) Income from an interest in an estate or trust;

   xi) Social Security (SSA) income; and

   xii) Distributive share of partnership gross income (limited partner).

c. Additional Income: In addition to the types of income identified in section 8.100.4.C.1.a-b., the following income is included in the MAGI calculation.

   i) Any tax exempt interest income.

ii) Untaxed foreign wages and salaries.

iii) Social Security Title II Benefits (Old Age, Disability and Survivor's benefits).

d. The following are Income exclusions:

i) An amount received as a lump sum is counted as income only in the month received;

ii) Scholarships, awards, or fellowship grants used for educational purposes and not for living expenses;

iii) Child support received;

iv) Worker's Compensation;

v) Supplemental Security Income (SSI);

vi) Veteran's Benefits;

vii) The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act and the American Rescue Plan (ARP) Act Recovery Rebate, also known as the COVID-19 Economic Stimulus, shall be exempt from consideration as income.

viii) Federal Pandemic Unemployment Compensation (FPUC) program, which provides an extra $600.00 a week for qualified individuals, is exempt as countable unearned income.

ix) American Indian/Alaskan Native income exceptions listed at 42 C.F.R. § 435.603(e) (2012) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 435.603(e) (2012) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

e. Allowable Deductions: For an in-depth treatment of allowable deductions from gross income, please refer to 26 U.S.C. 62, which is hereby incorporated by reference. The incorporation of 26 U.S.C. 62 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

The following deductions can be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income (AGI) including (but not limited to):

i) Student loan interest deductions;

ii) Certain Self- employment expenses SEP, SIMPLE and qualified plans, and health insurance deductions;

iii) Deductible part of self-employment tax;

iv) Health savings account deduction;

v) Certain business expenses of reservists, performing artist, and fee-basis government officials;

vi) Reimbursed expenses of employees;

vii) Moving expenses for active duty military who are moving due to a permanent change of station;

viii) IRA deduction: Regular Individual Retirement Account (IRA) contributions claimed on a federal income tax return and which does not exceed the IRA contributions limits;

ix) Penalty on early withdrawal of savings;

x) Domestic production activities deduction;

xi) Alimony paid can be deducted only if the divorce or legal separation is executed on or before December 31, 2018. It cannot be deducted if the divorce or separation is modified or executed on or after January 1, 20019. ;

xii) Certain educator expenses; and

xiii) Certain pre-tax contributions.

f. Income of children and tax dependents:

i) The income of a child who is included in the household of their natural, adopted, or step parent will not be included in the household income unless that child has income above the tax filing threshold..

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a child is required to file taxes.

ii) The income of a person, other than a child or spouse, who expects to be claimed as a tax dependent will not be included in the household income of the taxpayer unless that tax dependent has income above the tax filing threshold.

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a tax dependent is required to file taxes.

ii) The income of a child or tax dependent who does not live with their natural, adopted, or step parent will always count towards the determination of their own eligibility, even if the child's or tax dependent's income is below the tax filing threshold.

2. Income verifications: When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see section 8.100.3.H.9.

a. Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 20%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall continue to be determined eligible during the federal Coronavirus COVID-19 Public Health Emergency.

b. If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy shall be requested during the federal Coronavirus COVID-19 Public Health Emergency. If the applicant does not provide the required documentation within the reasonable opportunity period, then the applicant's Medical Assistance benefits shall not be terminated during the federal Coronavirus COVID-19 Public Health Emergency. When the federal COVID-19 Public Health Emergency has ended, a reasonable opportunity period will be given to request proper documentation from the member.

i) During the federal Coronavirus COVID-19 Public Health Emergency the Department may request paper documentation when the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period.

3. Self-Employment – If the applicant is self-employed the ledger included in the Single Streamlined Application shall be sufficient verification of earnings, unless questionable.

4. Budget Periods for MAGI-based Income determination – The financial eligibility of applicants for Medical Assistance shall be determined based on current or previous monthly household income and family size.

a. Applicants who are found financially ineligible based on current or previous monthly household income and family size, and whose household has earned income from self-employment, seasonal employment, and/or commission-based employment, shall have their financial eligibility determined using annualized self-employment, seasonal employment, and commission-based employment income.

5. If an applicant does not meet the financial eligibility requirements for Medical Assistance based on MAGI, but meets all other eligibility requirements, the applicant shall be found eligible for MAGI Medical Assistance if the applicant’s income, as calculated using the methodology for determining eligibility for Advanced Premium Tax Credits or Cost Sharing Reductions through the marketplace, is below 100% of the federal poverty level.

8.100.4.D. Income Disregard

1. An income disregard equivalent to five percentage points of the Federal Poverty Level for the applicable family size will be subtracted from MAGI-based income.

    a. If an individual's MAGI-based countable income is above the income threshold for the applicable MAGI program under title XIX (Medicaid) or title XXI (CHP+) of the Social Security Act, the five percent (5%) disregard will be applied for each qualifying MAGI program as the last step to determine eligibility.

    b. If the countable income is below the income threshold for the applicable MAGI program, the individual is income eligible and the five percent (5%) disregard will not be applied to determine eligibility.

8.100.4.E. Determining MAGI Household Composition.

1. MAGI household composition is similar to, but not necessarily the same as a tax household. To determine MAGI household composition, the individual's relationship to the tax filer must be established as declared on the Single Streamlined Application.

    a. In the case of an applicant who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and does not expect to be claimed as a tax dependent by anyone else, then the applicant's MAGI household shall consist of the following:

        i) The Tax-Filer;

        ii) The Tax-Filer's spouse if living in the home;

        iii) All persons whom the Tax-Filer expects to claim as a tax dependent on their personal income tax return

    b. In the case of an applicant who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the applicant's MAGI household shall be:

        i) The Tax Dependent;

        ii) The Tax-Filer and their spouse if living in the home;

        iii) The Tax-Filer's other tax dependents;

        iv) The Tax Dependent's spouse, if living with the Tax Dependent.

    c. The MAGI household of an applicant who expects to be claimed as a tax dependent is as outlined in 8.100.4.E.b above, except in the following circumstances:

        i) The applicant expects to be claimed as a tax dependent by someone other than a spouse, biological, adoptive or step parent.

        ii) The applicant is a child under 19 who is expected to be claimed by one parent as a tax dependent and is living with both parents, but the parents do not expect to file a joint tax return.

iii) The applicant is a child under 19 and who expects to be claimed as a tax dependent by anon-custodial parent.

d. If the applicant meets one of the exceptions in 8.100.4.E.c above or is a non-filer, household composition shall be determined using the following non-filer rules and the applicant's household shall consist of the following:

i) The applicant;

ii) The applicant's spouse who lives in the household;

iii) The applicant's natural, adopted, and step children under the age of 19, who live in the household; and

iv) In the case of applicants under the age of 19, the applicant's natural, adoptive, and step parents and natural, adoptive, and step siblings under age 19, who live in the household.

2. When a household includes a pregnant woman, regardless of the Medical Assistance category, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

3. Married couples living together will each be included in the other's MAGI household regardless of whether or not they expect to file taxes jointly, separately or if one expects to be claimed as a tax dependent of the other.

4. If a child is claimed as a tax dependent by both parents who are married and who will file taxes jointly but one parent lives outside of the household due to separation or pending divorce, the child's household composition is determined by non-filer rules. The parent living outside of the household will not be counted as part of the household.

5. An individual who is both a tax dependent and a tax filer will be considered a tax dependent for the purpose of determining eligibility for Medical Assistance.

8.100.4.F. MAGI Category Presumptive Eligibility

1. A pregnant applicant may apply for presumptive eligibility for ambulatory services through Medical Assistance presumptive eligibility sites. A child under the age of 19may apply or have an adult apply on their behalf for presumptive eligibility for State Plan approved medical services through presumptive eligibility sites.

2. To be eligible for presumptive eligibility:

a. a pregnant woman shall have an attested pregnancy, declare that her household's income shall not exceed 185% of the federal poverty level (MAGI-equivalent) and declare that she is a United States citizen or a documented immigrant. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website

b. a child under the age of 19 shall have a declared household income that does not exceed 133% of federal poverty level (MAGI-equivalent) and declare that the child is a United States citizen or a documented immigrant.

3. Presumptive eligibility sites shall be certified by the Department to make presumptive eligibility determinations. Sites shall be re-certified by the Department every 2 years to remain approved presumptive eligibility sites.

4. The presumptive eligibility site shall forward the application to the county within five business days.

5. The presumptive eligibility period begins on the date the applicant is determined eligible and ends with the earlier of:

    a. The day an eligibility determination for Medical Assistance is made for the applicant(s); or

    b. The last day of the month following the month in which a determination for presumptive eligibility was made.

6. A presumptive eligible client may not appeal the end of a presumptive eligibility period.

7. Presumptively eligible women and Medical Assistance clients may appeal the county department's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in the State Hearings section of this volume.

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Refer to the MAGI-Medicaid income guidelines chart available on the Department’s website.

    a. Children are eligible for Children’s MAGI Medical Assistance through the end of the month in which they turn 19 years old. After turning 19, the individual may be eligible for a different Medical Assistance category.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 60% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household.

    a. A dependent child is considered to be living in the home of the parent or caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child even if:

        i) The child is under the jurisdiction of the court (for example, receiving probation services);

        ii) Legal custody is held by an agency that does not have physical possession of the child;

        iii) The child is in regular attendance at a school away from home;

        iv) Either the child or the relative is away from the home to receive medical treatment;

        v) Either the child or the relative is temporarily absent from the home;

vi) The child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court ordered, the child is no longer considered to be living in the home as of the time the foster care plan is changed.

4. Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.

   a. A dependent child living in the household of a parent or caretaker relative shall have minimum essential coverage, in order for the parent or caretaker relative to be eligible for Medical Assistance under this category. Refer to section 8.100.4.G.3.a on who is considered a dependent child.

   b. Due to the COVID-19 Public Health Emergency an applicant who is not eligible for Medical Assistance but has been impacted through exposure to or potential infection with COVID-19 may be eligible to receive services for COVID-19 testing only. To qualify for this limited benefit, the applicant must satisfy residency and immigration or citizenship status and not be enrolled in other health insurance.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level (MAGI-equivalent) are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage will be provided regardless of changes in the woman's financial circumstances once the income verification requirements are met.

   a. A pregnant women’s eligibility period will end effective the earliest possible month, if the following occurs:

      i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90 day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

6. A lawfully admitted non-citizen who is pregnant and who has been in the United States for less than five years is eligible for Medical Assistance if she meets all of the other eligibility requirements specified at 8.100.4.G.5 and fits into one of the immigration categories listed in 8.100.3.G.1.g.iii.1-5 and 8.100.3.G.1.g.vi.1-15. This population is referenced as Legal Immigrant Prenatal.

7. A child whose mother is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as “Eligible Needy Newborn”. This coverage also applies in instances where the mother received Medical Assistance to cover the child’s birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.

   a. To receive Medical Assistance under this category, the birth must be reported verbally or in writing to the County Department of Human Services or eligibility site. Information provided shall include the baby’s name, date of birth, and mother’s name or Medical Assistance number. A newborn can be reported at any time by any person. Once

reported, a newborn meeting the above criteria shall be added to the mother's Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn's agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn

8.100.4.H. Needy Persons

1. Medical Assistance shall be provided to certain needy persons under 21 years of age, including the following:

    a. Those receiving care in a Long Term Care Institution eligible for Medical Assistance reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement and whose household income is less than the MAGI needs standard for his/her family size when the client applies for assistance. Clients that are receiving benefits under this category and are still receiving active inpatient treatment in the facility at age 21 shall be eligible to age 22. This population is referenced as Psych <21.

    b. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. A child shall be the responsibility of the county, even if the child may be in a medical institution at that time. See Colorado Department of Human Services "Social Services Staff Manual" section 7 for specific eligibility requirements (12 CCR § 2509-1). 12 CCR § 2509-1 (2013) is hereby incorporated by reference. The incorporation of 12 CCR § 2509-1 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

    c. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.

    d. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose household income is less than the MAGI needs standard for his/her family size.

    e. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.

    f. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption program, including a clause in the subsidized adoption agreement to provide Medical Assistance for the child.

    g. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments from the State of Colorado pursuant to article 7 of title 26, C.R.S. immediately prior to the

date the individual attained 18 years of age or was emancipated. Eligibility shall be extended until the individual's 21st birthday for these individuals with the exception of those receiving subsidized adoption payments.

2. Medical Assistance shall be extended to certain needy persons until the end of the month of the individual's 26th birthday, including the following:

   a. Those individuals that were formerly in foster care under the responsibility of the State or Tribe on their 18th, 19th, 20th or up to their 21st birthday and were receiving Medical Assistance.

      i) This extension does not apply to youth that are receiving subsidized adoption payments or

      ii) To youth that are enrolled in mandatory Medical Assistance.

   b) Former Foster Care youth are not subject to either an income or resource test.

   c) Former Foster Care youth's newborn shall be considered a needy newborn.

8.100.4.I. Transitional Medical Assistance and 4 Month Extended Medical Assistance

1. Eligibility for Transitional Medical Assistance shall be granted for twelve months (beginning with the first month of ineligibility) to individuals who are no longer eligible for the Parent/Caretaker Relative category due to a change in income.

   The extension shall be applied to individuals who:

   a. Were eligible for the Parent/Caretaker Relative category in at least three of the six months preceding the month in which the individual would have become ineligible, and

   b. Are no longer eligible for coverage under the Parent/Caretaker Relative category because of new or increased income from employment or hours of employment

      i) At least one Parent/Caretaker Relative must continue to be employed and cannot terminate employment without good cause. This does not need to be the same person for the whole period the family is receiving Transitional Medical Assistance.

2. Any dependent child or Parent/Caretaker Relative who was or becomes part of the Medical Assistance household after the individual has begun receiving Transitional Medical Assistance is eligible for the remaining months of Transitional Medical Assistance.

   a. A dependent child in the household who received Medical Assistance through continuous eligibility, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance.

   b. An individual in the household who received Medical Assistance, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance

3. To become or remain eligible for Transitional Medical Assistance:

a. The household must include a dependent child. If it is determined that the household no longer has a child living in the home, Transitional Medicaid Assistance shall discontinue at the end of the month in which the household does not include a dependent child.

b. If health insurance is available from the employer to the employee, at no cost to the Medical Assistance recipient, the client shall enroll in the insurance program.

4. When Transitional Medical Assistance ends the case will be reassessed for all other categories of Medical Assistance for which the family members may be eligible. A new application shall not be required for this process.

5. Eligibility for Medical Assistance shall be extended for four months (beginning with the first month of ineligibility) for certain families who become ineligible for Medical Assistance due solely or partially to the receipt of support income, such as alimony. The extension shall be applied for a family which receives assistance under Medical Assistance in at least three of the six months immediately preceding the month in which the family becomes ineligible for assistance. To be eligible for the four month Medical Assistance extension, the family shall meet all other eligibility criteria for Medical Assistance before the alimony income is applied.

a. Alimony received will be countable income only if the divorce or legal separation is executed on or before December 31, 2018. Alimony will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019.

8.100.4.J. Express Lane Eligibility

Express Lane Eligibility shall allow for automatic initiation of Medical Assistance enrollment by using available data and findings from other programs as listed below.

1. Free/Reduced Lunch Program

a. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced Lunch application at a participating school district-

i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

ii) Children who meet all necessary eligibility requirements as outlined in this volume shall be automatically enrolled.

iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity shall receive 90days of eligibility while awaiting this verification.

iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.

v) Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in this volume.

vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child’s eligibility will be evaluated using the Single Streamlined Application for Medical Assistance.

b. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district-

i) Families who are automatically enrolled Free/Reduced Lunch recipient children shall not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.

ii) These families must apply for Medical Assistance in order to give consent for request of benefits.

2. Direct Certification

a. Individuals who have submitted a Food Assistance or Colorado Works application

i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

ii) Children who meet all necessary eligibility requirements as outlined throughout 8.100.4 shall be automatically enrolled

iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 90 days of eligibility while awaiting this verification.

iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.

v) Eligibility is based on income declared on the Food Assistance or Colorado Works application as well as eligibility requirements outlined throughout this volume.

vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility shall be evaluated using the Single Streamlined Application for Medical Assistance.

vii) Individuals whose eligibility is not determined through Express Lane Eligibility can also submit a separate Single Streamlined Application for Medical Assistance to determine eligibility.

8.100.5. Aged, Blind, and Disabled, Long Term Care, and Medicare Savings Plan Medical Assistance General Eligibility

8.100.5.A. Application Requirements

1. When an individual applies for Medical Assistance on the basis of disability or blindness, the eligibility sites shall take the application and determine whether the individual is eligible for Long Term Care or any of the Aged, Blind, and Disabled categories of assistance described in section 8.100.6. If the applicant does not qualify for Medical Assistance on one of those bases, he/she shall be referred to the local Social Security office to apply for SSI.

a. Applicants who apply for Long-Term Care Medical Assistance on the basis of disability or blindness, or who apply for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities without a current disability determination, shall complete a Medical Assistance disability determination application in addition to the required Single Streamlined Application. The disability determination application is not required for individuals that have already been determined disabled by the Social Security Administration.

b. The Medical Assistance disability determination application shall be collected by a designated eligibility site representative and shall be forwarded to the state disability determination contractor upon completion. The state disability determination contractor shall conduct a client disability determination and shall forward the determination to the designated eligibility site representative.

c. For the Medicaid Buy-In Program for Working Adults with Disabilities, if an individual does not meet the Social Security Administration definition of disability, the state disability determination contractor can review the individual's circumstances to determine if the individual meets limited disability.

d. Due to the Coronavirus COVID-19 Public Health Emergency, if a person's existing disability determination has expired, the person shall remain enrolled in Medical Assistance until the emergency has ended and the state has processed the verification of eligibility, unless the individual requests a voluntary termination of eligibility.

2. Persons requesting Aged, Blind, and Disabled Medical Assistance need only to complete the Single Streamlined Application.

8.100.5.B. Verification Requirements

1. The particular circumstances of an applicant will dictate the appropriate documentation needed for a complete application. The following items shall be verified for individuals applying for Medical Assistance:

a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

i) Due to the Coronavirus COVID-19 Public Health Emergency, at application, self-attestation is acceptable for SSN criteria, with the exception of verification of citizenship and immigration status. At the end of the COVID-19 Public Health Emergency, verification for SSN eligibility criteria will be required.

1) Applicants who meet the criteria for any categorical Medical Assistance programs, but do not meet the federal and state criteria of citizenship and immigration status are only eligible to receive emergency medical services.

b. Verification of citizenship and identity as outlined in the section 8.100.3.H under Citizenship and Identity Documentation Requirements.

c. Earned income may be self-declared by an individual and verified by the Income and Eligibility Verification System (IEVS). Individuals who provide self-declaration of earned income must also provide a Social Security Number for wage verification purposes. If a discrepancy occurs between self-declared income and IEVS wage data reports, IEVS wage data will be used to determine eligibility. An individual may dispute IEVS wage data by submitting all wage verification for all months in which there is a wage discrepancy.

When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see section 8.100.3.H.9.

Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 20%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall continue to be determined eligible during the federal Coronavirus COVID-19 Public Health Emergency.

If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy will not be requested during the federal COVID-19 Public Health Emergency. If the applicant does not provide the required documentation within the reasonable opportunity period, then the applicant's Medical Assistance benefits shall not be terminated during the federal Coronavirus COVID-19 Public Health Emergency. When the federal Public Health Emergency has ended, a reasonable opportunity period will be given to request proper documentation from the member.

iv) During the federal Coronavirus COVID-19 Public Health Emergency the Department may request paper documentation when the Department does not find income to be reasonably compatible. If the member does or does not provide paper documentation they will remain eligible during the public health emergency period.

If the applicant is self-employed, ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable. The ledger included in the Medical Assistance application is sufficient verification of earnings, unless questionable. If an individual cannot provide verification through self-declaration, income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

As of CBMS implementation, estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call shall also be acceptable verification of earned income. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

v) During the federal COVID-19 Public Health Emergency, all earned income and self-employment may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified income shall be provided.

d. Verification of all unearned income shall be provided if the unearned income was received in the month for which eligibility is being determined or during the previous month. If available, information that exists in another case record or verification system shall be used to verify unearned income.

i) During the federal COVID-19 Public Health Emergency, all unearned income may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified income shall be provided.

e. Verification of all resources shall be provided if the resources were available to the applicant in the month for which eligibility is being determined.

Resource information that is verified through an electronic data source, such as the Asset Verification Program, shall be a valid verification. Supplemental physical verifications for the same resource is not required unless further information is needed for clarification.

i) During the federal COVID-19 Public Health Emergency, all resources may be reported by self-attestation. At the end of the federal COVID-19 Public Health Emergency, proof of any unverified resources shall be provided.

f. Immigrant registration cards or papers, if applicable, to determine if the client is eligible for full Medical Assistance benefits. If an applicant does not provide this, he/she shall only be eligible for emergency Medical Assistance if they meet all other eligibility requirements.

g. Additional verification-If the requested verification is submitted by the applicant, no other additional verification shall be required unless the submitted verification is found to be questionable on the basis of fact.

h. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

8.100.5.C. Effective Date of Eligibility

1. Eligibility for the Aged, Blind and Disabled categories shall be approved effective on the later of:

a. The first day of the month of the Single Streamlined Application for Medical Assistance; or

b. The first day of the month the person becomes eligible for Medical Assistance.

2. The date that eligibility begins for Long-Term Care Medical Assistance is defined in section 8.100.7.A and B.

3. For the Medicaid Buy-In Program for Children with Disabilities, any child who is determined to be eligible for Medical Assistance at any time during a calendar month shall be eligible for benefits during the entire month.

4. Clients applying for Medical Assistance under the Aged, Blind and Disabled category shall be reviewed for retroactive eligibility as described at 8.100.3.E. When reviewing for retroactive

eligibility for an individual who is SSI eligible or applied and became SSI eligible in each of the retroactive months, the applicant must:

a. Be aged at least 65 years; or

b. Meet the Social Security Administration definition of disability by:

i) Being approved as eligible to receive either SSI or SSDI, on or prior to the date of a medical service; or

ii) Having a disability onset date determined on or prior to the date of a medical service; and

c. Meet the financial requirements as described at 8.100.5.E.

8.100.5.D. Medical Assistance Estate Recovery Program

1. The eligibility site shall provide written information from the Department to the following people explaining the provisions of the Medical Assistance Estate Recovery Program and how those provisions may pertain to the applicant/client:

a. Applicants age 55 and older who are institutionalized.

b. Applicants/clients who will turn age 55 before their next eligibility re-determination who are institutionalized.

c. Clients age 55 and older who are approved for admittance to an institution

8.100.5.E. Availability of Resources and Income

Consistent with the legislative declaration outlined at C.R.S. § 25.5-4-300.4, Medicaid should be the payer of last resort for payment of medically necessary goods and services furnished to clients. All other sources of payment, including an individual's own countable income and resources, should be utilized to the fullest extent possible before Medicaid is accessed.

1. Income, which includes earned and unearned income, shall be calculated on a monthly basis regardless of whether it is received annually, semi-annually, quarterly or weekly.

2. For married couples, the income and resources of both spouses are counted in determining eligibility for either or both spouses. Refer to section 8.100.7.C for exceptions.

3. Resources and income shall be considered available when actually available; or, shall be deemed available when all of the following apply to the resources or income of the individual or individual's spouse:

a. has any ownership interest in income or resources or equity value of a resource;

b. has the right, authority, or power to convert the resource or income to cash or to cause the resource or income to be converted to cash; and

c. is not legally restricted from using the resource or income for his or her support and maintenance.

4. Resources and income shall not be considered unavailable merely because the individual or individual's spouse may need to initiate legal proceedings to access the resources or income.

5. If the applicant or client demonstrates with clear and convincing evidence that appropriate steps are being taken to secure the resources, Medical Assistance shall not be delayed or terminated. Verification of efforts to secure the resources must be provided at regular intervals as requested by the Eligibility Site.

6. Resources will be considered available and Medical Assistance shall be denied or terminated if the applicant or client refuses or fails to make a reasonable effort to secure potential resources or income.

7. Timely and adequate notice must be given regarding a proposed action to deny, reduce, or terminate assistance due to failure to make reasonable efforts to secure resources or income. If upon receipt of the prior notice, the individual acts to secure the potential resource, the proposed action to deny, reduce, or terminate assistance must be withdrawn, and assistance must be approved or continued until the resource or income is, in fact, available.

8. If the resources or income has been transferred to a trust, the trust shall be submitted for review to the Department to determine the effect of the trust on eligibility in accordance with section 8.100.7.E.

9. A resource may not necessarily be unavailable by virtue that an individual may be unaware of his or her ownership of an asset. The Department will not treat the unknown asset as a resource during the period in which the individual was unaware of his/her ownership. However, the value of the previously unknown asset, including any monies such as interest that have accumulated on the asset through the month of discovery, is evaluated under regular income-counting rules in the month of discovery, and the asset is a resource subject to the resource-counting rules following the month of discovery.

    a. The burden is on the individual to prove by clear and convincing evidence that the asset was unavailable by virtue of being unknown by the recipient.

    b. Unknown assets shall not be deemed an overpayment pursuant to Section 8.065 of the Department's regulations where the asset was unknown through no fault of the individual.

    c. If the previously unknown asset causes the individual to be ineligible, the individual may repay the Department from the excess resources to retain Medicaid eligibility.

8.100.5.F. Income Requirements

1. This section reviews how income is looked at for the ABD and Long Term Care Medical Programs and determining premiums for the Medicaid Buy-In Program for Working Adults with Disabilities. For more general income information and income types refer to the Medical Assistance General Eligibility Requirements section 8.100.3.

2. Income for the ABD Medical Programs eligibility is income which is received by an individual or family in the month in which they are applying for or receiving Medical Assistance, or the previous month if income for the current month is not yet available to determine eligibility.

3. A self-declared common law spouse retains the same financial responsibility as a legally married spouse. Once self-declared as married under the common law, financial responsibility remains unless legal separation or divorce occurs. If two persons live together, but are not married to each other, neither one has the legal responsibility to support the other. This is not changed by the fact that the unmarried individuals may share a common child.

4. Earned income is countable as income in the month received and a countable resource the following month. Earned Income includes the following:

    a. Wages, which include salaries, commissions, bonuses, severance pay, and any other special payments received because of employment.

    b. Net earnings from self-employment

    c. Payments for services performed in a sheltered workshop or work activities center

    d. Certain Royalties and honoraria

5. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment.

    Unearned income is countable as income in the month received and any unspent amount is a countable resource the following month. Unearned income includes, but is not limited to, the following:

    a. Death benefits, reduced by the cost of last illness and burial

    b. Prizes and awards

    c. Gifts and inheritances

    d. Interest payments on promissory notes established on or after March 1, 2007.

    e. Interest or dividend payments received from any resources

    f. Lump sum payments from workers' compensation, insurance settlements, etc.

    g. Dividends, royalties or other payments from mineral rights or other resources listed for sale within the resource limits

    h. Income from annuities that meet requirements for exclusion as a resource

    i. Pensions and other period payments, such as:

        i) Private pensions or disability benefits

        ii) Social Security benefits (Retirement, survivors, and disability)

        iii) Workers' Compensation payments

        iv) Railroad retirement annuities

        v) Unemployment insurance payments

        vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME).

        vii) Alimony and support payments

    j. Support and maintenance in kind - The support and maintenance in kind amount should not be greater than one third of the Federal Benefit Rate (FBR). Use the Presumed

Maximum Value (PMV) of 1/3 of the recipient's portion of the rent to determine the support and maintenance in kind amount. Use one third of the FBR if an amount is not declared by the client.

6. For the purpose of determining eligibility for the Long Term Care and Aged, Blind, and Disabled Medical Assistance categories the following shall be exempt from consideration as either income or resources:

   a. A bona fide loan. Bona fide loans are loans, either private or commercial, which have a repayment agreement. Declaration of such loans is sufficient verification.

   b. Benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act.

   c. Title XVI (SSI) or Title II (Retirement Survivors or Disability Insurance) retroactive payments (lump sum) for nine months following receipt and the remainder countable as a resource thereafter.

   d. The value of supplemental food assistance received under the special food services program for children provided for in the National School Lunch Act and under the Child Nutrition Act, including benefits received from the special supplemental food program for women, infants and children (WIC).

   e. Home produce utilized for personal consumption.

   f. Payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act; relocation payments to a displaced homeowner toward the purchase of a replacement dwelling are considered exempt for up to 6 months.

   g. The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

      i) Experimental Housing Allowance Program (EHAP) payments made by HUD under section 23 of the U.S. Housing Act.

      ii) The United States Housing Act of 1937 (§ 1437 et seq. of 42 U.S.C.)

      iii) The National Housing Act (§ 1701 et seq. of 12 U.S.C.)

      iv) Section 101 of the Housing and Urban Development Act of 1965 (§ 1701s of 12 U.S.C., § 1451 of 42 U.S.C.);

      v) Title V of the Housing Act of 1949 (§ 1471 et seq. of 42 U.S.C.); or

      vi) Section 202(h) of the Housing Act of 1959.

   h. Payments made from Indian judgment funds and tribal funds held in trust by the Secretary of the Interior and/or distributed per capita; and initial purchases made with such funds. (Public Law No 98-64 and Public Law No. 97-458).

   i. Distributions from a native corporation formed pursuant to the Alaska Native Claims Settlement Act (ANCSA) which are in the form of: cash payments up to an amount not to exceed $ 2000 per individual per calendar year; stock; a partnership interest; or an interest in a settlement trust. Cash payments, up to $ 2000, received by a client in one

calendar year which is retained into subsequent years is excluded as income and resources; however, cash payments up to $ 2000 received in the subsequent year would be excluded from income in the month(s) received but counted as a resource if retained beyond that month(s).

j. Assistance from other agencies and organizations.

k. Major disaster and emergency assistance provided to individuals and families, and comparable disaster assistance provided to states, local governments and disaster assistance organizations shall be exempt as income and resources in determining eligibility for Medical Assistance.

l. Payments received for providing foster care.

m. Payments to volunteers serving as foster grandparents, senior health aids, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title I (VISTA) when the value of all such payments adjusted to reflect the number of hours such volunteers are serving is not equivalent to or greater than the minimum wage, and Title II and Title III of the Domestic Volunteer Services Act.

n. The benefits provided to eligible persons or households through the Low Income Energy Assistance (LEAP) Program.

o. Training allowances granted by the Workforce Investment Act (WIA) to enable any individual whether dependent child or caretaker relative, to participate in a training program

p. Payments received from the youth incentive entitlement pilot projects, the youth community conservation and improvement projects, and the youth employment and training programs under the Youth Employment and Demonstration Project Act.

q. Social Security benefit payments and the accrued amount thereof to a client when an individual plan for self-care and/or self-support has been developed. In order to disregard such income and resources, it shall be determined that (1) SSI permits such disregard under such developed plan for self-care-support goal, and (2) assurance exists that the funds involved will not be for purposes other than those intended.

r. Monies received pursuant to the “Civil Liberties Act of 1988” P.L. No. 100-383, (by eligible persons of Japanese ancestry or certain specified survivors, and certain eligible Aleuts).

s. Payments made from the Agent Orange Settlement Fund or any fund established pursuant to the settlement in the In Re Agent Orange product liability litigation, M.D.L. No 381 (E.D.N.Y).

t. A child receiving subsidized adoption funds shall be excluded from the Medical Assistance budget unit and his income shall be exempt from consideration in determining eligibility, unless such exclusion results in ineligibility for the other members of the household.

u. The Earned Income Tax Credit (EIC). EIC shall also be exempt as resources for the month it is received and for the following month.

v. Any money received from the Radiation Exposure Compensation Trust Fund, Including the Energy Employees Occupational Illness Compensation Program Act, pursuant to P.L. No. 101-426 as amended by P.L. No. 101-510.

w. Reimbursement or restoration of out-of-pocket expenses. Out-of-pocket expenses are actual expenses for food, housing, medical items, clothing, transportation, or personal needs items.

x. Payments to individuals because of their status as victims of Nazi persecution pursuant to Public Law No. 103-286.

y. General Assistance, SSI, OAP-A and cash assistance under the Temporary Assistance to Needy Families (TANF) funds.

z. All wages paid by the United States Census Bureau for temporary employment related to the decennial Census.

aa. Any grant or loan to an undergraduate student for educational purposes made or insured under any programs administered by the Commissioner of Education (Basic Education Opportunity Grants, Supplementary Education Opportunity Grants, National Direct Student Loans and Guaranteed Student Loans), Pell Grant Program, the PLUS Program, the BYRD Honor Scholarship programs and the College Work Study Program.

bb. Any portion of educational loans and grants obtained and used under conditions that preclude their use for current living cost (need-based).

cc. Financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act that is made available for attendance cost shall not be considered as income or resources. Attendance cost includes tuition, fees, rental or purchase of equipment, materials or supplies required of all students in the same course of study, books, supplies, transportation, dependent care and miscellaneous personal expenses of students attending the institution on at least a half-time basis, as determined by the institution.

dd. The additional unemployment compensation of $25 a week enacted through the American Recovery and Reinvestment Act of 2009.

8.100.5.G. Deeming Of Income And Resources For The OAP Program

1. All aliens who apply for OAP on or after April 16, 1988, for three years after the date of admission into the United States, shall have the income and resources of their sponsors other than relatives deemed for their care. Refer to the Medical Assistance General Eligibility Requirements section 8.100.3.K for specific information on deeming of income and resources.

8.100.5.H. Income Allocations and Disregards

1. The following income allocations and disregards are only applicable to SSI related, OAP, Medicare Savings Programs (MSP), and the Medicaid Buy-In Program for Working Adults with Disabilities.

   These allocations and disregards are not applicable to the HCBS waivers or the LTC programs.

   For the Medicaid Buy-In Program for Working Adults with Disabilities, the applicant’s spouse’s income does not count toward the applicant.

a. Income of spouses living together is considered mutually available for SSI related, OAP, and Medicare Savings Programs (MSP).

b. For a person living in the household of another and not paying shelter costs, one third of the Federal Benefit Rate (FBR) is counted as in-kind income and is added to the countable income. This does not apply to unemancipated children.

2. For the purposes of this rule, the following definitions apply:

a. unemancipated child is:

i) a child under age 18 who is living in the same household with a parent or spouse of a parent, or

ii) a child under age 21 who is living in the same household with a parent or spouse of a parent, if the child is regularly attending a school, college, or university, or is receiving technical training designed to prepare the child for gainful employment.

b. Ineligible child is a child who is not applying or eligible for SSI.

c. Ineligible parent/spouse is a parent or spouse who is not applying or eligible for SSI.

3. Countable income is calculated by reducing the gross income by the following allocations and disregards.

a. Income allocations are the part of the gross income that is allocated to individuals in the home who are not eligible for Supplemental Security Income or Old Age Pension. The allocation reduces the gross income that is deemed available to the applicant/client. The allocation is deducted from the gross income prior to applying the other disregards.

The allocations are:

i) An Ineligible Child Allocation is an amount equal to one half the current year's SSI FBR that is disregarded from the ineligible parents' gross income. This allocation is used to meet the needs of ineligible children in the household. This allocation is available for each ineligible child in the home. The amount of the allocation is reduced by any of the ineligible child's own income.

ii) An Ineligible Parent(s) Allocation is an amount equal to the current year's SSI FBR for a single individual or a couple, as applicable. This amount is used to meet the needs of the ineligible parent(s) in the home with an applicant/client child.

iii) No allocations are allowed for applicant/recipient spouses who do not have children in the home.

b. Allocations are applied to the income in the following manner:

i) Allocation disregards are deducted from unearned income before earned income.

ii) Ineligible child allocation disregards are deducted from parents' income before any standard disregards are applied.

iii) Ineligible parent(s) allocation disregards are deducted after any ineligible child allocation disregards and after the standard income disregards.

4. Income disregards

a. $20 General Income Disregard

If there is unearned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied, a General Income Disregard of $20 shall be applied as follows:

i) The first $20 of total available unearned income (except for SSI income) must be disregarded. The remaining amount of unearned income is countable.

ii) If the client has less than $20 of unearned income, the difference between the gross unearned income and the $20 deduction shall be applied as an earned income disregard, if applicable.

iii) Only one $20 general income disregard is allowed per couple and is divided between the two spouses. If one of the spouses has no income the other spouse shall get the full $20 disregard.

b. $65 Plus One Half Remainder Earned Income Disregard

i) If there is earned income left after the Ineligible Child and Parent(s) Allocation Disregards are applied:

1) Deduct the first $65 of all earned income.

2) Divide the remaining income in half.

3) The result is the amount of earned income used for determining eligibility.

c. Child support received by an applicant/recipient child is reduced by one third of the total child support payment. This reduction does not apply to ineligible children when calculating the ineligible child allocation disregard.

d. The first $400 of the gross monthly earned income is exempt for a blind or disabled child who is a student that is regularly attending school. The exemption cannot exceed $1,620 in a calendar year.

e. Title 20 of the Code of Federal Regulations, § 416.1112 (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.5.I. Determining Ownership of Income

1. If payment is made solely to one individual, the income shall be considered available income to that individual.

2. If payment is made to more than one individual, the income shall be considered available to each individual in proportion to their interests.

3. In case of a married couple in which there is no document establishing specific ownership interests, one-half of the income shall be considered available to each spouse.

4. Income from the Community Spouse's Monthly Income Allowance, as defined in the spousal protection rules in this volume at 8.100.7.R, is income to the community spouse.

8.100.5.J. Income-Producing Property

1. Net rental income from an exempt home or a life estate interest in an exempt home is countable after the following allowable deductions:

    a. Property taxes and insurance

    b. Necessary reasonable routine maintenance expenses

    c. Reasonable management fee for a professional property manager.

2. Non-business property that is necessary to produce goods or services essential to self- support is excluded up to $6,000.

3. Property used in a trade or business which is essential to self-support is excluded up to a limit of $6,000 if it produces 6% return of the $6,000 excluded value.

8.100.5.K. Department of Veterans Affairs (VA) Payments

The portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall not be considered as income when determining eligibility.

1. The portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall not be used as patient payment to the medical facility:

    a. for a veteran or surviving spouse of a veteran in a medical facility other than State Veterans Home; or

    b. for a veteran or surviving spouse of a veteran in a State Veterans Home with dependents.

2. For a veteran or surviving spouse of a veteran in a State Veterans Home with no dependents the portion of the pension payments for Aid and Attendance (A&A) and Unusual Medical Expenses (UME), as determined by the VA, shall be used as patient payment to the medical facility.

8.100.5.L. Reverse Mortgages

1. In accordance with C.R.S. § 11-38-110, reverse mortgages payments made to a borrower shall not be treated as income for eligibility purposes.

2. Funds remaining the following month after the payment is made will be countable as a resource.

3. Any payments from a reverse mortgage that are transferred to another individual without fair consideration shall be analyzed in accordance with the rules on transfers without fair consideration in the Long-Term Care section and may result in a penalty period of ineligibility.

8.100.5.M. Resource Requirements

1. Consideration of resources: Resources are defined as cash or other assets or any real or personal property that an individual or spouse owns. The resource limit for an individual is $2,000. For a married couple, the resource limit is $3,000. If one spouse is institutionalized, refer to Spousal Protection-Treatment of Income and Resources for Institutionalized Spouses. Effective

January 1, 2011, the resource limits for the Qualified Medicare Beneficiaries (QMB), Specified Low Income Medicare Beneficiaries (SLMB), and Qualified Individuals 1 (QI-1) programs are $8,180 for a single individual and $13,020 for a married individual living with a spouse and no other dependents. The resource limits for the QMB, SLMB, and QI programs shall be adjusted annually by the Centers for Medicare and Medicaid Services on January 1 of each year. These resource limits are based upon the change in the annual consumer price index (CPI) as of September of the previous year. Resources are not counted for the Medicaid Buy-In Program for Working Adults with Disabilities or the Medicaid Buy-In Program for Children with Disabilities.

2. The following resources are exempt in determining eligibility:

a. A home, which is any property in which an individual or spouse of an individual has an ownership interest and which serves as the individual's principal place of residence. The property includes the shelter in which an individual resides, the land on which the shelter is located and related outbuildings.

i) Only one principal place of residence is excluded for a single individual or a married couple.

ii) The individual's ownership interest in the home must have an equity value that:

1) From January 1, 2006 thru December 31, 2010 is $500,000 or less, or;

2) Is less than the amount that results from the year to year percentage increase to the $500,000 limit. The increase is based upon the consumer price index for all urban consumers (all items; United States city average), rounded to the nearest $1,000.

iii) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual intends to return to that home, then the individual does not meet the residency requirement for Colorado Medicaid eligibility.

iv) If an individual or spouse of an individual owns a home of any value located outside Colorado, and if the individual does not intend to return to that home, then the home is a countable resource unless the individual's spouse or dependent relative lives in the home.

v) If an individual or spouse of an individual owns a home located inside Colorado with an equity value lower than the limit in subparagraph (1), above, and if the individual intends to return to that home, then the home is considered an exempt resource if:

1) The individual is institutionalized; and

2) The intent to return home is documented in writing.

vi) If an individual or spouse of an individual owns a home with an equity value greater than the limit that is located inside Colorado, and if the individual intends to return to that home, then the home is considered to be a countable resource unless spouse or dependent relative lives in the home.

vii) If an individual or spouse of an individual owns a home of any value located inside Colorado, and if the individual does not intend to return to that home, then

the home is a countable resource unless spouse or dependent relative lives in the home.

viii) If an individual or spouse moves out of his or her home without the intent to return, the home becomes a countable resource because it is no longer the individual's principal place of residence.

ix) If an individual leaves his or her home to live in an institution, the home shall still be considered the principal place of residence, irrespective of the individual's intent to return as long as the individual's spouse or dependent relative continues to live there.

x) The individual's equity in the former home becomes a countable resource effective with the first day of the month following the month it is no longer his or her principal place of residence.

xi) The intent to return home applies to the home in which the individual or spouse of the individual was living prior to being institutionalized or to a replacement home as long as the individual’s spouse or dependent relative continues to live in the home.

xii) The intent to return home also applies if the individual is living in an assisted living facility or alternative care facility and receives HCBS while in that facility or transfers into a Long-Term Care institution to receive services.

xiii) For an individual in a Long-Term Care institution, receiving HCBS, or enrolled in PACE, the exemption for the principal place of residence does not apply to a residence which has been transferred to a trust or other entity, such as a partnership or corporation.

1) The exemption shall be regained if the residence is transferred back into the name of the individual.

xiv) The principal place of residence, which is subject to estate recovery, becomes a countable resource upon the execution and recording of a beneficiary deed.

The exemption can be regained if a revocation of the beneficiary deed is executed and recorded.

b. Excess property will not be included in countable resources as long as reasonable efforts to sell it have been unsuccessful. Reasonable efforts to sell means:

i.) The property is listed with a professional such as a real estate agent, broker, dealer, auction house, etc., at current market value.

ii) If owner listed, the property must be for sale at current market value, advertised and shown to the public.

iii) Any reasonable offer must be accepted.

iv) If an offer is received that is at least two-thirds of the current market value, that offer is presumed reasonable.

v) The client must continue reasonable efforts to sell and must submit verification of these efforts to the Eligibility Site on a quarterly basis. Reasonable effort is at Eligibility Site discretion.

vi) If the exemption is used to become eligible under the Spousal Protection rules, the property shall continue to be viewed according to 8.100.7.L while efforts to sell it are being made.

vii) Eligibility under this exemption is conditional. Once the property sells, the client shall be ineligible until the resources are below the prescribed limit.

c. One automobile is totally excluded regardless of its value if it is used for transportation for the individual or a member of the individual's household. An automobile includes, in addition to passenger cars, other vehicles used to provide necessary transportation.

d. Household goods are not counted as a resource to an individual (and spouse, if any) if they are:

i) Items of personal property, found in or near the home, that are used on a regular basis; or

ii) Items needed by the household for maintenance, use and occupancy of the premises as a home.

iii) Such items include but are not limited to: furniture, appliances, electronic equipment such as personal computers and television sets, carpets, cooking and eating utensils, and dishes.

e. Personal effects are not counted as a resource to an individual (and spouse, if any) if they are:

i) Items of personal property ordinarily worn or carried by the individual; or

ii) Articles otherwise having an intimate relation to the individual.

iii) Such items include but are not limited to: personal jewelry including wedding and engagement rings, personal care items, prosthetic devices, and educational or recreational items such as books or musical instruments.

iv) Items of cultural or religious significance to the individual and items required because of an individual’s impairment are also not counted as a resource.

f. The cash surrender value of all life insurance policies owned by an individual and spouse, if any, is exempt if the total face value of all life insurance policies does not exceed $1,500 on any person. If the total face value of all the life insurance policies exceeds $1,500 on one person, the cash surrender value of those policies will be counted.

g. Term life insurance having no cash surrender value, and burial insurance, the proceeds of which can be used only for burial expenses, are not countable toward the resource limit.

h. The total value of burial spaces for the applicant/recipient, his/her spouse and any other members of his/her immediate family is exempt as a resource. If any interest is earned on

the value of an agreement for the purchase of a burial space, such interest is also exempt.

i. An applicant or recipient may own burial funds through an irrevocable trust or other irrevocable arrangement which are available for burial and are held in an irrevocable burial contract, an irrevocable burial trust, or in an irrevocable trust which is specifically identified as available for burial expenses without such funds affecting the person's eligibility for assistance.

j. An applicant or recipient may also own up to $1,500 in burial funds through a revocable account, trust, or other arrangement for burial expenses, without such funds affecting the person's eligibility for assistance. This exclusion only applies if the funds set aside for burial expenses are kept separate from all other resources not intended for burial of the individual or spouse's burial expenses. Interest on the burial funds is also excluded if left to accumulate in the burial fund. For a married couple, a separate $1,500 exemption applies to each spouse.

The $1,500 exemption is reduced by:

i) the amount of any irrevocable burial funds such as are described in the preceding subparagraph, and

ii) the face value of any life insurance policy whose cash surrender value is exempt.

k. Achieving a Better Life Experience (ABLE) Accounts.

3. Countable resources include the following:

a. Cash;

b. Funds held by a financial institution in a checking or savings account, certificate of deposit or money market account;

c. Current market value of stocks, bonds, and mutual funds;

d. All funds in a joint account are presumed to be a resource of the applicant or client. If there is more than one applicant or client account holder, it is presumed that the funds in the account belong to those individuals in equal shares. To rebut this presumption, evidence must be furnished that proves that some or all of the funds in a jointly held account do not belong to him or her. To rebut the sole ownership presumption, the following procedure must be followed:

i) Submit statements from all of the account holders regarding who owns the funds, why there is a joint account, who has made deposits and withdrawals, and how withdrawals have been spent.

ii) Submit account records showing deposits, withdrawals and interest in the months for which ownership of funds is at issue.

iii) Correct the account title and submit revised account records showing that the applicant or client is no longer an account holder or separate the funds to show they are solely owned by the individual within 45 days.

e. Any real property that is subject to a recorded beneficiary deed and on which an estate recovery claim can be made.

f. For applications filed on or after January 1, 2006, an individual’s home if the individual’s equity interest in the home exceeds the equity value limit described at 8.100.5.M.2.a.i)1).

g. Real property not exempt as the principal place of residence and not exempt as income producing property with a value of $6,000 or less, as described at 8.100.5.J.

h. When the applicant alleges that the sale of real property would cause undue hardship to the co-owner due to loss of housing, all of the following information must be obtained:

    i) The applicant or client's signed statement to that effect.

    ii) Verification of joint ownership.

    iii) A statement from the co-owner verifying the following:

        1) The property is used as his principal place of residence.

        2) The co-owner would have to move if the property were sold.

        3) The co-owner would be unable to buy the applicant or client's interest in the property.

        4) There is no other readily available residence because there is no other affordable housing available or no other housing with the necessary modifications for the co-owner if he is a person with disabilities.

i. Personal property such as a mobile home or trailer or the like, that is not exempt as a principal place of residence or that is not income producing.

j. Personal effects acquired or held for their value or as an investment. Such items can include but are not limited to: gems, jewelry that is not worn or held for family significance, or collectibles.

k. The equity value of all automobiles that are in addition to one exempt vehicle.

l. The cash surrender value of all life insurance policies owned by an individual and spouse is counted if the total face value of all the policies combined exceeds $1,500 on any person.

m. Promissory notes established before April 1, 2006 are treated as follows:

    i) The fair market value of a promissory note, mortgage, installment contract or similar instrument is an available countable resource.

    ii) In order to determine the fair market value, the applicant shall obtain three estimates of fair market value from a private note broker, who is engaged in the business of purchasing such notes. In order to obtain the estimates and locate willing buyers, the note shall be advertised in a newspaper with state wide circulation under business or investment opportunities.

    iii) A note or similar instrument which transferred funds or assets for less than fair consideration shall be considered as a transfer for less than fair consideration and a period of ineligibility shall be imposed.

n. Promissory notes established on or after April 1, 2006 and before March 1, 2007 are treated as follows:

i) The value of a promissory note, loan or mortgage is an available countable resource unless the note, loan or mortgage:

1) Has a repayment term that is actuarially sound based on the individual's life expectancy, found in the tables at 8.100.7.J, for annuities purchased on or after February 8, 2006;

2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

3) Prohibits the cancellation of the balance upon the death of the lender.

ii) The value of a promissory note, loan or mortgage which does not meet the criteria in outlined in 8.100.5.M.3.n.i)1)-3) is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is subject to the transfer of assets without fair consideration provisions as outlined in section 8.100.7.F.

o. Promissory notes established on or after March 1, 2007 are treated as follows:

i) The value of a promissory note, loan or mortgage is the outstanding balance due as of the date of the individual's application for HCBS, PACE or institutional services and is an available countable resource, and

ii) A promissory note, loan or mortgage which does not meet the following criteria shall be considered to be a transfer without fair consideration and shall be subject to the provisions outlined at 8.100.7.F.

1) Has a repayment term that is actuarially sound based on the individual's life expectancy as found in the tables in section 8.100.7.J for annuities purchased on or after February 8, 2006;

2) Provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

3) Prohibits the cancellation of the balance upon the death of the lender.

p. Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.

i) Ownership of land and mineral rights. If the individual owns the land to which the mineral rights pertain, the current market value of the land generally includes the value of the mineral rights.

ii) If the individual does not own the land to which the mineral rights pertain, the individual should obtain a current market value estimate from a knowledgeable source. Such sources may include:

1) any mining company that holds leases;

2) the Bureau of Land Management;

3) the U.S. Geological Survey.

8.100.5.N. Treatment of Self-Funded Retirement Accounts

1. The following regulations apply to self-funded retirement accounts such as an Individual Retirement Account (IRA), Keogh Plan, 401(k), 403(b) and any other self-funded retirement account.

2. Self-funded retirement accounts in the name of the applicant are countable as a resource to the applicant.

3. Self-funded retirement accounts in the name of the applicant's spouse who is living with the applicant are exempt in determining eligibility for the applicant, except as set forth in 4. below.

4. Self-funded retirement accounts in the name of a community spouse who is married to an applicant who is applying for Long Term Care in a Long Term Care institution, HCBS or PACE, are countable as a resource to the applicant and may be included in the Community Spouse Resource Allowance (CSRA) up to the maximum amount allowable. The terms community spouse and CSRA are further defined in the regulations on Spousal Protection in this volume.

5. The value of a self-funded retirement account is determined as follows:

   a. The gross value of the account, less any taxes due, is the amount that is countable as a resource, regardless of whether any monthly income is being received from the account.

   b. If the applicant is not able to provide the amount of taxes that are due, the value shall be determined by deducting 20% from the gross value of the account.

8.100.5.O. Treatment of Inheritances

1. An inheritance is cash, other liquid resources, non-cash items, or any right in real or personal property received at the death of another.

2. If an Individual or individual’s spouse is the beneficiary of a will, the inheritance is presumed to be available at the conclusion of the probate process or within 6 months if the estate is not in probate.

3. If an individual or individual’s spouse is eligible for a family allowance in a probate proceeding, that allowance will be considered available three months after death or when actually available, whichever is sooner.

4. Evidence demonstrating that the inheritance is not available due to probate or other legal restrictions must be provided to rebut the presumption.

8.100.5.P. Treatment of Proceeds from Disposition of Resources

Treatment of proceeds from disposition of resources is determined as follows:

1. The net proceeds from the sale of exempt or non-exempt resources are considered available resources.

2. The net proceeds are the selling price less any valid encumbrances and costs of sale.

3. After deducting any amount necessary to raise the individual's and spouse's resources to the applicable limits, the balance of the net proceeds, in excess of the resource limits, shall be

considered available resources. In lieu of terminating eligibility due to excess resources, the client may request that the proceeds be used to reimburse the Medical Assistance Program for previous payments for Medical Assistance.

4. The proceeds from the sale of an exempt home will be excluded to the extent they are intended to be used and are, in fact, used to purchase another home in which the individual, a spouse or dependent child resides, within three months of the date of the sale of the home.

8.100.6 Aged, Blind, and Disabled Medical Assistance Eligibility

8.100.6.A. Aged, Blind, and Disabled (ABD) General Information

1. Medical Assistance for ABD includes SSI eligible individuals, OAP recipients, and the Medicare Savings Program (MSP) individuals. Refer to section 8.100.5 of this volume for income and resource criteria for these categories of assistance.

8.100.6.B. Disability Determinations

1. Beginning on July 1, 2001, the Department or its contractor shall determine whether the client is disabled or blind in accordance with the requirements and procedures set forth elsewhere in this volume and according to Federal regulations regarding disability determinations.

2. A client who disagrees with the decision on disability or blindness shall have the right to appeal that decision to a state-level fair hearing in accordance with the procedures at 8.057.

8.100.6.C. SSI Eligibles

1. Benefits of the Colorado Medical Assistance Program must be provided to the following:

    a. persons receiving financial assistance under SSI;

    b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;

    c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.

2. The Department has entered into an agreement with SSA in which SSA shall determine Medical Assistance for all SSI applicants. Medical Assistance shall be provided to all individuals receiving SSI benefits as determined by SSA to be eligible for Medical Assistance.

3. The eligibility sites shall have access to a weekly unmatched listing of all individuals newly approved and a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the eligibility site to authorize Medical Assistance.

4. Medical Assistance shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.

5. Notification shall be sent to the SSI recipient advising him/her of the approval of Medical Assistance.

6. The SISC Code for this type of assistance is B.

7. Denied or terminated Medical Assistance based on a denial or termination of SSI which is later overturned, must be approved from the original SSI eligibility date.

8. Individuals who remain eligible as SSI recipients but are not receiving SSI payments shall receive Medical Assistance benefits. This group includes persons whose SSI payments are being withheld as a means of recovering an overpayment, whose checks are undeliverable due to change of address or representative payee, and persons who lost SSI financial assistance due to earned income.

9. If the eligibility site obtains information affecting the eligibility of these SSI recipients, they shall forward such information to the local Social Security office.

10. For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on which the individual became eligible for SSI, whichever is later.

    a. Special Provisions for Infants

        i) For an infant who is eligible for or who is receiving SSI, the effective date of Medicaid eligibility shall be the infant's date of birth if:

            1) the infant was born in a hospital;

            2) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and

            3) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI

8.100.6.D. Pickle Amendment

1. Beginning July 1977, Medical Assistance must be provided to an individual if their countable income is below the current years SSI standard after a cost of living adjustment (COLA) disregard is applied to their OASDI (excluding Railroad Retirement Benefits) and they meet all other eligibility criteria. This is referred to as Pickle Disregard.

2. The Pickle Disregard applies to an individual who:

    a. lost SSI and/or OAP because of a cost of living adjustment to his/her own OASDI benefits.

    b. lost SSI and/or OAP because a cost of living adjustment to OASDI income deemed from a parent or spouse.

    c. lost OAP and/or SSI due to the receipt of, or increase to, OASDI, and would be eligible for OAP and/or SSI if all COLA'S on the amount that caused them to lose eligibility is disregarded from their current OASDI amount.

8.100.6.E. Pickle Determination

1. To determine eligibility of Medical Assistance recipients to whom the Pickle disregards apply, the eligibility site must:

a. establish whether the person was eligible for SSI or OAP and, for the same month, was entitled to OASDI;

b. determine the previous amount of the OASDI that caused them to lose SSI and/or OAP;

c. determine the current OASDI income;

d. subtract the previous OASDI income from the current OASDI income to find the cumulative OASDI COLAs since SSI and/or OAP was lost. This is the Pickle Disregard amount;

e. subtract the Pickle Disregard amount from the current OASDI income to get the countable OASDI income.

2. If the countable OASDI income and all other countable income is less than the current SSI or OAP standard, and the individual meets all other eligibility criteria then medical eligibility must continue or be reinstated.

3. This disregard must also be applied to any OASDI cost of living increases paid to any financially responsible individual such as a parent or spouse whose income is considered in determining the person's continued eligibility for Medical Assistance.

4. The cost of living increase disregard specified in the preceding action must continue to be applied at each eligibility redetermination.

5. An SSI medical only individual who loses SSI due to an OASDI cost-of-living increase shall be contacted by the eligibility site to determine if the individual would continue to remain eligible for Medical Assistance under the provisions for SSI related cases. The individual must complete an application for assistance to continue receiving benefits.

8.100.6.F. 1972 Disregard Individuals

1. Medical Assistance must be provided to a person who was receiving financial assistance under AND or Aid to the Blind (AB) for August 1972 and who – except for the October 1972 Social Security (includes RRB) 20% increase amount would currently be eligible for financial assistance. This disregard must also be applied to a person receiving Medical Assistance in August 1972 who was eligible for financial assistance but was not receiving the money payment and to a person receiving Medical Assistance as a resident in a medical institution in August 1972.

2. To redetermine the eligibility of Medical Assistance recipients to whom the 1972 disregard applies, the eligibility site must:

a. review the case against the current applicable program definitions and requirements;

b. apply the resource and income criteria specified in section 8.100.5;

c. subtract the 1972 disregard amount from the income;

d. consider the remainder against the current appropriate SSI benefit level.

8.100.6.G. Individuals Eligible in 1973

1. Medical Assistance must be provided to ABD persons who are receiving mandatory state supplementary payments (SSP). Such persons are those with income below their December 1973 minimum income level (MIL).

2. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an inpatient of a medical facility, who continues to meet the December 1973 eligibility criteria for institutionalized persons and who remains institutionalized.

3. Medical Assistance must be provided to a person who was eligible for Medical Assistance in December 1973 as an "essential spouse" of an AND or AB financial assistance recipient, and who continues to be in the grant and continues to meet the December 1973 eligibility criteria. Except for such persons who were grandfathered-in for continued assistance, essential spouses included in assistance grants after December 1973 are not eligible for Medical Assistance.

8.100.6.H. Eligibility for Certain Disabled Widow(er)s

1. Medical Assistance shall be provided retroactive to July 1, 1986, to qualified disabled widow(er)s who lost SSI and/or state supplementation due to the 1983 change in the actuarial reduction formula prescribed in section 134 of P.L. No. 98 21.

   In order for these widow(er)s to qualify, these individuals must:

   a. have been continuously entitled to Title II benefits since December 1983;

   b. have been disabled widow(er)s in January 1984;

   c. have established entitlement to Title II benefits prior to age 60;

   d. have been eligible for SSI/SSP benefits prior to application of the revised actuarial reduction formula;

   e. have subsequently lost eligibility for SSI/SSP as a result of the change in the actuarial table; and

   f. reapply for assistance prior to July 1, 1987.

8.100.6.I. Eligibility for Disabled Widow(er)s

1. Effective January 1, 1991, Medical Assistance shall be provided to disabled widow(er)s age 50 through 64 who lost SSI and/or OAP due to the receipt of Social Security benefits as a disabled widow(er). The individual shall remain eligible for Medical Assistance until he/she becomes eligible for Part A of Medicare (hospital insurance).

   To qualify these individuals must:

   a. be a widow(er);

   b. have received SSI in the past;

   c. be at least 50 years old but not 65 years old;

   d. no longer receive SSI payments because of Social Security payments;

   e. not have hospital insurance under Medicare; and,

   f. meet all other Medical Assistance requirements.

8.100.6.J. Disabled Adult Children

1. Medical Assistance shall be provided to an individual aged 18 or older who loses SSI due to the receipt of OASDI drawn from his/her parents' Social Security Number; and:

    a. who was determined disabled prior to the age of 22; and

    b. who is currently receiving OASDI income as a Disabled Adult Child; and

    c. who would continue to be eligible for SSI if:

        i) the current OASDI income of the applicant is disregarded; and

        ii) the resources are below the applicable limit as listed at 8.100.5.M; and

        iii) other countable income is below the current years SSI FBR.

2. Disabled Adult Children are identified by the OASDI Beneficiary Identification Code (BIC) of “C”.

8.100.6.K. Old Age Pension (OAP) Eligibles

1. Individuals that are 65 and over are defined as the OAP-A category. Individuals who attain the age of 60 but not yet 65 are defined as the OAP-B category.

2. Medical Assistance must be provided to persons receiving OAP-A or OAP-B and SSI (SISC B).

3. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria but are not receiving a money payment (SISC-B).

4. Medical Assistance must be provided to all OAP-A and OAP-B persons who also meet SSI eligibility criteria except for the level of their income (SISC-B).

5. Medical Assistance must be provided to persons in a facility eligible for Medical Assistance reimbursement whose income is under 300% of the SSI benefit level and who, but for the level of their income, would be eligible for OAP “A” or OAP “B” and SSI financial assistance. This group includes persons 65 years of age or older receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement (SISC A). This population is referenced as Psych >65.

6. The OAP B individual included in AFDC assistance unit shall receive Medical Assistance as a member of the AFDC household (SISC B).

7. The OAP State Only Medical Assistance Program provides Medical Assistance to OAP-A, OAP-B or OAP Refugees who lost their OAP financial assistance because of a cost of living adjustment other than OASDI. Examples of other sources of income are VA, RRB, PERA, etc. (SISC C).

8. For the purpose of identifying the proper SISC code for persons receiving assistance under OAP “A” or OAP “B”, if the person:

    a. receives an SSI payment (SISC B);

    b. does not receive an SSI payment but is receiving assistance under OAP “A”, a second evaluation of resources must be made using the same resource criteria as specified in section 8.100.5.M for those who meet this criteria the SISC code is B for money payment and “disregard” case, A for institutional cases;

c. does not receive an SSI payment and does not otherwise qualify under SISC code B or A as described in item b. above (SISC C).

8.100.6.L. Qualified Medicare Beneficiaries (QMB)

1. Medical Assistance coverage for QMB clients is payment of Medicare part B premiums, co-insurance and deductibles.

2. Effective July 1, 1989, a Qualified Medicare Beneficiary is an individual who:

   a. is entitled to Part A Medicare; and

   b. resources may not exceed the standard for an individual or couple who have resources, as described in section 8.100.5.M; and

   c. has income at or below the percentage of the federal poverty level for the size family as mandated for QMB by federal regulations. Poverty level is established by the Executive Office of Management and Budget.

3. For QMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for QMB.

4. For QMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

5. Medicare cost sharing expenses must be provided to qualified Medicare beneficiaries. This limited Medical Assistance package of Medicare cost sharing expenses only includes:

   a. payment of Part A Medicare premiums where applicable;

   b. payment of Part B Medicare premiums; and

   c. payment of coinsurance and deductibles for Medicare services whether or not a benefit of Medical Assistance up to the full Medicare rate or reasonable rates as established in the State Plan.

6. Individuals may be QMB recipients only or the individual may be classified as a dual eligible. A dual eligible is a Medicare recipient who is otherwise eligible for Medical Assistance.

7. A QMB-only recipient is an individual who is not eligible for other categorical assistance program due to their income and/or resources but who meets the eligibility criteria for QMB described above.

8. Individuals who apply for QMB assistance have the right to have their eligibility determined under all categories of assistance for which they may qualify.

9. All other general non-financial requirements or conditions of eligibility must also be met such as age, citizenship, residency requirements as well as reporting and redetermination requirements. These criteria are defined in section 8.100.3 of this volume.

10. Eligibility for QMB benefits shall be effective the month following the month of determination. Beneficiaries who submit and complete an application within the 45-day standard shall be eligible

for benefits no later than the first of the month following the 45th day of application. Administrative delays shall not postpone the effective date of eligibility.

11. QMB benefits are not retroactive and the three month retroactive Medical Assistance rule does not apply to QMB benefits.

12. Clients who would lose their QMB entitlement due to annual social security COLA will remain eligible for QMB coverage under Medical Assistance, as income disregard cases, until the next year's federal poverty guidelines are published.

8.100.6.M. Specified Low Income Medicare Beneficiaries

1. Medical Assistance coverage for SLMB clients is limited to payment of monthly Medicare Part B (Supplemental Medical Insurance Benefits) premiums.

2. Effective January 1, 1993, a Specified Low Income Medicare Beneficiary (SLMB) is an individual who:

    a. is entitled to Medicare Part A;

    b. resources may not exceed the standard for an individual or couple who has resources as described in section 8.100.5.M of this volume.

    c. has income at or below a percentage of the federal poverty level for the family size as mandated by federal regulations for SLMB. Income limits have been defined through CY 1995, as follows: CY 1993 and 1994 100-110% of FPL, CY 1995 100-120% of FPL.

3. For SLMB purposes, couples shall have their income compared against the federal poverty level couples income maximum. This procedure shall be applied whether one or both members apply for SLMB.

4. For SLMB purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

5. SLMB eligibility starts on the date of application or up to three month prior to the application date for retroactive Medical Assistance.

6. Eligibility may be made retroactive up to 90 days, but may not be effective prior to 1/1/93.

7. Clients who would lose their SLMB entitlement due to annual SSA COLA will remain eligible for SLMB coverage, as income disregard cases, through the month following the month in which the annual federal poverty levels (FPL) update is published.

8.100.6.N. Medicare Qualifying Individuals 1 (QI1)

1. Medical Assistance coverage is limited to monthly payment of Medicare Part B premiums. Payment of the premium shall be made by the Department on behalf of the individual.

2. Eligibility for this benefit is limited by the availability of the allocation set by CMS. Once the state allocation is met, no further benefits under this category shall be paid and a waiting list of eligible individuals shall be maintained.

3. Eligibility for QI1 benefits shall be effective the month in which application is made and the individual is eligible for benefits. Eligibility may be retroactive up to three months from the date of application, but not prior to January 1, 1998.

4. In order to qualify as a Medicare Qualifying Individual 1, the individual must meet the following:

    a. be entitled to Part A of Medicare,

    b. income of at least 120%, but less than 135% of the FPL.

    c. resources may not exceed the standard as described in section 8.100.5.M, and

    d. he/she cannot otherwise be eligible for Medical Assistance.

5. For QI1 purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

6. Clients who would lose QI-1 entitlement due to annual social security COLA will remain eligible for QI-1 coverage under Medical Assistance, as an income disregard case, until the next year's federal poverty guidelines are published.

8.100.6.O. Qualified Disabled And Working Individuals

1. Medical Assistance coverage is limited to monthly payment of Medicare Part A premiums, and any other Medicare cost sharing expenses determined necessary by CMS.

2. Effective July 1, 1990, a Qualified Disabled and Working Individual (QDWI) is an individual who:

    a. was a recipient of federal Social Security Disability Insurance (SSDI) benefits, who continues to be disabled but lost SSDI entitlement due to earned income in excess of the Social Security Administration's Substantial Gainful Activity (SGA) threshold, and;

    b. has exhausted SSA's allowed extension of "premium free" Medicare Part A coverage under SSDI, and;

    c. has resources at or below twice the SSI resource limit as described in section 8.100.5., and;

    d. has income less than 200% of FPL.

3. For QDWI purposes, income of the applicant and/or the spouse shall be determined as described under Income Requirements in section 8.100.5. If two or more individuals have earned income, the income of all the individuals shall be added together and the $65 plus one half remainder earned income disregard shall be applied to the total amount of earned income.

4. An individual may be eligible under this section only if he/she is not otherwise eligible under another Medical Assistance category of eligibility.

5. Eligibility for QDWI benefits shall be effective the month of determination of entitlement.

6. Eligibility may be retroactive only to the date as of which SSA approves an individual's application for coverage as a "Qualified Disabled and Working Individual". However, eligibility may not begin prior to 07/01/90.

8.100.6.P. Medicaid Buy-In Program for Working Adults with Disabilities.

1. To be eligible for the Medicaid Buy-In Program for Working Adults with Disabilities:

   a. Applicants must be at least age 16 but less than 65 years of age.

   b. Income must be less than or equal to 450% of FPL after income allocations and disregards. See 8.100.5.F for Income Requirements and 8.100.5.H for Income allocations and disregards. Only the applicant's income will be considered.

   c. Resources are not counted in determining eligibility.

   d. Individuals must have a disability as defined by Social Security Administration medical listing or a limited disability as determined by a state contractor.

   e. Individuals must be employed. Please see Verification Requirements at 8.100.5.B.1.c.

      i) Due to the federal COVID-19 Public Health Emergency, and required by the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program until the end of the federal Public Health Emergency. At the end of the federal Public Health Emergency, members will be redetermined based on their current employment status. New applicants enrolled will still need to meet the work requirement.

   f. Individuals will be required to pay monthly premiums on a sliding scale based on income.

      i) The amount of premiums cannot exceed 7.5% of the individual's income.

      ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.

      iii) Premium amounts are as follows:

         1) There is no monthly premium for individuals with income at or below 40% FPL.

         2) A monthly premium of $25 is applied to individuals with income above 40% of FPL but at or below 133% of FPL.

         3) A monthly premium of $90 is applied to individuals with income above 133% of FPL but at or below 200% of FPL.

         4) A monthly premium of $130 is applied to individuals with income above 200% of FPL but at or below 300% of FPL.

         5) A monthly premium of $200 is applied to individuals with income above 300% of FPL but at or below 450% of FPL./

      iv) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by $10 or more.

v) A change in client net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

vi) Due to the federal COVID-19 Public Health Emergency, the Department will waive premiums for the Medicaid Buy-In for Working Adults with Disability Program during the federal COVID-19 emergency declaration. Once the federal emergency declaration has concluded, the Department will notify all members as to when required premiums will resume.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation

3. Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Working Adults with Disabilities. This is also called "opt out."

8.100.6.Q. Medicaid Buy-In Program for Children with Disabilities

1. To be eligible for the Medicaid Buy-In Program for Children with Disabilities:

a. Applicants must be age 18 or younger.

b. Household income will be considered and must be less than or equal to 300% of FPL after income disregards. The following rules apply:

i) 8.100.4.E - MAGI Household Requirements

ii) 8.100.5.F - Income Requirements

iii) 8.100.5.F.6 - Income Exemptions

iv) An earned income of $90 shall be disregarded from the gross wages of each individual who is employed

v) A disregard of a 33% (.3333) reduction will be applied to the household's net income.

c. Resources are not counted in determining eligibility.

d. Individuals must have a disability as defined by Social Security Administration medical listing.

e. Children age 16 through 18 cannot be employed. If employed, children age 16 through 18 shall be determined for eligibility through the Medicaid Buy-In Program for Working Adults with Disabilities.

f. Families will be required to pay monthly premiums on a sliding scale based on household size and income.

i) For families whose income does not exceed 200% of FPL, the amount of premiums and cost-sharing charges cannot exceed 5% of the family's adjusted gross income. For families whose income exceeds 200% of FPL but does not

exceed 300% of FPL, the amount of premiums and cost-sharing charges cannot exceed 7.5% of the family's adjusted gross income.

ii) Premiums are charged beginning the month after determination of eligibility. Any premiums for the months prior to the determination of eligibility will be waived.

iii) For households with two or more children eligible for the Medicaid Buy-In Program for Children with Disabilities, the total premium shall be the amount due for one eligible child.

iv) Premium amounts are as follows:

1) There is no monthly premium for households with income at or below 133% of FPL.

2) A monthly premium of $70 is applied to households with income above 133% of FPL but at or below 185% of FPL.

3) A monthly premium of $90 is applied to individuals with income above 185% of FPL but at or below 250% of FPL.

4) A monthly premium of $120 is applied to individuals with income above 250% of FPL but at or below 300% of FPL.

v) The premium amounts will be updated at the beginning of each State fiscal year based on the annually revised FPL if the revised FPL would cause the premium amount (based on percentage of income) to increase by $10 or more.

vi) A change in household net income may impact the monthly premium amount due. Failure to pay premium payments in full within 60 days from the premium due date will result in client's assistance being terminated prospectively. The effective date of the termination will be the last day of the month following the 60 days from the date on which the premium became past due.

vii) Due to the federal COVID-19 Public Health Emergency, the Department will waive premiums for the Department's Children with Disabilities Program during the federal emergency declaration. Once the federal emergency declaration has concluded, the Department will notify all members as to when required premiums will resume.

2. Retroactive coverage is available according to 8.100.3.E, however is not available prior to program implementation.

3. Verification requirements will follow the MAGI Category Verification Requirements found at 8.100.4.B.

4, Individuals have the option to request to be disenrolled if they have been enrolled into the Medicaid Buy-In Program for Children with Disabilities. This is also called "opt out."

8.100.7 Long-Term Care Medical Assistance Eligibility

8.100.7.A. Persons in Long-Term Care Institutions or Other Residential Placement

1. For Long-Term Care services to be covered in a Long-Term Care institution, a client must be determined eligible under the 300% Institutionalized Special Income category. If the client is

already Medicaid eligible, a new application is not required but the client must be determined to meet the eligibility criteria.

For a client entering a Long-Term Care Institution from the community, the Eligibility Site must notify the Single Entry Point/Case Management Agency, upon receipt of the application or client request, to schedule the institutional level of care assessment. This is not applicable to a client being discharged from a hospital, nursing facility or Long-Term Home Health.

For purposes of applying the special income standard for the aged, disabled or blind persons in Long-Term Care Institutions, gross income means income before application of deductions, exemptions or disregards appropriate to the SSI program.

Medical Assistance will be provided beginning the first day of the month following the month during which a child under the age of 18 ceases to live with his or her parent(s). Once determined to meet the institutional requirement, parental income and resources will cease to be deemed available to the child because the child is institutionalized and not living in the parents' home.

2. Eligibility under the 300% Institutionalized Special Income category will be provided to applicants who:

   a. Have attained the age of 65 years or;

   b. Have met the requirements according to the definition of disability or blindness applicable to the Social Security Disability Insurance (SSDI) and Supplemental Security Income (SSI)

   c. Have been institutionalized for at least 30 consecutive full days in a Long-Term Care institution. The 30 consecutive full day stay may be a combination of days in a hospital, Long-Term Care institution, or receiving services from a Home and Community Based Services (HCBS) program or Program of All Inclusive Care for the Elderly (PACE).

      Supporting documentation must be provided which verifies the 30 consecutive full days. This documentation shall include the ULTC 100.2 and/or medical records which must be verified by a physician or case manager.

      If a client dies prior to the 30th consecutive full day, the client shall be determined to have met the 30 consecutive full day requirement if:

      i) There is a statement from a physician, or case manager that declares if the client had not died, he/she would have been institutionalized for 30 consecutive full days, and;

      ii) The statement is verified by supporting documentation from the beginning of the institutionalized period, which is the first 15 days, or prior to the death of the client, whichever is earliest.

      iii) Once the 30 consecutive days of institutionalization requirement has been met, Medical Assistance benefits start as of the first day when institutionalization began if all other eligibility requirements were met as of that date.

   d. Are in a facility eligible for Medical Assistance Program reimbursement if the individual is in a hospital or Long-Term Care institution; and

   e. Have gross income that does not exceed 300% of the current individual SSI benefit level or;

Are in a Long-Term Care institution (excluding hospital) whose gross income exceeds the 300% level and who establishes an income trust in accordance with the rules on income trusts in section 8.100.7 of this volume;

i) This special income standard must be applied for:

1) A person 65 years of age or older, or disabled or blind receiving care in a hospital, nursing facility; or

2) A person who is not SSI eligible needing Long-Term Care from HCBS or PACE; or

3) A person 65 years of age or older receiving active treatment as an inpatient in a psychiatric facility eligible for Medical Assistance reimbursement; and

f. Have resources that conform with the regulations regarding resource limits and exemptions set forth in section 8.100.5 of this volume; and

g. If married, Income and resources conform to rules set forth at 8.100.7.C and 8.100.7.K; and

h. Have not transferred assets without fair consideration on or after the look-back date defined in section 8.100.7.F.2.d. which would incur a penalty period of ineligibility in accordance with the regulations on transfers without fair consideration in section 8.100.7 of this volume; and

i. Have submitted trust documents to the Department if the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of trust. The Department shall determine the effect of the trust on Medical Assistance Program eligibility.

j. Have submitted documents verifying that an annuity conforms to the regulations regarding Annuities at 8.100.7.I.

3. An appeal process is available to children identified by C.R.S. 27-10.3-101 to 108, The Child Mental Health Treatment Act, who are denied residential treatment. The appeal process is outlined in the Income Maintenance Staff Manual of the Department of Human Services (9 CCR 2503-1). A determination made in connection with this appeal shall not be the final agency action with regard to Medical Assistance eligibility

8.100.7.B. Persons Requesting Long-term Care through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE)

1. HCBS or PACE shall be provided to persons who have been assessed by the Single Entry Point/Case Management Agency to have met the functional level of care and will remain in the community by receiving HCBS or PACE; and

a. are SSI (including 1619b) or OAP Medicaid eligible; or

b. are eligible under the Institutionalized 300% Special Income category described at 8.100.7.A; or

c. are eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P. For this group, access to HCBS:

i) Is limited to the Elderly, Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Brain Injury (BI), Spinal Cord Injury (SCI) and Supported Living Services (SLS) waivers; and

ii) Is contingent on the Department receiving all necessary federal approval for the waiver amendments that extend access to HCBS to the Working Adults with Disabilities population described at 8.100.6.P.

2. A client who is already Medicaid eligible does not need to submit a new application. The client must request the need for Long-Term Care services and the Eligibility Site must redetermine the client's eligibility.

a. All individuals applying for or requesting Long-Term Care services must disclose and provide documentation of:

i) any transfer of assets without fair consideration as described at 8.100.7.F; and

ii) any interest in an annuity as described at 8.100.7.I; and

iii) any interest in a trust as described at 8.100.7.E.

b. Failure to disclose and provide documentation of the assets described at 8.100.7.B.2.a may result in the denial of Long-Term Care services.

c. The requirements at 8.100.7.B.2.a and 8.100.7.B.2.b do not apply to individuals who have been determined eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P.

3. For individuals served in Alternative Care Facilities (ACF), income in excess of the personal needs allowance and room and board amount for the ACF shall be applied to the Medical Assistance charges for ACF services. The total amount allowed for personal need and room and board cannot exceed the State's Old Age Pension Standard.

8.100.7.C. Treatment of Income and Resources for Married Couples

1. The income of a community spouse is not deemed to the institutionalized spouse in determining eligibility. If both spouses are institutionalized, their individual income is counted in determining their own eligibility. The income of one institutionalized spouse is not deemed to the other institutionalized spouse when determining eligibility.

2. The income and resources of both spouses are counted in determining eligibility for either or both spouses with the following exceptions:

a. If spouses share the same room in an institution, the income of the individual spouse is counted in determining his or her eligibility, and each spouse is allowed the $2000 limit for resources.

b. Beginning the first month following the month the couple ceases to live together, only the income of the individual spouse is counted in determining his or her eligibility.

c. If one spouse is applying for Long-Term Care in a Long-Term Care institution or Home and Community Based Services (HCBS), refer to the rules on Treatment of Income and Resources for Institutionalized Spouses.

3. Long term care insurance benefits are not countable as income, but are payable as part of the patient payment to the Long-Term Care institution.

4. For living expense purposes, income and resources of spouses living in the same household for a full calendar month or more must be considered as available to each other, whether or not they are actually contributed, and must be evaluated in accordance with rules contained in 8.100.7.Q.

Long-Term Care

8.100.7.D. Other Medical Assistance Clients Requesting Long-Term Care in an Institution or through HCBS or PACE

Clients who need Long-Term Care services who are eligible for the State Only Health Care Program shall submit an application because they are not already Medicaid eligible.

8.100.7.E Consideration of Trusts in Determining Medical Assistance Eligibility

1. Trusts established before August 11, 1993:

   a. Medical Assistance Qualifying Trust (MQT)

      i) In the case of a Medical Assistance qualifying trust, as defined in 42 U.S.C. Sec. 1396a(k), the amount of the trust property that is considered available to the applicant/recipient who established the trust (or whose spouse established the trust) is the maximum amount that the trustee(s) is permitted under the trust to distribute to the individual assuming the full exercise of discretion by the trustee(s) for the distribution of the maximum amount to the applicant/recipient. This amount of property is deemed available resources to the individual, whether or not is actually received.

      ii) 42 U.S.C. Sec. 1396a(k) was repealed in 1993 and is reprinted here exclusively for purposes of trusts established before August 11, 1993. 42 U.S.C. Sec. 1396a(k) defines a Medical Assistance qualifying trust as “a trust, or similar legal device, established (other than by will) by an individual (or an individual's spouse) under which the individual may be the beneficiary of all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.”

   b. This provision does not apply to any trust or initial decrees established before April 7, 1986, solely for the benefit of a developmentally disabled individual who resides in an Long Term Care Institution for the developmentally disabled.

   c. This provision does not apply to individuals who are receiving SSI.

2. Trusts established on or after July 1, 1994:

   Assets include all income and resources of the individual and the individual's spouse, including all income and resources which the individual or the individual's spouse is entitled to but does not receive because of action by any of the following:

   a. The individual or the individual's spouse,

b. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse, or

c. Any person court or administrative body acting at the direction of or upon the request of the individual or the individual's spouse.

3. In determining an individual's eligibility for Medical Assistance, the following regulations apply to a trust established by an individual:

a. An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust, and if any of the following individuals established the trust, other than by will:

i) The individual or the individual's spouse

ii) A person, including a court or administrative body, with legal authority to act in place of, or on the behalf of, the individual or the individual's spouse;

iii) A person, including a court or administrative body acting at the direction or upon the request of the individual or the individual's spouse.

b. In the case of a trust, the corpus of which includes assets of an individual and the assets of any other person(s), this regulation shall apply to the portion of the trust attributable to the assets of the individual.

c. These regulations apply without regard to the following:

i) The purposes for which a trust is established;

ii) Whether the trustees have or exercise any discretion under the trust;

iii) Any restrictions on when or whether distributions may be made from the trust; or

iv) Any restrictions on the use of distributions from the trust.

4. Revocable Trusts are considered as follows:

a. The corpus of the trust shall be considered resources available to the individual.

b. Payments from the trust to or for the benefit of the individual shall be considered income to the individual, and

c. Any other payments from the trust shall be considered assets transferred by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.

5. Irrevocable Trusts

If there are any circumstances under which payments from the trust could be made to or for the benefit of the individual, the following shall apply:

a) The portion of the corpus of the trust, or the income on the corpus, from which payment to the individual could be made, shall be considered as resources available to the individual.

b) Payments from that portion of the corpus, or income to or for the benefit of the individual, shall be considered income to the individual.

c) Payments from that portion of the corpus or income for any other purpose shall be considered as a transfer of assets by the individual for less than fair market value and are subject to a 60 month look back period and a penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume.

d) Any portion of the trust from which, or any income on the corpus from which no payment could be made to the individual under any circumstances, shall be considered as a transfer of assets for less than fair market value and shall be subject to a 60 month look back period and penalty period of ineligibility as set forth in the regulations on transfers without fair consideration in this volume. The transfer will be effective as of the date of the establishment of the trust, or the date on which payment to the individual from the trust was foreclosed, if later. The value of the trust shall be determined by including the amount of any payments made from such portion of the trust after such date.

6. The preceding regulations for trusts established on or after July 1, 1994, do not apply to the following:

a. Income Trusts

i) A trust consisting only of the individual's pension income, social security income and other monthly income that is established for the purpose of establishing income eligibility for Long Term Care institution care or Home and Community Based Services (HCBS). To be valid, the trust must meet the following criteria:

a) The individual's gross monthly income must be above the 300%-SSI limit but below the average cost of private Long Term Care institution care in the geographic region in which the individual resides and intends to remain. The Colorado Department of Health Care Policy and Financing shall calculate the average rates for such regions on an annual, calendar-year basis. The geographic regions which are used for calculating the average private pay rate for Long Term Care institution care shall be based on the Bureau of Economic Analysis Regions and consist of the following counties:

REGION I: (Adams, Arapahoe, Boulder, Broomfield, Denver, Jefferson)

REGION II: (Cheyenne, Clear Creek, Douglas, Elbert, Gilpin, Grand, Jackson, Kit Carson, Larimer, Logan, Morgan, Park, Phillips, Sedgwick, Summit, Washington, Weld, Yuma)

REGION III: (Alamosa, Baca, Bent, Chaffee, Conejos, Costilla, Crowley, Custer, El Paso, Fremont, Huerfano, Kiowa, Lake, Las Animas, Lincoln, Mineral, Otero, Prowers, Pueblo, Rio Grande, Saguache, Teller)

REGION IV: (Archuleta, Delta, Dolores, Eagle, Garfield, Gunnison, Hinsdale, La Plata, Mesa, Moffat, Montezuma, Montrose, Ouray, Pitkin, Rio Blanco, Routt, San Juan, San Miguel)

b) For Long Term Care institution clients, each month the trustee shall distribute the entire amount of income which is transferred into the trust. An amount not to exceed $20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust.

c) The only deductions from the monthly trust distribution to the Long Term Care institution are the allowable deductions which are permitted for Medical Assistance-eligible persons who do not have income trusts. Allowable deductions include only the following:

i) Personal need allowance

ii) Spousal income payments

iii) Approved PETI payments

d) Any funds remaining after the allowable deductions shall be paid solely to the cost of the Long Term Care institution care in an amount not to exceed the Medical Assistance reimbursement rate. Any excess income which is not distributed shall accumulate in the trust.

e) No other deductions or expenses may be paid from the trust. Expenses which cannot be paid from the trust include, but are not limited to, trustee fees, attorney fees and costs (including attorney fees and costs incurred in establishing the trust), accountant fees, court fees and costs, fees for guardians ad litem, funeral expenses, past-due medical bills and other debts. Trustee fees which were ordered prior to April 1, 1996 may continue until the trust terminates.

f) For HCBS clients, the amount distributed each month shall be limited to the 300% of the SSI limit. Any monthly income above that amount shall remain in the trust. An amount not to exceed $20.00 may be retained for trust expenses such as bank charges if such charges are expected to be incurred by the trust. No other trust expenses or deductions may be paid from the trust. For the purpose of calculating Individual Cost Containment or client payment (PETI), the client's monthly income will be 300% of the SSI limit. Upon termination, the funds which have accumulated in the trust shall be paid to the Department up to the total amount of Medical Assistance paid on behalf of the individual.

g) For a court-approved trust, notice of the time and place of the hearing, with the petition and trust attached, shall be given to the eligibility site and the Department in the manner prescribed by law.

h) The sole beneficiaries of the trust are the individual for whose benefit the trust is established and the Department. The trust terminates upon the death of the individual or if the trust is not required for Medical Assistance eligibility in Colorado.

i) The trust must provide that upon the death of the individual or termination of the trust, whichever occurs sooner, the Department shall receive all amounts remaining in the trust up to the total amount of Medical Assistance paid on behalf of the individual.

j) The trust must include the name and mailing address of the trustee. The trustee must notify the Department of any trustee address changes or change of trustee(s) within 30 calendar days.

k) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the eligibility site or to the Department upon reasonable request or upon any change of trustee.

l) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.

m) The regulations in this section for income trusts shall also apply to income trusts established after January 1, 1992, under the undue hardship provisions in 26-4-506.3(3),C.R.S. and 15-14-412.5,C.R.S.

b. Disability Trusts

i) A trust that is established solely for the benefit of a disabled individual under the age of 65, which consists of the assets of the individual, and is established for the purpose or with the effect of establishing or maintaining the individual's resource eligibility for Medical Assistance and which meets the following criteria:

a) The individual for whom the trust is established must meet the disability criteria of Social Security.

b) The only assets used to fund the trust are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under Sullivan v. Zebley. (This provision is applicable to disability trusts established from July 1, 1994 to December 31, 2000.)

c) The trust is established solely for the benefit of the disabled individual by the individual, the individual’s parent, the individual’s grandparent, the individual’s legal guardian, or by the court.

d) The sole lifetime beneficiaries of the trust are the individual for whose benefit the trust is established and the Colorado Department of Health Care Policy and Financing

e) The trust terminates upon the death of the individual or if the trust is no longer required for Medical Assistance eligibility in Colorado.

f) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the trust and approval of the trust.

g) If the trust is funded with an annuity or other periodic payments, the Department shall be named on the contract or settlement as the remainder beneficiary up to the amount of Medical Assistance paid on behalf of the individual.

h) The trust shall provide that, upon the death of the beneficiary or termination of the trust, the Department shall receive all amounts remaining in the trust up to the amount of total Medical Assistance paid on behalf of the individual.

i) No expenditures may be made after the death of the beneficiary, except for federal and state taxes. However, prior to the death of the individual beneficiary, trust funds may be used to purchase a burial fund for the beneficiary.

j) The amount remaining in the trust and an accounting of the trust shall be due to the Department within three months after the death of the individual or termination of the trust, whichever is sooner. An extension of time may be granted by the Department if a written request is submitted within two months of the termination of the trust.

k) The trust fund shall not be considered as a countable resource in determining eligibility for Medical Assistance.

l) [Rule 8.110.52 B 5. b. 1) l), adopted or amended on or after November 1, 2000 and before November 1, 2001 was not extended by HB 02-1203, and therefore expired May 15, 2002.]

m) Distributions from the trust may be made only to or for the benefit of the individual beneficiary. Cash distributions from the trust shall be considered income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.

n) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward eligibility.

o) The trust must include the name and mailing address of the trustee. The Department must be notified of any trustee address changes or change of trustee(s) within 30 calendar days.

p) The trust must provide that an annual accounting of trust income and expenditures and an annual statement of trust assets shall be submitted to the eligibility site or to the Department upon reasonable request or upon any change of trustee.

q) Prior to the establishment or funding of a disability trust, the trust shall be submitted for review to the Department, along with proof that the individual beneficiary is disabled according to Social Security criteria. No disability trust shall be valid unless the Department has reviewed the trust and determined that the trust conforms to the requirements of 15-14-412.8,C.R.S., as amended, and any rules adopted by the Medical Services Board.

c. Pooled Trusts

i) A trust consisting of individual accounts established for disabled individuals for the purpose of establishing resource eligibility for Medical Assistance. A valid pooled trust shall meet the following criteria:

a) The individual for whom the trust is established must meet the disability criteria of Social Security.

b) The trust is established and managed by a non-profit association which has been approved by the Internal Revenue Service.

c) A separate account is maintained for each beneficiary; however, the trust pools the accounts for the purposes of investment and management of the funds.

d) The sole lifetime beneficiaries of each trust account are the individual for whom the trust is established and the Department.

e) If the trust is funded with an annuity or other periodic payments, the Department or the pooled trust shall be named as remainder beneficiary.

f) The trust account shall be established by the disabled individual, parent, grandparent, legal guardian, or the court.

g) The only assets used to fund each trust account are (1) the proceeds from any personal injury case brought on behalf of the disabled individual, or (2) retroactive payments of SSI benefits under Sullivan v. Zeblev . (This provision is applicable to pooled trusts established from July 1, 1994 to December 31, 2000.)

h) Any statutory lien pursuant to section 25.5-4-301(5), C.R.S. must be satisfied prior to funding of the individual's trust account and approval of the joinder agreement.

i) Following the disabled individual's death or termination of the trust account, whichever occurs sooner, to the extent that the remaining funds in the trust account are not retained by the pooled trust, the Department shall receive any amount remaining in the individual's trust account up to the total amount of Medical Assistance paid on behalf of the individual.

j) The pooled trust account shall not be considered as a countable resource in determining Medical Assistance eligibility.

k) Distributions from the trust account may be made only to or for the benefit of the individual. Cash distributions to the individual from the trust shall be considered as income to the individual. Distributions for food or shelter are considered in-kind income and are countable toward income eligibility.

l) If exempt resources are purchased with trust funds, those resources continue to be exempt. If non-exempt resources are purchased, those resources are countable toward resource eligibility.

ii) If an institutionalized individual for whom a pooled trust is established is 65 years of age or older, the transfer of assets into the pooled trust creates a rebuttable resumption that the assets were transferred without fair consideration and shall be analyzed in accordance with the rules on transfers without fair consideration in this volume. This regulation is effective for transfers to pooled trusts after January 1, 2001.

iii) When the individual beneficiary of an income, disability or pooled trust dies or the trust is terminated, the trustee shall promptly notify the eligibility site and the Department. To the extent required by these rules the trustee shall promptly forward the remainder of the trust property to the Department, up to the amount of Medical Assistance paid on behalf of the individual beneficiary.

d. Third Party Trusts

i) Third party trusts are trusts which are established with assets which are contributed by individuals other than the applicant or the applicant's spouse for the benefit of an applicant or client

ii) The terms of the trust will determine whether the trust fund is countable as a resource or income for Medical Assistance eligibility.

iii) Trusts which limit distributions to non-support or supplemental needs will not be considered as a countable resource. If distributions are made for income or resources, such distributions are countable as such for eligibility.

iv) If the trust requires income distributions, the amount of the income shall be countable as income in determining eligibility.

v) If the trust requires principal distributions, that amount shall be considered as a countable resource.

vi) If the trustee may exercise discretion in distributing income or resources, the income or resources are not countable in determining eligibility. If distributions are made for income or resources, such distributions are countable as such for eligibility.

e. Federally Approved Trusts

i) If an SSI recipient has a trust which has been approved by the Social Security Administration, eligibility for Medical Assistance cannot be delayed or denied. Individuals on SSI are automatically eligible for Medical Assistance despite the existence of a federally approved trust.

ii) If the eligibility site has a copy of a federally approved trust, the eligibility site must send a copy to the Department.

7. Submission of Trust Documents and Records

a. The trustee of a trust which was established by or which benefits a Medical Assistance Applicant or client shall submit trust documents and records to the eligibility site and to the Department.

b. This requirement includes documents and records for income trusts, disability trusts and the joinder agreement for each pooled trust account.

c. The eligibility site shall submit any trust which is submitted with an application or at redetermination to The Department. The eligibility site shall determine Medical Assistance eligibility based on the determination of The Department as to the effect of the trust on eligibility.

8.100.7.F. Transfers of Assets Without Fair Consideration

1. Definitions. The following definitions apply to transfers of assets without fair considerations:

   a. “Assets” include all income and resources of the individual and such individual's spouse, including any interest in income or a resource as well as all income or resources which the individual or such individual's spouse is entitled to but does not receive because of action by any of the following:

      i) The individual or such individual's spouse,

      ii) A person, a court, or administrative body with legal authority to act on behalf of the individual or such individual's spouse, or

      iii) Any person, court or administrative body acting at the direction of or upon the request of the individual or such individual's spouse.

   b. “Fair market value” is the value of the asset if sold at the prevailing price at the time it was transferred.

   c. “Fair consideration” is the amount the individual receives in exchange for the asset that is transferred, which is equal to or greater than the value of the transferred asset.

   d. “Look-back period” means the number of months prior to the month of application for long-term care services that the Department will consider for transfer of assets.

   e. “Penalty period” means a period of time for which an applicant or client will not be eligible to receive long-term care services.

   f. “Uncompensated value” shall mean the fair market value of an asset at the time of the transfer minus the value of compensation the individual receives in exchange for the asset.

   g. “Valuable consideration” shall mean what an individual receives in exchange for his or her right or interest in an asset which has a tangible and/or intrinsic value to the individual that is equivalent to or greater than the value of the transferred asset.

2. General Provisions

   If an institutionalized individual or the spouse of such individual disposes of assets without fair consideration on or after the look-back period, the individual shall be subject to a period of ineligibility for Long-Term Care services, including Long-Term Care institution care, Home and Community Based Services (HCBS), and the Program of All Inclusive Care for the Elderly (PACE).

   a. For transfers made before February 8, 2006, the look-back period is 36 months prior to the date of application. For transfers made on or after February 8, 2006, the look-back date is 60 months prior to the date of application.

   b. An institutionalized individual is one who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

   c. If an institutionalized individual or such individual's spouse transfers assets without fair consideration on or after the look-back period, the transfer shall be evaluated as follows:

i) The fair market value of the transferred asset, less the actual amount received, if any, shall be divided by the average of the regions, defined at 8.100.7.E, monthly private pay cost for Long-Term Care institution care in the state of Colorado at the time of application.

ii) The resulting number is the number of months that the individual shall be ineligible for Medical Assistance. For transfers made before February 8, 2006, the period of ineligibility shall begin with the first day of the month following the month in which the transfer occurred. For transfers made on or after February 8, 2006, the period of ineligibility shall begin on the later of the following dates:

a) The first day of the month following the month in which the transfer occurred or is discovered. For transfers discovered after the date the transfer occurred, the date of transfer shall be the discovery date.

Or;

b) The date on which the individual would initially be eligible for HCBS, PACE or institutional services based on an approved application for such assistance that were it not for the imposition of the penalty period, would be covered by Medical Assistance;

And;

c) Which does not occur during any other period of ineligibility for services by reason of a transfer of assets penalty.

d. The period of ineligibility shall also include partial months, which shall be calculated by multiplying 30 days by the decimal fractional share of the partial month. The result is the number of days of ineligibility. For transfers occurring on or after April 1, 2006, the result shall be rounded up to the nearest whole number.

e. There is no maximum period of ineligibility.

f. For transfers prior to February 8, 2006, the total amount of all of the transfers are added together and the period of ineligibility begins the first day of the month following the month in which the resources are transferred.

i) If the previous penalty period has completely expired, the transfers are not added together.

ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior penalty period, the new penalty period begins the first day after the prior penalty period expires.

g. For transfers on or after February 8, 2006, the total amounts of all of the transfers are added together and the penalty period is assessed as outlined in section 8.100.7.F.2.c-dabove.

i) If the previous penalty period has completely expired, the transfers are not added together.

ii) If the previous penalty period has not completely expired and the first day of the month following the month in which the resources are transferred is part of a prior

penalty period, the new penalty period begins the first day after the prior penalty period expires.

h. The institutionalized individual may continue to be eligible for Supplemental Security Income (SSI) and basic Medical Assistance services, but shall not be eligible for Medical Assistance for Long-Term Care institution services, Home and Community Based Services or the Program of All Inclusive Care for the Elderly due to the transfer without fair consideration.

i. If a transfer without fair consideration is made during a period of eligibility, a period of ineligibility shall be assessed in the same manner as stated above.

j. Actions that prevent income or resources from being received, or reduce an individual's ownership, right or interest in an asset such that the individual does not receive valuable consideration as set forth on the following list, which is not exclusive, shall create a rebuttable presumption that the transfer was without fair consideration:

i) Waiving pension income.

ii) Waiving a right to receive an inheritance.

iii) Preventing access to assets to which an individual is entitled by diverting them to a trust or similar device. This is not applicable to valid income trusts, disability trusts and pooled trusts for individuals under the age of 65 years.

iv) Failure of a surviving spouse to elect a share of a spouse's estate or failure to open an estate within 6 months after a spouse's death.

v) Failure to obtain a family allowance or exempt property allowance from an estate of a deceased spouse or parent. Such allowances are presumed to be available 3 months after death.

vi) Not accepting or accessing a personal injury settlement.

vii) Transferring assets into an irrevocable private annuity which was not purchased from a commercial company.

viii) Transferring assets into an irrevocable entity such as a Family Limited Partnership which eliminates or restricts the individual's access to the assets.

ix) Refusal to take legal action to obtain a court ordered payment that is not being paid, such as child support or alimony, if the benefit outweighs the cost.

x) Failure to exercise rights in a Dissolution of Marriage case, which insure an equitable distribution of marital property and income.

xi) Purchasing a single-premium life insurance policy, endowment policy or similar instrument within the look-back period, which has no cash value, and for which the individual receives no valuable consideration shall be considered an uncompensated transfer. The total amount of the purchase price shall be considered a transfer without fair consideration.

8.100.7.G. Treatment of Certain Assets as Transfers Without Fair Consideration

1. Promissory notes established before April 1, 2006:

a. The fair market value of promissory notes is a countable resource and must be evaluated in accordance with the regulations on consideration of resources in this volume.

b. Promissory notes with one or more of the following provisions, indicating they have little or no market value, shall create a rebuttable presumption of a transfer without fair consideration:

i) An interest rate lower than the prevailing market rate.

ii) A term for repayment longer than the life expectancy of the holder of the note, as determined by the tables at 8.100.7.J.for annuities purchased on or after February 8, 2006.

iii) Low payments.

iv) Cancellation at the death of the note holder.

c. Promissory notes which have been appraised by a note broker as having little or no value shall create a rebuttable presumption of a transfer without fair consideration.

2. Promissory notes established on or after April 1, 2006 but before March 1, 2007

a. Subject to the look-back date described in section 8.100.7.F.2.b for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.n. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c.

3. Promissory notes established on or after March 1, 2007

a. Subject to the look-back date described in section 8.100.7.F.2.b, for the purpose of calculating the penalty period of ineligibility for a transfer without fair consideration, the value of a promissory note, loan or mortgage which does not meet the criteria in section 8.100.5.M.3.o. is the outstanding balance due as of the date of the individual's application for Medical Assistance for services, described in section 8.100.7.F.2.c..

4. Personal care services

a. Effective for agreements that were signed and notarized prior to March 1, 2007, family members who provide assistance or services are presumed to do so for love and affection, and compensation for past assistance or services shall create a rebuttable presumption of a transfer without fair consideration unless the compensation is in accordance with the following:

i) A written agreement must be executed prior to the delivery of services.

ii) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement.

iii) The agreement must be dated and the signature must be notarized; and

iv) Compensation for services rendered must be comparable to what is received in the open market.

b. Effective for agreements that are signed and notarized on or after March 1, 2007, compensation under personal service agreements will be deemed to be a transfer without fair consideration unless the following requirements are met:

i) A written agreement was executed prior to the delivery of services; and

a) The agreement must be signed by the applicant, or a legally authorized representative, such as agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative may not be a beneficiary of the agreement; and

b) The legally authorized representative, agent, guardian, conservator, or other representative of the applicant's estate may not be a beneficiary of a care agreement; and

c) The agreement specifies the type, frequency and time to be spent providing the services agreed to in exchange for the payment or transferred item; and

d) The agreement provides for payment of services on a regular basis, no less frequently than monthly, while the services are being provided; and

ii) Compensation for services rendered must be comparable to what is received in the open market. The burden is on the applicant to prove that the compensation is reasonable and comparable; and

iii) A record or log is provided which details the actual services rendered. The services cannot be services that duplicate services that another party is being paid to provide or which another party is responsible to provide.

c. Payment for services, which were rendered previously and for which no compensation was made, shall be considered as a transfer without fair consideration.

d. Assets transferred in exchange for a contract for personal services for future assistance after the date of application are considered available resources.

e. A care agreement must be entered into, signed, and notarized prior to providing any services for which a beneficiary will be compensated.

5. Transfers of real property into joint tenancy without fair consideration

a. If real property is transferred into joint tenancy with right of survivorship with one or more joint tenants, the amount transferred depends on the number of joint tenants to whom the property is transferred. The following are examples:

i) If the transfer is to one joint tenant, the amount transferred is equal to one-half of the value of the property at the time of the transfer.

ii) If the transfer is to two joint tenants, the amount transferred is equal to two-thirds of the value.

iii) If the transfer is to three joint tenants, the amount transferred is equal to three-fourths of the value of the property at the time of the transfer.

b. If the transfer is completed with two deeds or transactions, the first of which transfers a fractional share of the property into tenancy in common, and the second into joint tenancy, the amount transferred shall be determined in the same manner as set forth above.

6. No period of ineligibility will be imposed if the individual transferred the assets under any of following circumstances:

a. The asset transferred was a home and title to the home was transferred to:

i) The spouse of such individual;

ii) A child of such individual who is either

1) Under the age of 21 years, or

2) Is blind or totally and permanently disabled as determined by the Social Security Administration.

iii) A brother or sister

1) Who has an equity interest in the home and

2) Who was residing in such individual's home for at least one year immediately before the date that the individual becomes institutionalized.

iv) A son or a daughter of such individual

1) Who was residing in the home for a period of at least two years immediately before the date the individual becomes institutionalized and

2) Who provided care to such individual by objective evidence, that permitted such individual to reside at home rather than in an institution.

3) Documentation shall be submitted proving that the son or daughter's sole residence was the home of the parent. The parent's attending physician(s) or professional health provider(s) during the past two years must substantiate in writing that the care was provided, and that the care prevented the parent from requiring placement in a Long-Term Care institution.

b. The assets were transferred:

i) To the individual's spouse or to another for the sole benefit of the individual's spouse.

ii) From the individual's spouse to another for the sole benefit of the individual's spouse.

iii) To a trust which is established solely for benefit of the individual's child who is determined to be blind or totally disabled by the Social Security Administration or to that child directly for the sole benefit of the child.

iv) To a trust established solely for the benefit of an individual under 65 years of age who is determined to be blind or totally disabled by the Social Security Administration.

c. Definition of the term “for the sole benefit of,” as used in the preceding exceptions to the transfer penalty rules:

i). A transfer or a trust is considered to be for the sole benefit of the spouse, blind or disabled child, or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child, or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any time in the future.

ii). To insure that the asset transferred is for the sole benefit of the spouse, blind or disabled child or disabled individual, the following criteria must be met:

1) The transfer must be accomplished by a written instrument which legally binds the parties to a specified course of action and sets forth:

a) The conditions under which the transfer was made, and

b) A statement as to whom can benefit from the transfer.

2) The written instrument must provide for the spending of funds or use of the transferred assets for the benefit of the individual on a basis that is actuarially sound based on the life expectancy of the individual.

3) Disability trusts and income trusts, which designate the Colorado Department of Health Care Policy and Financing as the remainder beneficiary up to the amount of Medical Assistance paid on behalf of the individual, are exempt from this requirement.

4) A community spouse to whom a Community Spouse Resource Allowance has been transferred does not have to provide a written document or comply with the requirement that the transfer is actuarially sound. However, the Community Spouse Resource Allowance must be for the sole benefit of the community spouse to whom it is transferred. Upon the death of the community spouse, those resources shall be made available to the surviving spouse, at least up to the amount of the elective share of the augmented estate, the family allowance and the exempt property allowance.

7. There is a rebuttable presumption the transfer without fair consideration was made for purposes of Medical Assistance eligibility or avoiding the medical assistance estate recovery program.

a. The presumption that an asset was transferred to establish or maintain Medicaid eligibility or to avoid the medical assistance estate recovery program is rebutted only if the individual or individual’s spouse demonstrates by providing convincing evidence that the asset was transferred exclusively for some other purpose and the reason for the transfer did not include Medical Assistance eligibility or avoidance of medical assistance estate recovery..

b. A subjective statement of intent or ignorance of the transfer penalty or verbal assurances that the individual was not considering Medical Assistance eligibility when the transfer was made are not sufficient.

c. There is a rebuttable presumption that transfers without fair consideration were made for the purpose of Medical Assistance eligibility in the following cases:

i) In any case in which the individual's assets and the assets of the individual's spouse remaining after the transfer total an amount insufficient to meet all living expenses and medical expenses reasonably expected to be incurred by the individual or the individual's spouse in the sixty (60) months following the transfer. Medical expenses include the cost of Long-Term Care unless the future necessity of such care could have been absolutely precluded because of the particular circumstances.

ii) In any case where:

1) the transfer was made on behalf of the individual or the individual's spouse;

2) the transfer was made by:

a) the individual or individual’s spouse

b) a guardian,

c) a conservator, or

d) agent under a power of attorney; and

3) the transfer was made to:

a) anyone related to the individual or individual’s spouse by birth, adoption or marriage, other than between the individual and the individual’s spouse; or to

b) anyone related to the guardian, conservator, or agent under a power of attorney by birth, adoption or marriage.

d. Convincing evidence may include, but is not limited to, verification which establishes:

i) That at the time of the transfer the individual could not have anticipated needing long term Medical Assistance due to the existence of other circumstances which would have precluded the need.

ii) Other assets were available at the time of the transfer to meet current and future needs of the individual, including the cost of Long-Term Care institution or other institutionalized care for a period of sixty (60) months.

iii) The specific purpose for which the assets were transferred and the reason the transfer was necessary and the reason there was no alternative but to transfer the assets without fair consideration.

8. Apportionment of penalty period between spouses

a. If a transfer results in a period of ineligibility for an individual, and the individual's spouse becomes institutionalized and is otherwise eligible for Medical Assistance, the period of ineligibility shall be apportioned equally between the spouses.

b. If one spouse dies or is no longer institutionalized, any months remaining in the period of ineligibility shall be assigned to the spouse who remains institutionalized.

9. If the individual or the individual's spouse has transferred assets into a trust or is a beneficiary of a trust, the trust document shall be submitted to the Colorado Department of Health Care Policy and Financing to determine the effect of the trust on Medical Assistance eligibility.

10. Notice

a. The Colorado Department of Health Care Policy and Financing is an interested person according to 15-14-406, C.R.S. or a successor statute.

b. As an interested party, the department shall be given notice of a hearing in cases in which Medical Assistance planning or Medical Assistance eligibility is set forth in the petition as a factor for requesting court authority to transfer property.

11. Undue Hardship

a. The period of ineligibility resulting from the imposition of the transfer or the trust provisions may be waived if denial of eligibility would create an undue hardship for an individual who is otherwise eligible. Undue hardship can be established if application of the transfer penalty would:

i) deprive the individual of medical care such that the individual’s health or life would be endangered; or

ii) deprive the individual of food, clothing, shelter or other necessities of life.

b. Undue hardship shall not exist when the application of the trust or transfer rules merely causes the individual inconvenience or when such application might restrict his or her lifestyle but would not put him or her at risk of serious deprivation.

c. Notice of an undue hardship exception shall be given to the applicant or client. The Eligibility Site shall make a determination on the request within 15 working days from when the request is received. The Eligibility Site shall issue a notice of action on the determination of hardship. An adverse determination may be appealed in accordance with the appeal process as described at Section 8.057 of this volume.

d. The facility in which an institutionalized individual is residing may file an undue hardship waiver application on behalf of the individual with the individual's or his or her personal representative's consent. Where the individual is unable to give consent and where the personal representative of the individual has a conflict of interest concerning the particular circumstance giving rise to the period of ineligibility, the facility may request an undue hardship on behalf of the individual. An example of such a conflict of interest would be a situation where the personal representative who is also an agent under a power of attorney transfers property to himself or herself. The facility shall submit the undue hardship request to the Eligibility Site and give sufficient detail of the circumstance surrounding the conflict of interest and the information required below to the Eligibility Site. These provisions are not intended to change the Department’s requirements under Section 8.057 of the Department’s regulations as to who has standing to file an appeal.

e. An individual or representative may request that the Eligibility Site waive a transfer penalty on the basis of undue hardship. The request shall be made in writing to the applicant's or client's Eligibility Site case worker. The individual making the request has the burden of proof and must provide clear and convincing evidence to substantiate the circumstances surrounding the transfer, attempts to recover the assets, and the impact of the denial of Medicaid payments for Long-Term Care services. The request and documentation shall include all of the following:

i) the reason(s) for the transfer including the individual's participation in the transfer or grant of legal authority to another that gave rise to the transfer, and the relationship between the transferor and transferee;

ii) evidence to prove that the assets have been irretrievably lost and that all reasonable attempts made to recover the asset(s), including any legal actions and the results of the attempts, including but not limited to a request for an adult protection investigation (such as in a case of financial exploitation), filing a police report, or filing a civil action have been exhausted or have been or are being pursued; and,

iii) documentation such as a notice of discharge or pending discharge from the facility and a physician's statement detailing how the inability to receive nursing facility or community based services would result in the individual's inability to obtain life-sustaining medical care or that the individual would not be able to obtain food, clothing or shelter.

f. To the extent that the transferred assets are recovered pursuant to the attempts in (e)(ii) above, the individual shall reimburse Medicaid for the funds expended as a result of an approved undue hardship request.

g. If the transferee and the transferor of the assets for which the transfer penalty is being imposed are related parties there shall be a rebuttable presumption that the transferred assets are not irretrievably lost as required under (e)(ii) above. Related parties are described in Section 8.100.7.G.7.c.ii of these regulations.

12. No period of ineligibility shall be assessed in any of the following circumstances:

a. Convincing and objective evidence is provided that the individual intended to dispose of the resources either at fair market value or for other fair consideration.

b. Convincing and objective evidence is presented proving that the resources were transferred exclusively for a purpose other than to qualify or remain eligible for Medical Assistance.

c. All of the resources transferred without fair consideration have been returned to the individual.

d. For assets transferred before February 8, 2006, the assets were transferred more than 36 months prior to the date of application.

e. For assets transferred before February 8, 2006, the penalty period has expired based on the following formula: The fair market value of the transferred asset is divided by the average cost of Long Term Care institution care in the state at the time of application and the resulting number of months of ineligibility has ended prior to the date of application.

8.100.7.H. Life Estates

1. Definitions

a. “Fair Market Value” means the amount for which a property or interest in a property could reasonably be expected to sell on the open market.

b. “Life Estate.” A life estate conveys upon a grantee certain rights in property measured by the life of the life estate holder or of some other person. The owner of a life estate has the right to possess the property, the right to use the property, the right to obtain profits from the property, and the right to sell the life estate interest in the property. The establishment of a life estate on a property results in the creation of two interests: a life estate interest and a remainder interest.

c. “Remainder Interest” means an interest in property created at the time a life estate is established which gives the holder of the interest the right to ownership of the property upon the death of the life estate holder. An individual holding a remainder interest is free to sell his or her interest in the property unless the sale is restricted by the terms of the instrument which established the remainder interest.

2. General Provisions

a. Life Estates Established before July 1, 1995

i) Transfer without fair consideration Treatment

1) The establishment of a life estate before July 1, 1995 by an individual or individual’s spouse shall not be considered a transfer without fair consideration.

ii) Resource Treatment

1) A life estate owned by an individual or individual’s spouse that was established on exempt property shall be considered to be an exempt resource.

2) A life estate owned by an individual or individual’s spouse that was established on countable property shall be considered a countable resource.

i) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.

3) A remainder interest held by an individual or individual’s spouse on exempt property shall be considered an exempt resource.

4) A remainder interest held by an individual or individual’s spouse on countable property shall be considered a countable resource

i) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.a.

b. Life Estates Established on or after July 1, 1995

i) Transfer without fair consideration Treatment

1) The establishment of a life estate on or after July 1, 1995 on property owned by an individual or individual's spouse shall be considered a transfer without fair consideration if the life estate was established within the look-back period described at 8.100.7.F.2.b.

a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be based on the value of the remainder interest, as calculated using the methodology described at 8.100.7.H.4.a.

2) The purchase of a life estate interest in a home not owned by an individual or individual's spouse on or after April 1, 2006 within the look-back period described at 8.100.7.F.2.b. shall be considered a transfer without fair consideration unless the purchaser lives in the home for a period of at least twelve (12) consecutive months after the date of the purchase.

a) For the purpose of determining the transfer without fair consideration penalty period, the amount of the transfer shall be the entire amount used to purchase the life estate.

b) If the payment for the life estate exceeds the value of the life estate, as calculated using the methodology described at 8.100.7.H.3, then the difference between the amount paid and the value of the life estate shall be considered to be a transfer without fair consideration.

ii) Resource Treatment

1) A life estate owned by an individual or individual's spouse that was established on exempt property shall be considered an exempt resource.

2) A life estate owned by an individual or individual's spouse that was established on countable property shall be considered a countable resource.

a) The value of the life estate shall be determined by using the methodology described at 8.100.7.H.3.a.

3) A remainder interest held by an individual or individual's spouse on exempt property shall be considered an exempt resource.

5) A remainder interest held by an individual or individual's spouse on countable property shall be considered a countable resource

a) The value of the remainder interest shall be determined by using the methodology described at 8.100.7.H.4.

3. Determining the Value of a Life Estate

a. The value of a life estate interest is calculated using the following method:

i) Determine the fair market value of the property on which the life estate was established. The fair market value shall be obtained by using the most recent

actual value reported by the county assessor or from the most recent property assessment notice. If the actual value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

ii) Multiply the fair market value of the property by the "Life Estate" factor in Column 1 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the life estate interest.

b. If a life estate was established on property held by spouses in joint tenancy, then the age of the youngest individual shall be used to calculate the value of the life estate.

4. Determining the Value of a Remainder Interest

a. The value of a remainder interest is calculated using the following method:

i) Determine the fair market value of the property on which the remainder interest was established. The fair market value shall be obtained by using the most recent actual value reported by the county assessor or from the most recent property assessment notice. If the market value is not shown on the property assessment notice, the assessed value shall be divided by the appropriate property assessment rate to obtain the market value.

ii) Multiply the fair market value of the property by the "Remainder" factor in Column 2 from the Life Estate Table at 8.100.7.H.5, in this section, that corresponds to the life estate holder's age as of his or her last birthday. The result is the value of the remainder interest.

b. If a life estate was established on property held by spouses in joint tenancy, then the age of the youngest individual shall be used to calculate the value of the remainder interest.

5. Life Estate Table

This rule incorporates by reference the Social Security life estate and remainder interest table effective April 1999 to the present. The incorporation of the table excludes later amendments, or editions of, the referenced material.

The Social Security life estate and remainder interest tables are available at http://policy.ssa.gov/poms.nsf/lnx/0501140120

Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.7.I. Annuities

1. DEFINITIONS

a. "Annuity" means a contract between an individual and a commercial company in which the individual invests funds and in return receives installments for life or for a specified number of years.

b. "Annuitant" means an individual who is entitled to receive payments from an annuity.

c. “Annuitization Period” means the period of time during which an annuity makes payments to an annuitant.

d. “Annuitized” means an annuity that has become irrevocable and is making payments to an annuitant.

e. “Assignable” means an annuity that can have its owner and/or annuitant changed.

f. “Balloon Payment” means a lump sum equal to the initial annuity premium less any distributions paid out before the end of an annuitization period.

g. “Beneficiary” means an individual or individuals entitled to receive any remaining payments from an annuity upon the death of the annuitant.

h. “Department” means the Department of Health Care Policy and Financing, its successor(s), or its designee(s).

i. “Irrevocable” means an annuity that cannot be canceled, revoked, terminated, or surrendered under any circumstances.

j. “Non-assignable” means an annuity that cannot have its owner and/or annuitant changed under any circumstances.

k. “Owner” means the person who may exercise the rights provided in an annuity contract during the life of the annuitant. An owner can generally name himself or herself or another person as the annuitant.

l. “Revocable” means an annuity that can be canceled, revoked, terminated, or surrendered.

m. “Transaction” means:

i) The purchase of an annuity;

ii) The addition of principal to an annuity;

iii) Elective withdrawals from an annuity;

iv) Requests to change the distributions from an annuity;

v) Elections to annuitize an annuity contract; or

vi) Any other action taken by an individual that changes the course of payments made by an annuity or the treatment of income or principal of an annuity.

2. Annuities purchased on or before June 30, 1995

a. A revocable or irrevocable annuity established on or before June 30, 1995 is not a countable resource if it is annuitized and regular returns are being received by the annuitant.

i) Payments from the annuity to the individual or individual’s spouse are income in the month received.

b. A revocable or irrevocable annuity established on or before June 30, 1995 is a countable resource if it has not been annuitized.

3. Annuities Established on or after July 1, 1995 but before February 8, 2006

a. The purchase of an annuity shall be considered to be a transfer without fair consideration unless the following criteria are met:

i) The annuity is purchased from a life insurance company or other commercial company that sells annuities as part of its normal course of business;

ii) The annuity is annuitized for the individual or individual's spouse;

iii) The annuity is purchased on the life of the individual or individual's spouse; and

iv) The annuity provides payments for a period not exceeding the annuitant's projected life expectancy based on life expectancy tables described at 8.100.7.J.

b. To determine if a transfer without fair consideration has occurred in the purchase of an annuity, the Eligibility Site shall:

i) Determine the date on which the annuity was purchased;

ii) Determine the amount of money used to purchase the annuity and the length of the annuitization period;

iii) Determine the age of the annuitant at the time the annuity was purchased; and

iv) Determine the life expectancy of the annuitant at the time the annuity was purchased using the appropriate life expectancy table described at 8.100.7.J.

1) If the length of the annuitization period exceeds the annuitant's life expectancy, then a transfer without fair consideration exists for the portion of the annuitization period that exceeds the annuitant's life expectancy.

2) If the total value of the annuity's payments during the annuitization period is less than the original purchase price of the annuity, then the difference shall be considered to be a transfer without fair consideration.

3) If the total value of the annuity's payments during the annuitization period is equal to or greater than the original purchase price of the annuity, then the purchase of the annuity shall not be considered to be a transfer without fair consideration. However, any payments made by the annuity shall be considered to be countable income in the month received.

4) If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period. However, any payments made by the annuity shall be considered to be countable income in the month received.

4. Annuities Established on or after April 1, 1998 but before February 8, 2006

a. The Eligibility Site shall determine the Minimum Monthly Maintenance Needs Allowance (MMMNA) of the community spouse, if applicable.

i) If the monthly payment amount provided by the annuity to the community spouse exceeds the MMMNA, then the amount of the annuity which causes the monthly annuity payment to exceed the MMMNA shall be considered to be a transfer without fair consideration in determining the institutionalized spouse's eligibility. This applies only to the extent that the transferred amount causes the Community Spouse Resource Allowance to exceed the maximum.

b. The Eligibility Site shall determine if the Individual is receiving substantially equal installments from the annuity for the annuitization period of the annuity.

i) If the annuity is not paid in substantially equal installments, then the original purchase price of the annuity shall be considered to be a transfer without fair consideration.

c. If the annuity was purchased more than 36 months before the date of application for Medicaid, then there is no transfer without fair consideration penalty period.

i) Any payments made by the annuity shall be considered to be countable income in the month received.

5. Annuities Purchased on or after February 8, 2006

a. As a condition of Medicaid eligibility, at the time of application or redetermination, an applicant or his or her spouse for Medicaid Long-Term Care services shall disclose any interest that the Medicaid applicant or his or her spouse has in an annuity.

i) A complete copy of the annuity contract, including the most recent beneficiary designation, shall be provided to the eligibility site.

b. By providing Medicaid Long-Term Care services, the Department shall be a remainder beneficiary of any annuity in which an individual or individual's spouse has an interest. The purchase of the annuity shall not be considered to be a transfer without fair consideration if:

i) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the individual; or

ii) The Department is named as the remainder beneficiary in the next position after the community spouse or minor or disabled child.

iii) This provision shall not apply to annuities that are revocable and/or assignable.

c. The Eligibility Site shall notify the issuer of the annuity that the Department is a preferred remainder beneficiary in the annuity for medical assistance provided to the institutionalized individual. This notice shall include a statement requiring the issuer to notify the Eligibility Site of any changes in the amount of income or principal that is being withdrawn from the annuity or any other transactions, as defined at 8.100.7.I.1., regardless of when the annuity was purchased.

d. If the Department is not named on the annuity as a remainder beneficiary, then the value of funds used to purchase the annuity shall be deemed a transfer without fair consideration and shall be subject to the penalty period provisions described at 8.100.7.F.

i) This provision shall not apply to annuities that are revocable and/or assignable.

e. Revocable Annuities

i) A revocable annuity is a countable resource. The value of the annuity is the total value of the annuity principal plus any accumulated interest.

a) If the annuity includes a surrender charge or other financial penalty (other than tax withholding or a tax penalty) for withdrawing funds from the annuity, then the value of the annuity is the net amount the individual would receive upon full surrender of the annuity.

ii) Payments from a revocable annuity are not countable as income.

f. Irrevocable Assignable Annuities

i) An irrevocable assignable annuity is a countable resource. The value of the annuity is presumed to be the total value of the annuity principal plus any accumulated interest.

a) An individual or individual's spouse can rebut the presumption by providing documented offers from at least three companies who are active in the market for buying and selling annuities an annuity income streams. The value of the annuity shall then be the highest of the offers.

b) Any payments from an irrevocable assignable annuity that is considered to be a countable resource are not considered to be countable income.

ii) An individual or individual's spouse can rebut the presumption that an irrevocable assignable annuity is not a countable resource by providing documented offers from at least three companies who are active in the market for buying and selling annuities and annuity income streams stating their unwillingness or inability to purchase the annuity or annuity income stream.

a) Any payments from an irrevocable assignable annuity that is not considered to be a countable resource are considered to be countable income in the month received.

g. Irrevocable Non-Assignable Annuities

i) An irrevocable non-assignable annuity is not considered to be a countable resource.

ii) Payments from an irrevocable non-assignable annuity are considered countable income in the month received.

iii) An irrevocable non-assignable annuity purchased by or for the benefit of a community spouse shall not be considered to be a transfer without fair consideration if:

1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

iv) An irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if:

1) The Department is named as the remainder beneficiary in the first position for the total amount of medical assistance paid on behalf of the institutionalized individual; or

2) The Department is named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or a representative of such child disposes of any such remainder without fair consideration.

v) In addition to the requirements listed at 8.100.7.I.5.g.iv) for naming the Department as remainder beneficiary, an irrevocable non-assignable annuity purchased by or for the benefit of an institutionalized individual shall not be considered to be a transfer without fair consideration if the annuity meets any one of the following conditions:

1) The annuity is considered either:

a) An Individual Retirement Annuity as described in Section 408(b) of the Internal Revenue Code of 1986; or

b) A deemed Individual Retirement Account under a qualified employer plan described in Section 408(q) of the Internal Revenue Code of 1986; or

2) The annuity is purchased with proceeds from one of the following:

a) An Individual Retirement Account as described in Section 408(a) of the Internal Revenue Code of 1986; or

b) An account established by an employer or association of employers as described in Section 408(c) of the Internal Revenue Code of 1986; or

c) A simple retirement account as described in Section 408(p) of the Internal Revenue Code of 1986; or

d) A simplified employee pension plan as described in Section 408(k) of the Internal Revenue Code of 1986; or

e) A Roth IRA as described in Section 408A of the Internal Revenue Code of 1986; or

3) The annuity meets all of the following requirements:

a) The annuity is irrevocable and non-assignable; and

b) The annuity is actuarially sound based on the life expectancy tables described at 8.100.7.J.; and

c) The annuity provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

vi) If an irrevocable non-assignable annuity is considered to be a transfer without fair consideration, then, for the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount of funds used to purchase the annuity.

h. Annuity Transactions

i) If an Individual or individual's spouse undertakes any transaction, as defined at 8.100.7.I.1. which has the effect of changing the course of payments to be made by an annuity or the treatment of income or principal of the annuity, such a transaction shall be deemed to be a transfer without fair consideration, regardless of when the annuity was originally purchased. For the purpose of calculating the transfer without fair consideration penalty period, the value that was transferred shall be the amount used to purchase the annuity.

a) Routine changes such as a notification of an address change or death or divorce of a remainder beneficiary are excluded from treatment as a transfer without fair consideration.

b) Changes which occur based on the terms of the annuity which existed before February 8, 2006 and which do not require a decision, election, or action to take effect are excluded from treatment as a transfer without fair consideration.

c) Changes which are beyond the control of the individual, such as a change in law, a change in the policies of the annuity issuer, or a change in terms based on other factors, such as the annuity issuer's financial condition, are excluded from treatment as a transfer without fair consideration.

8.100.7.J. Life Expectancy Tables

This rule incorporates by reference the Social Security Office of the Chief Actuary Period Life Table 2011 for both males and females. The incorporation of the table excludes later amendments, or editions of, the referenced material.

The Social Security Office of the Chief Actuary Period Life Table 2011 is available at www.ssa.gov/oact/STATS/table4c6.html.

Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.100.7.K. Spousal Protection - Treatment of Income and Resources for Institutionalized Spouses

1. The spousal protection regulations apply to married couples where one spouse is institutionalized or likely to be institutionalized for at least 30 consecutive days and the other spouse remains in the community. Being a community spouse does not prohibit Medicaid eligibility if all criteria are met. The community spouse resource allowance does not supersede the Medicaid eligibility criteria.

2. For purposes of spousal protection, an institutionalized spouse is an individual who:

    a. Begins a stay in a medical institution or nursing facility on or after September 30, 1989, or

    b. Is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or

    c. Receives Home and Community Based Services on or after July 1, 1999; and

    d. Is married to a spouse who is not in a medical institution or nursing facility; but does not include any such individual who is not likely to meet the requirements of subparagraphs 8.100.7.K.2.a thru c for at least 30 consecutive days.

3. A community spouse is defined as the spouse of an institutionalized spouse.

8.100.7.L. Assessment and Documentation of The Couple's Resources

An assessment of the total value of the couple’s resources shall be completed at the time of initial Medical Assistance application or when requested by either spouse of a married couple. All non-exempt resources owned by a married couple are counted, whether owned jointly or individually. There are no exceptions for legal separation, pre-nuptial, or post-nuptial agreements. Once the applicant is approved, the Community Spouses’ resources are not reviewed again unless the Community Spouse applies for Medical Assistance.

8.100.7.M. Calculation of the Community Spouse Resource Allowance

1. A Community Spouse Resource Allowance (CSRA) shall be allocated based on the total resources owned by the couple as of the time of Medical Assistance application. The CSRA is established at intake only, and; once approved the community spouse’s resources are not considered again until the community spouse applies for Medical Assistance. This is true even if the community spouse becomes institutionalized but does not apply for Medical Assistance. In calculating the amount of the CSRA, resources shall not be attributed to the community spouse based upon state laws relating to community property or the division of marital property.

    For persons whose Medical Assistance application is for an individual who meets the definition of an institutionalized spouse, the CSRA is the largest of the following amounts:

    a. The total resources of the couple but no more than the current maximum allowance which, changes each year beginning January 1st.; or

    b. The increased CSRA calculated pursuant to section 8.100.7.S; or

    c. The amount a court has ordered the institutionalized spouse to transfer to the community spouse for monthly support of the community spouse or a dependent family member.

2. The resources allotted to the community spouse as the CSRA shall be transferred into the name of the community spouse and shall not be considered available to the institutionalized spouse. After the transfer of the CSRA to the community spouse, the income from these resources shall be attributed to the community spouse.

3. The transfer of the CSRA shall be completed as soon as possible, but no later than the next redetermination when the community spouse becomes institutionalizes; whichever is earlier. If the transfer is not completed within this time period, the resources shall be attributed to the institutionalized spouse and shall affect his/her Medical Assistance eligibility. Verification of the transfer of assets to the community spouse shall be provided to the eligibility site.

   The institutionalized spouse may transfer the resources allotted to the community spouse as the CSRA to another person for the sole benefit of the community spouse.

4. If the community spouse is in control of resources attributed to the institutionalized spouse, but fails to make such resources available for his/her cost of care, this fact shall not make the institutionalized spouse ineligible for Medical Assistance, where:

   a. The institutionalized spouse has assigned The Department any rights to support from the community spouse; or

   b. The institutionalized spouse lacks the ability to execute an assignment due to physical or mental impairment but The Department has the right to bring a support proceeding against the community spouse without such assignment; or

   c. The eligibility site determines that the denial of eligibility would work an undue hardship upon the institutionalized spouse. For the purposes of this subparagraph, undue hardship means that an institutionalized spouse, who meets all the Medical Assistance eligibility criteria except for resource eligibility, has no alternative living arrangement other than the medical institution or Long Term Care institution.

8.100.7.N. Treatment of the Home and Other Exempt Resources

The CSRA shall not include the value of exempt resources including the home. It is not necessary for the home to be transferred to the community spouse. The rules regarding countable and exempt resources can be found in the section 8.100.5. However, for Spousal Protection there is no limit to the value of household goods and personal effects and one automobile.

8.100.7.O. Determination of the Institutionalized Spouse's Income and Resource Eligibility

1. The institutionalized spouse is resource eligible for Medical Assistance when the total resources owned by the couple are at or below the amount of the Community Spouse Resource Allowance plus the Medical Assistance resource allowance for an individual of $2,000.

2. The eligibility site shall determine whether the institutionalized spouse is income eligible for Medical Assistance. The institutionalized spouse shall be income eligible if his/her gross income is at or below the Medical Assistance income limit for recipients of long-term care. If an income trust is used the trust must be established before the MIA is calculated.

8.100.7.P. Attribution of Income

During any month in which a spouse is institutionalized, the income of the community spouse shall not be deemed available to the institutionalized spouse except as follows:

1. If payment of income from resources is made solely in the name of either the institutionalized spouse or the community spouse, the income shall be considered available only to the named spouse.

2. If payment of income from resources is made in the names of both the institutionalized spouse and the community spouse, one-half of the income shall be considered available to each spouse.

3. If payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income shall be considered available to each spouse in proportion to the spouse's interest.

4. The above regulations of attribution of income are superseded if the institutionalized spouse can establish by a preponderance of the evidence that the ownership interests in the income are other than that provided in the regulations.

8.100.7.Q. Calculating the Community Spouse's Monthly Income Needs

1. The community spouse's total minimum monthly needs shall be determined as follows:

   a. The current minimum monthly maintenance needs allowance (MMMNA), which is equal to 150% of the federal poverty level for a family of two and is adjusted in July of each year;

   b. An excess shelter allowance, in cases where the community spouse's expenses for shelter exceed 30% of the MMMNA. The excess shelter allowance is computed by adding (a) and (b) together:

      i) The community spouse's expenses for rent or mortgage payment including principal and interest, taxes and insurance, and, in the case of a condominium or cooperative, any required maintenance fee, for the community spouse's principal residence; and

      ii) The larger of the following amounts: the standard utility allowance used by Colorado under U.S.C. 2014(e) of Title 7; or the community spouse's actual, verified, utility expenses. A utility allowance shall not be allowed if the utility expenses are included in the rent or maintenance charge, which is paid by the community spouse.

      iii) The excess shelter allowance is the amount, if any, that exceeds 30% of the MMMNA.

2. An additional amount may be approved for the following expenses:

   a. Medical expenses of the community spouse or dependent family member for necessary medical or remedial care. Each medical or remedial care expense claimed for deduction must be documented in a manner that describes the service, the date of the service, the amount of the cost incurred, and the name of the service provider. An expense may be deducted only if it is:

      i) Provided by a medical practitioner licensed to furnish the care;

      ii) Not subject to payment by any third party, including Medical Assistance and Medicare;

b. The cost of Medicare, Long Term Care insurance, and health insurance premiums. A health insurance premium may be allowed in the month the premium is paid or may be prorated and allowed for the months the premium covers. This allowance does not include payments made for coverage which is:

i) Limited to disability or income protection coverage;

ii) Automobile medical payment coverage;

iii) Supplemental to liability insurance;

iv) Designed solely to provide payments on a per diem basis, daily indemnity or non-expense-incurred basis; or

v) Credit life and/or accident and health insurance.

3. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

4. The total that results from adding the current MMMNA and the excess shelter allowance shall not exceed the current maximum MMMNA which is $2,175.00 for the year 2001 and is adjusted by the Health Care Financing Administration in January of each year.

8.100.7.R. Calculating the Amount of Income to be Contributed by the Institutionalized Spouse for the Community Spouse's Monthly Needs

1. The Monthly Income Allowance (MIA) is the amount of money necessary to raise the community spouse's income to the level of his/her monthly needs, and shall be obtained from the monthly income of the institutionalized spouse. For individuals who become institutionalized on or after February 8, 2006, all income of the institutionalized spouse that could be made available to the community spouse must be considered to have been made available to the community spouse before an MIA is allocated to the community spouse.

2. The MIA shall be the amount by which the community spouse's minimum monthly needs, which is the MMMNA, exceed his/her income from sources other than the institutionalized spouse. The community spouse’s income shall be calculated by using the gross income less mandatory deduct ions for FICA and Medicare tax.

3. If a court has entered an order against the institutionalized spouse for monthly support of the community spouse, the MIA shall not be less than the monthly amount ordered by the court.

4. The eligibility site shall make adjustments to the MMMNA and/or the MIA on a monthly basis for any continuing change in circumstances that exceeds $50 a month. Continuing changes of less than $50 in a month, and any infrequent or irregular changes, shall be considered at redetermination.

8.100.7.S. Increasing the Community Spouse Resource Allowance

1. The CSRA shall be increased above the maximum amount if additional resources are needed to raise the community spouse's monthly income to the level of the Minimum Monthly Maintenance

Needs Allowance (MMMNA). In making this determination the items listed below are calculated in the following order:

a. The community spouse's MMMNA;

b. The community spouse’s own income; and

c. The Monthly Income Allowance (MIA) contribution that the community spouse is eligible to receive from the institutionalized spouse.

d. If the community spouse’s own income, and the Monthly Income Allowance contribution from the institutionalized spouse’s income is less than the Minimum Monthly Maintenance Needs Allowance, additional available resources shall be shifted to the community spouse to bring his/her income up to the level of the MMMNA. The additional resources necessary to raise the community spouse’s monthly income to the level of the MMMNA shall be based upon the cost of a single-premium lifetime annuity with monthly payments equal to the difference between the MMMNA and the community spouse’s income. The following steps shall be followed to determine the amount of resources to be shifted:

i) The applicant shall obtain three estimates of the cost of an annuity that would generate enough income to make up the difference between the MMMNA and the combined community spouse’s income as described above.

ii) The amount of the lowest estimate shall be used as the amount of resources to increase the CSRA.

iii) The applicant shall not be required to purchase the annuity in order to have the CSRA increased.

e. The CSRA shall not be increased if the institutionalized spouse refuses to make the monthly income allowance (MIA) available to the community spouse.

8.100.7.T. Deductions from Monthly Income of the Institutionalized Spouse

1. During each month after the institutionalized spouse becomes Medical Assistance eligible, deductions shall be made from the institutionalized spouse's monthly income in the following order.

a. A personal needs allowance or the client maintenance allowance as allowed by program eligibility.

b. A Monthly Income Allowance (MIA) for the community spouse, but only to the extent that income of the institutionalized spouse is actually made available to, or for the benefit of, the community spouse;

c. A family allowance for each dependent family member who lives with the community spouse.

i) The allowance for each dependent family member shall be equal to one third of the amount of the MMMNA and shall be reduced by the monthly income of that family member.

ii) Family member means dependent children (minor or adult), dependent parents or dependent siblings of either spouse that are residing with the community

spouse and can be claimed by either the institutionalized or community spouse as a dependent for federal income tax purposes.

d. Allowable deductions identified in section 8.100.7.V.

e. If the institutionalized spouse fails to make his/her income available to the community spouse or eligible dependent family members in accordance with these regulations, that income shall be applied to the cost of care for the institutionalized spouse.

f. No other deductions shall be allowed.

8.100.7.U. Right to Appeal

1. Both spouses shall be informed of the following:

   a. The amount and method by which the eligibility site calculated the community spouse resource allowance (CSRA), community spouse monthly income allowance (MIA), and any family allowance;

   b. The spouses' right to a fair hearing concerning these calculations;

   c. The eligibility site conclusions with respect to the spouses' ownership and availability of income and resources, and the spouses' right to a fair hearing concerning these conclusions.

2. If either spouse establishes that the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance due to exceptional circumstances, which result in significant financial duress, such as loss of home and possessions due to fire, flood, or tornado, an additional amount may be substituted for the MMMNA if established through a fair hearing.

3. Appeals from decisions made by the eligibility site shall be governed by the provisions under Recipient Appeals Protocols/Process at 8.058.

8.100.7.V. Long-Term Care Institution Recipient Income

1. Determination of Income and Communication between the Long-Term Care institution and the Eligibility Site Using the AP-5615 Form for Patient Payment

   a. Sections I, II and IV of the AP-5615 form are to be completed by the Long-Term Care institution for all admissions, readmissions, transfers to and from another payer source, including private pay and Medicare, discharges, deaths, changes in income and/or patient payment, medical leaves of absence and non-medical/programmatic leave in excess of 42 days combined per calendar year.

   b. The initial determination of resident income for patient payment shall be made by the Eligibility Site. The Eligibility Site shall notify the Long-Term Care institution of current resident income.

   c. On receipt of AP-5615 form, the Eligibility Site will, within five working days:

      i) For an admission, a readmission or a transfer from/to private pay, Medicare, or another payer source:

1) Verify and correct, if necessary, data entered by the Long-Term Care institution.

2) List and/or verify the resident's monthly income adjustments and/or Long-Term Care Insurance benefit payments; and compute patient payment. Provide the completed AP-5615 to the Long-Term Care institution.

3) Correct the automated system to indicate the Long-Term Care institution name and provider number and to reflect the current distribution of income. Submit the AP-5615 form to the Department.

d. For change in patient payment with respect to changes in resident income:

i) Verify changes in resident income, and correct if necessary. All such corrections must be initialed,

ii) Compute patient payment and provide the completed AP-5615 to the Long-Term Care institution.

e. For change in patient payment with respect to the post-eligibility treatment of income, the Eligibility Site shall:

i) Review the AP-5615 form for Medicare part B premium deduction allowances for the first two months of admission.

ii) If client is already on the Medicare Buy-In program for Medicare part B, do not adjust patient payment on AP-5615 form for the Medicare premium deduction. If client is not on the Buy-In program, adjust AP-5615 form for the Medicare premium deduction for the first two months of Long-Term Care institution eligibility.

iii) If the client has a Medicare D premium, the Eligibility Site shall use the amount as an income adjustment/deduction in the patient payment calculation and complete the AP-5615 form.

f. For resident leave of absence:

i) Non-Medical/Programmatic Leave. When combined non-medical/programmatic days in excess of 42 days are reported, verify adherence to the restrictions and conditions of section 8.482.44.

ii) Medical Leave/Hospitalization. Verify that the patient payment is apportioned correctly between the nursing facility and the hospital so that no Medicaid payment is requested for the period. See also section 8.482.43.

iii) The nursing facility may wait until the end of the month to complete the AP-5615 form for an ongoing hospitalization.

g. For change in payer status:

i) If Medicare or insurance is a primary payer during the month, verify the nursing facility’s calculation of the patient payment.

ii) Complete and provide the AP-5615 to the nursing facility.

h. For discharge or death of resident:

i) Verify the date of death or discharge, and verify the correct patient payment including the resident's monthly income for the discharged month, and the amount calculated by per diem. All corrections must be initialed.

ii) Note if the resident entered another Long-Term Care institution and, if so, enter the name of the new Long-Term Care institution in the system.

iii) In the event the resident may return to the same facility, the AP-5615 form may be completed at the end of the month for discharges due to hospitalization.

i. For discontinuation of Long-Term Care eligibility:

i) Initiate and send an AP-5615 form to the Long-Term Care institution within 5 working days of the date of determination that the client’s eligibility will be discontinued. Indicate the date the discontinuation will be effective.

j. Failure to provide a correct and timely AP-5615 to the Long-Term Care institution may result in the refusal of the Department to reimburse such Long-Term Care institution care. The AP-5615 form is required in order for a Prior Authorization Request (PAR) to be issued for Long-Term Care institution claim reimbursement.

k. General Instructions:

i) The AP-5615 form must be verified and a signed AP-5615 form returned to the Long-Term Care institution.

ii) The AP-5615 form must be signed and dated by the director of the Eligibility Site or by his/her designee.

iii) AP-5615 forms may be initiated by either the Long-Term Care institution or Eligibility Site. If the Eligibility Site is aware of information requiring a change in financial arrangements of a resident, and a new AP-5615 form is not forthcoming from the Long-Term Care institution, the Eligibility Site may initiate the revision to the AP-5615 form. In such case, one copy of the AP-5615 form showing the changes will be sent to the Long-Term Care institution.

l. The Department may deduct excess payments from the Eligibility Site administrative reimbursement as stated in the Colorado Department of Human Services Finance Staff Manual, Volume 5 if the Eligibility Site fails to:

i) Perform the duties as detailed in this section; or

ii) Adhere to the limitations on a reduced patient payment; as detailed in section 8.100.7.V.4; or

iii) Notify the Long-Term Care institution within 5 working days of any changes in resident income, provided the Long-Term Care institution is not authorized to receive the resident's income; and excessive Medicaid funds are paid to the Long-Term Care institution as a result of this negligence.

2. Collection of Patient Payment

a. It shall be the responsibility of the Long-Term Care institution to collect from the client, or from the client's family, conservator or administrator, the patient payment, which is to be applied to the cost of client care. The Department is not responsible for any deficiency in patient payment accounts, due to failure of the Long-Term Care institution to collect such income.

b. If, however, the Long-Term Care institution is unable to collect such funds, through refusal of the resident or the resident's family, conservator, administrator or responsible party to release such income, the Long-Term Care institution shall immediately notify the Eligibility Site.

c. When notified by the Long-Term Care institution of the refusal of the client or the client's family, conservator administrator or responsible party to pay the patient payment due, the Eligibility Site shall immediately contact the refusing party. If, after such contact, the party still refuses to release such income, the action shall be deemed a failure to cooperate, and the Eligibility Site shall proceed to discontinue Medicaid benefits for the resident.

3. Calculation of Patient Payment

a. Specific instructions for computing the patient payment amount are contained in this volume under The “Status of Long-Term Care institution Care” Form, AP-5615

b. Once an applicant for Nursing Facility Medical Assistance has been determined eligible for Medical Assistance, the Eligibility Site shall determine the patient payment due to the Nursing Facility which is to be applied to the Medicaid reimbursement for the cost of care. That patient payment is calculated by:

i) Determining all applicable income of the recipient

ii) Deducting all applicable allowable monthly income adjustments, which include:

1) Personal Needs Allowance

2) If applicable, Monthly Income Allowance for the community spouse.

3) If applicable, Family Dependent Allowance

4) If applicable, Home Maintenance Allowance

5) If applicable, Trustee/Maintenance Fees: actual fees, with a maximum of $20 per month

6) If applicable, Mandatory Income Tax Withheld

7) Mandatory garnishments repaying Federal assistance overpayment

8) Medical or remedial care expenses that are not subject to payment by a third party:

a) Medicare Part B Premium expenses, if applicable, are deductible only for the first and second month in the Nursing Facility.

b) Medicare Part D Premium expenses, if applicable, are ongoing deductions.

c) Other medical and remedial expenses covered under the Nursing Facility PETI (NF PETI) program are not deductible. NF PETI-approved expenses are allowed only for residents with a patient payment, but do not change the patient payment amount. For NF PETI, see the Section 8.482.33 in this volume “Post Eligibility Treatment of Income”.

c. Long-Term Care Insurance

Long-Term Care insurance payments are not counted as income for eligibility purposes. However, they are income available for a patient payment. The patient payment shall include the client’s income after the allowable deductions and any Long-Term Care insurance payments for the month. In the event that the patient payment is greater than the cost of care, the Long-Term Care insurance payment shall be applied before the client’s income.

i) If Long-Term Care insurance is received for the month, and:

1) If, after all deductions, the client has income available for a patient payment, add this to the amount of the Long-Term Care insurance to determine the total patient payment.

a) If the total amount is greater that the allowable cost of care, the Long-Term Care insurance is applied before the client’s income, or;

b If after all deductions, the client does not have income available for the patient payment, only the Long-Term Care insurance payment is used.

d. Personal Needs Allowances

i) Non-Veteran related personal needs allowance

1) Prior to January 1, 2015 the personal needs allowance base amount is $50 per month.

2) Effective January 1, 2015 the personal needs allowance base amount is $75 per month and will be adjusted annually at the same rate as the statewide average of the nursing facility per diem rate net of patient payment pursuant to C.R.S. § 25.5-6-202(9)(b)(I). Each yearly adjustment will set a new base amount.

a) The first annual rate adjustment to the new $75 base amount will occur on January 1, 2015.

ii) Veterans-related personal needs allowance

Effective 07/01/91, the personal needs allowance shall be $90 per month for a veteran in a Long-Term Care institution who has no spouse or dependent child and who receives a non-service connected disability pension from the U.S. Veterans Administration. The personal needs allowance shall also be $90 per month for the widow(er) of a veteran with no dependent children.

1) Public Law requires that a veteran, without a spouse or dependent child, who enters a Long-Term Care institution have their veteran's pension reduced to $90 which is to be reserved for their personal needs. This reduction in pension is not applicable to veteran's who reside in a State Veteran's Nursing facility. If a veteran, who does not reside in a State Veteran's Nursing facility, receives a pension reduction of $90 he/she is allowed to apply this $90 to his/her personal needs allowance. It is not considered income toward the patient payment. The same regulation applies to a widow of a veteran without any dependent children.

2) To verify if those veterans residing in State Veteran's Nursing facilities are receiving a non-service connected pension you may request their award letter from the Department of Veterans Affairs or call the Department of Veterans Affairs and verify through contact. If they are receiving any amount in a non-service connected pension they are entitled to a $90 personal needs allowance so long as they do not have a spouse or dependent child. The same regulation applies to a widow of a veteran without any dependent children.

iii) For aged, disabled, or blind Long-Term Care institution recipients engaged in income-producing activities, an additional amount of $65 per month plus one-half of the remaining gross income may be retained by the individual.

iv) Effective September 15, 1994, aged, disabled, or blind Long-Term Care institution residents, HCBS or PACE recipients with mandatory withholdings from earned or unearned income to cover federal state, and local taxes may have an additional amount included as a deduction from the patient payment. The patient payment deduction must be for a specific accounting period when the taxes are owed and expected to be withheld from income or paid by the individual in the accounting period. The Eligibility Site must verify that the taxes were withheld. If the taxes are not paid, the Eligibility Site must establish a recovery. The deduction is also applicable for any Federal pensions with mandated tax withholdings from unearned income despite the individual earner being institutionalized. All other pensions will discontinue the tax withholding once notified that the recipient is receiving institutionalized care through Medicaid, thus signifying that the withholding was not mandatory. This deduction does not apply to individuals who have elected to have taxes withheld from their earnings as a means to receiving a greater tax refund.

e. The reserve specified in section 8.100.7.V.3.d.iii. of this volume shall apply to Long-Term Care institution residents who are engaged in income-producing activities on a regular basis. Types of income-producing activities include:

i) work in a sheltered workshop or work activity center;

ii) "protected employment" which means the employer gives special privileges to the individual;

iii) an activity that produced income in connection with a course of vocational rehabilitation;

iv) employment training sessions;

v) activities within the facility such as crafts products and facility employment.

f. In determining the personal needs reserve amount for Long-Term Care institution residents engaged in income-producing activities:

i) The personal needs allowance is reserved from earned income only when the person has insufficient unearned income to meet this need;

ii) In determining countable earned income of a Long-Term Care institution resident, the following rules shall apply:

1) $65 shall be subtracted from the gross earned income.

2) The result shall be divided in half.

3) The remaining income is the countable earned income and shall be considered in determining the patient payment.

iii) When the personal needs allowance is reserved from unearned income, the additional reserve is computed based on the total gross earned income.

g. Other Deductions Reserved from Recipient's Income:

i) In the case of a married, long-term care recipient who is institutionalized in a Long-Term Care institution and who has a spouse (and, in some cases, other dependent family members) living in the community, there are “spousal protection” rules which permit the contribution of the institutionalized spouse's income toward their living expenses. See section 8.100.7.K.

ii) For a Long-Term Care institution recipient with no family at home, an amount in addition to the personal needs allowance may be reserved for maintenance of the recipient's home for a temporary period, not to exceed 6 months, if a physician has certified that the person is likely to return to his/her home within that period.

This additional reserve from recipient income is referred to as Home Maintenance Allowance and the amount of the deduction must be based on actual and verified shelter expenses such as mortgage payments, taxes, utilities to prevent freeze, etc.

The Home Maintenance Allowance:

1) Prior to July 1, 2018 shall not exceed the total of the current shelter and utilities components of the applicable standard of assistance (OAP for aged recipients; AND/SSI-CS or AB/SSI-CS for disabled or blind recipients).

2) Beginning July 1, 2018

a) The Home Maintenance Allowance shall not exceed the Home Maintenance Allowance Maximum described in this section.

Claimable utility costs will be limited to the lessor of the following amounts:

The standard utility allowance used by Colorado under 7 U.S.C. 2014(e) (2018), which is hereby incorporated by reference.

The incorporation of 7 U.S.C. 2014(e) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

Or;

The individual's actual, verified, utility expenses.

b) The Maximum Home Maintenance Allowance is The Individual Needs Standard minus 105% Federal Poverty Limit (FPL) for a household of 1, rounded to the nearest whole dollar, and is determined as follows:

(1) The Department will calculate the Individual Needs Standard by dividing the Federal Minimum Monthly Maintenance Needs Allowance maximum by the Federal Minimum Monthly Maintenance Needs Allowance (MMMNA), described at 8.100.7.Q, which is in place on January 1st of each calendar year. The result of this division will be multiplied by 150% of FPL for a household of 1.

(2) The Home Maintenance Maximum is determined by subtracting 150% FPL for a household of 1 from the Individual Needs Standard and adding 30% of 150% FPL for a household of 1. The result will be rounded to the nearest whole dollar.

h. The necessity for the deduction from a recipient's income specified in section 8.100.7.V.3 shall be fully explained in the case record. Such additional reserve amount must be entered on the eligibility reporting form.

i. As of July 1, 1988, an SSI cash recipient may continue to receive SSI benefits when he/she is expected to be institutionalized for three months or less. This provision is intended to allow temporarily institutionalized recipients to pay the necessary expenses to maintain the principal place of residence.

i) Payments made under this continued benefit provision are not considered over-payments of SSI benefits if the recipient's stay is more than 90 days.

ii) The amount of Supplemental Security Income (SSI) benefit paid to an institutionalized individual is deducted from gross income when computing the patient payment.

j. When a nursing facility resident's SSI is reduced due to institutionalization, the difference between the reduced SSI payment and the personal needs allowance amount shall be provided through the Adult Financial program so that the resident receives the full personal needs allowance.

4. Reduction of the Patient Payment

a. Patient payment may be reduced only under the following conditions:

i) A resident's income is equal to or less than the personal needs allowance and there is no long term care insurance payment, in which case the patient payment is zero; or

ii) A resident's income is equal to or less than the sum of all allowable and appropriate deductions, and there is no long term care insurance payment; or

iii) A resident is admitted to the Long Term Care institution from his/her home and the resident's funds are committed elsewhere for that month; or

iv) The resident is admitted from his/her home, where his/her funds were previously committed, to the hospital, and subsequently to the Long Term Care institution, in the same calendar month; or

v) The resident is discharged to his/her home, and the Eligibility Site determines that the income is necessary for living expenses; or

vi) The resident is admitted from another Long Term Care institution or from private pay within the facility and has committed the entire patient payment for the month for payment of care already provided in the month of admission.

vii) Medicare assesses a co-insurance payment for a QMB recipient; the recipient's patient payment cannot be used for payment of Medicare co-insurance.

b. Patient payment may not be waived in the following instances:

i) Transfers between nursing facilities, except that the patient payment for the receiving facility may be waived if the patient payment has already been committed to the former nursing facility; or

ii) Discharges from nursing facility to a hospital or other medical institution when Medicaid is paying for services in the medical institution; or

iii) Changes from private pay within the facility and the patient payment is not already committed for care provided under private pay status; or

iv) The death of the resident.

c. The Eligibility Site shall verify and approve partial month patient payments due to transfers, discharges or death when calculated by the nursing facility based upon the nursing facility's per diem rate.

d. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.

5. Responsibilities of the Eligibility Site Regarding the Personal Needs Fund

a. It shall be the responsibility of the Eligibility Site to explain to the resident the various options for handling the personal needs monies, as well as the resident's rights to such funds. The resident has the option to allow the Long Term Care institution to hold such funds in trust.

b. It shall be the responsibility of the Eligibility Site to assure that the Long Term Care institution properly transfers or disposes of the resident's personal needs funds within 30 days of discharge from the Long Term Care institution, or transfer to another Long Term Care institution.

c. The Eligibility Site shall notify the State Department if they become aware that a Long Term Care institution has retained personal needs funds more than 30 days after the death of a resident.

6. For rules regarding post eligibility treatment of income, see the section in this volume titled “Post Eligibility Treatment of Income”

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 22-10-06-H
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-10-06-H, Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Sections 8.300.3 and 8.300.5, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes

   If yes, state effective date: October 14, 2022

   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Replace the current text at 8.300 with the proposed text beginning at 8.300.3.A.6 through the end of 8.300.A.6. Insert the proposed text beginning at 8.300.4 through the end of 8.300.4. Insert the proposed text beginning at 8.300.5.F through the end of 8.300.5.F. This rule is effective October 14, 2022.

*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).

   During the Coronavirus Disease 2019 (COVID-19) public health emergency, subacute care may be administered by an enrolled hospital in its inpatient hospital or alternate care facilities. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Patients may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital. Subacute care will be paid at the rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State Plan. Adding subacute care to the covered hospital services in an inpatient hospital, or an associated alternate care facility, increases access to such services for the duration of the COVID-19 public health emergency.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☒ for the preservation of public health, safety and welfare.

   Explain:

   Addition of subacute care to the list of the covered services for inpatient hospitals, and associated alternate care facilities, increases access to such care for the duration of the COVID-19 public health

emergency and is imperatively necessary for the preservation of public health, safety, and welfare.

3. Federal authority for the Rule, if any:

   42 CFR §447, Subpart C (2020)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);
   C.R.S. 25.5-5-102(1)(a) (2019)

Title of Rule: Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300
Rule Number: MSB 22-10-06-H
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Inpatient hospitals, and associated alternate care facilities (AFC), will be affected by, and benefit from, the proposed rule with the addition of subacute care as a covered treatment modality for the duration of the COVID-19 public health emergency. Clients receiving subacute care in an inpatient hospital, or in an AFC, for the duration of the COVID-19 public health emergency will also be affected by, and benefit from, the proposed rule. The Department will bear the cost of reimbursement for subacute care services authorized under the proposed rule.

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

   The qualitative impact of the proposed rule is adding the subacute care treatment modality to the inpatient hospital, and associated AFC, covered services for the duration of the COVID-19 public health emergency. The proposed rule increases access to such services during the COVID-19 public health emergency by allowing hospitals to treat clients that would normally be discharged from the hospital in order to receive a lower level of care. It may be difficult for hospitals to discharge and place such clients in a skilled nursing facility during the COVID-19 public health emergency due to COVID-19 positive or presumptive status. The proposed rule allows hospitals to treat

such clients on-site and be reimbursed for such care. Because the clients are being treated at an inpatient hospital or alternate care facility for the same care they would have otherwise received at a skilled nursing facility, the proposed rule is budget neutral.

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

   Because the clients treated at an inpatient hospital or alternate care facility for the subacute care under the authority of this rule would have otherwise received such care at a skilled nursing facility, the proposed rule is budget neutral. There are no probable implementation or enforcement costs to the Department or to any other agency. There is no anticipated effect on state revenues.

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

   The probable cost of the proposed rule is reimbursement for subacute care at inpatient hospitals and associated AFCs. The probable benefit of the proposed rule is increased access to subacute care for the duration of the COVID-19 public health emergency. There are no benefits to inaction. Diminished access to subacute care, as described in question two above, for the duration of the COVID-19 public health emergency could be a cost of inaction.

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

   There are no less costly or less intrusive methods for adding subacute care to the covered services for inpatient hospitals and associated AFCs for the duration of the COVID-19 public health emergency.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the

Department and the reasons why they were rejected in favor of the proposed rule.

There are no alternative methods for adding subacute care to the covered services for inpatient hospitals and associated AFCs for the duration of the COVID-19 public health emergency.

8.300 HOSPITAL SERVICES

8.300.3 Covered Hospital Services

8.300.3.A Covered Hospital Services - Inpatient

Inpatient Hospital Services are a Medicaid benefit, when provided by or under the direction of a physician, for as many days as determined Medically Necessary.

1. Inpatient Hospital services include:

    a. bed and board, including special dietary service, in a semi-private room to the extent available;

    b. professional services of hospital staff;

    c. laboratory services, therapeutic or Diagnostic Services involving use of radiology & radioactive isotopes;

    d. emergency room services;

    e. drugs, blood products;

    f. medical supplies, equipment and appliances as related to care and treatment; and

    g. associated services provided in a 24-hour period immediately prior to the Hospital admission, during the Hospital stay and 24 hours immediately after discharge. Such services can include, but are not limited to laboratory, radiology and supply services provided on an outpatient basis.

2. Medical treatment for the acute effects and complications of substance abuse toxicity is a covered benefit.

3. Prior to July 1, 2020, Medicaid payments on behalf of a newborn are included in reimbursement for the period of the mother's hospitalization for the delivery. If there is a Medical Necessity requiring that the infant remain hospitalized following the mother's discharge, services are reimbursed under the newborn's identification number, and separate from the payment for the mother's hospitalization.

    Beginning July 1, 2020, reimbursement for a mother's hospitalization for delivery does not include reimbursement for the newborn's hospitalization. Services shall be reimbursed under the identification number of each client.

4. Psychiatric Hospital Services

    Inpatient Hospital psychiatric care is a Medicaid benefit for individuals age 20 and under when provided as a service of an in-network Hospital.

    a. Inpatient care in a Psychiatric Hospital is limited to forty-five (45) days per state fiscal year, unless additional services are prior-authorized as medically necessary by the Department's utilization review vendor or other Department

representative, and includes physician services, as well as all services identified in 8.300.3.A.1, above.

b. Inpatient psychiatric care in Psychiatric Hospitals is a Medicaid benefit only when:

i. services involve active treatment which a team has determined is necessary on an Inpatient basis and can reasonably be expected to improve the condition or prevent further regression so that the services shall no longer be needed; the team must consist of physicians and other personnel qualified to make determinations with respect to mental health conditions and the treatment thereof; and

ii. services are provided prior to the date the individual attains age 21 or, in the case of an individual who was receiving such services in the period immediately preceding the date on which he/she attained age 21, the date such individual no longer requires such services or, if earlier, the date such individual attains age 22.

c. Medicaid clients obtain access to inpatient psychiatric care through the Community Mental Health Services Program defined in 10 CCR 2505-10, Section 8.212.

5. Inpatient Hospital Dialysis

Inpatient Hospital dialysis treatment is a Medicaid benefit at in-network DRG Hospitals for eligible recipients who are Inpatients only in those cases where hospitalization is required for:

a. an acute medical condition for which dialysis treatments are required; or

b. any other medical condition for which the Medicaid Program provides payment when the eligible recipient receives regular maintenance treatment in an Outpatient dialysis program; or

c. placement or repair of the dialysis route (“shunt”, “cannula”).

6. Inpatient Subacute Care

Administration of subacute care by an enrolled hospital in its inpatient hospital or alternate care facilities is covered for the duration of the Coronavirus Disease 2019 (COVID-19) public health emergency. Subacute care in a hospital setting shall be equivalent to the level of care administered by a skilled nursing facility for skilled nursing and intermediate care services as defined in 10 CCR 2505-10, Sections 8.406 and 8.409. Members may be admitted to subacute care after an inpatient admission, or directly from an emergency department, observation status, or primary care referral to the administering hospital.

8.300.4 Non-Covered Services

The following services are not covered benefits:

1. Inpatient Hospital Services defined as experimental by the United States Food and Drug Administration.

2. Inpatient Hospital Services which are not a covered Medicare benefit.

3. Court-ordered psychiatric Inpatient care which does not meet the Medical Necessity criteria established for such care by the Department's utilization review vendor or other Department representative.

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8.300.5 Payment for Inpatient Hospital Services

8.300.5.F Payment for Inpatient Subacute Care

1. Inpatient Subacute Care days shall be paid at a rate equal to the estimated adjusted State-wide average rate per patient-day paid for services provided in skilled nursing facilities under the State plan approved by the Centers for Medicare and Medicaid Services (CMS), for the State in which such hospital is located.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443
Rule Number: MSB 22-10-06-E
Division / Contact / Phone:Health Program Office / Christina Winship/303-866-5578

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-10-06-E, Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.815, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 10/14/2022

   Is rule to be made permanent? (If yes, please attach notice of hearing). No<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.815 with the proposed text beginning at 8.815.1 through the end of 8.815.1. Replace the current text at 8.815.3 with the proposed text beginning at 8.815.3.A through the end of 8.815.3.A. Replace the current text at 8.815.4 beginning at 8.815.4.A through the end of 8.815.4.C. Replace the current text at 8.815.6 with the proposed text beginning at 8.815.6 through the end of 8.815.6. Replace the current text at

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

8.443 with the proposed text beginning at 8.443.7.A.5 through the end of 8.443.7.A.5. This rule is effective October 14, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443
Rule Number: MSB 22-10-06-E
Division / Contact / Phone: Health Program Office / Christina Winship/303-866-5578

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   This rule revision will allow the Department to reimburse pharmacies for administration of the COVID-19 vaccine in Long-term Care Facilities through the Centers for Disease Control and Prevention's (CDC's) Pharmacy Partnership for Long-term Care Program or other partnership between an LTC and a pharmacy.

2. An emergency rule-making is imperatively necessary

   ☒ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   These revisions are required to facilitate administration of the forthcoming COVID-19 vaccine to nursing home facility residents.

3. Federal authority for the Rule, if any:

   Section 6008(b)(4) of the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), P.L. 116-136

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2022);

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.815 and 8.443
Rule Number: MSB 22-10-06-E
Division / Contact / Phone:Health Program Office / Christina Winship/303-866-5578

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

Health First Colorado members residing in nursing facilities and pharmacy providers licensed to administer vaccines will benefit from the flexibility provided by this rule revision. Current policy limits reimbursement to vaccines ordered by the resident's own physician and administration is either included in the facility's rate or part of a regularly scheduled home health service.

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

This revision will help expedite administration of the COVID-19 vaccine to Health First Colorado members residing in nursing facilities. The rule will also allow nursing facility providers to utilize existing partnerships with pharmacies to administer the vaccine.

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

   The Department expects this change to cost approximately $60,000 in total funds, which will be incorporated through the regular budget process.

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

The proposed rule will facilitate the expeditious administration of the COVID-19 vaccine to this population.

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

   There are no less costly or intrusive methods to achieve the purpose of the proposed rule.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are no alternative methods for achieving the purpose of the proposed rule.

8.815 IMMUNIZATION SERVICES

8.815.1 Definitions

8.815.1.A. Advisory Committee on Immunization Practices (ACIP) means the group of medical and public health experts that develops recommendations on how to use vaccines to control diseases in the United States. ACIP was established under Section 222 of the Public Health Service Act (42 U.S.C. § 2l7a).

8.815.1.B. Immunization means the process whereby a person is made immune or resistant to an infectious disease, typically by the administration of a vaccine.

8.815.1.C. School District means any board of cooperative services established pursuant to article 5 of title 22, C.R.S., any state educational institution that serves students in kindergarten through twelfth grade including, but not limited to, the Colorado School for the Deaf and Blind, created in article 80 of title 22, C.R.S., and any public School District organized under the laws of Colorado except a junior college district.

8.815.1.D. Vaccine means a biological preparation that improves immunity to a particular disease.

8.815.1.E. Vaccine Administration Services means the provision of an injection, nasal absorption, or oral administration of a vaccine product.

8.815.1.F. Vaccines for Children (VFC) means the federally funded program administered through the Centers for Disease Control for the purchase and distribution of pediatric vaccines to program-registered providers for the Immunization of vaccine-eligible children 18 years of age and younger.

8.815.2 Client Eligibility

8.815.2.A. All Colorado Medicaid clients are eligible for Immunization and Vaccine Administration Services.

8.815.3 Provider Eligibility

8.815.3.A. Rendering Providers

1. Colorado Medicaid enrolled providers are eligible to administer Vaccines and Vaccine Administration Services as follows:

    a. If it is within the scope of the provider’s practice;

    b. In accordance with the requirements at 10 CCR 2505-10, Section 8.200.2.; and

    c. If the provider is administering Vaccines and Vaccine Administration Services to a client 18 years of age or younger, the provider is using Vaccines provided free of cost by the federal government, including through the VFC program.

8.815.3.B. Prescribing Providers

1. Colorado Medicaid enrolled providers are eligible to prescribe Vaccines and Vaccine Administration Services in accordance with Section 8.815.3.A.1.a.-b.

8.815.4 Covered Services

8.815.4.A. Vaccines identified in the ACIP Vaccine Recommendations and Guidelines are updated routinely and are covered as follows:

1. For clients 18 years of age and younger, Vaccines are either provided through the VFC program or are otherwise provided without cost by the federal government.

2. For clients 19 years of age and older, Vaccines are covered by Colorado Medicaid.

8.815.4.B. Administration of Vaccines identified in the ACIP Vaccine Recommendations and Guidelines is a covered service for all clients.

8.815.4.C. Immunization and Vaccine Administration Services that are provided by home health agencies, physicians, or other non-physician practitioners to clients at nursing facilities, group homes, or residential treatment centers are covered only as follows:

1. Immunization services for clients who are residents of nursing facilities and clients receiving home health services are covered only if ordered by their physician. The skilled nursing component for Immunization administration provided at a nursing facility is included in the facility's rate or part of a regularly scheduled home health service for clients receiving home health services.

    a. Administration of the COVID-19 vaccine will be reimbursed as specified at 10 CCR 2505-10, Section 8.443.7.A.5.a.

2. Clients who are residents of an Alternative Care Facility, as defined at Section 8.495.1, may receive Immunization services from their own physician. They may also receive Immunization services as part of a home health service in accordance with Section 8.815.4.C.1.

8.815.5 Prior Authorization Requirements

8.815.5.A. Prior authorization is not required for this benefit.

8.815.6 Non-covered Services

8.815.6.A. The following services are not covered by Colorado Medicaid:

1. For clients 18 years of age and younger, Vaccines that have been obtained from a source other than the federal government;

2. Immunization and Vaccine Administration Services provided by a School District provider; and

3. Travel-related Immunization and Vaccine Administration Services.

8.443 NURSING FACILITY REIMBURSEMENT

8.443.7 HEALTH CARE REIMBURSEMENT RATE CALCULATION

8.443.7.A Health Care Services Defined: Health Care Services means the categories of reasonable, necessary and patient-related support services listed below. No service shall be considered a health care service unless it is listed below:

1. The salaries, payroll taxes, worker compensation payments, training and other employee benefits of registered nurses, licensed practical nurses, restorative aides, nurse aides, feeding assistants, registered dietician, MDS coordinators, nursing staff development personnel, nursing administration (not clerical) case manager, patient care coordinator, quality improvement, clinical director. These personnel shall be appropriately licensed and/or certified, although nurse aides may work in any facility for up to four months before becoming certified.

   If a facility employee or a management company/home office employee or owner has dual health care and administrative duties, the provider must keep contemporaneous time records or perform time studies to verify hours worked performing health care related duties. If no contemporaneous time records are kept or time studies performed, total salaries, payroll taxes and benefits of personnel performing health care and administrative functions will be classified as administrative and general. Licenses are not required unless otherwise specified. Periodic time studies in lieu of contemporaneous time records may be used for the allocation. Time studies used must meet the following criteria:

   a. A minimally acceptable time study must encompass at least one full week per month of the cost reporting period.

   b. Each week selected must be a full work week (Monday to Friday, Monday to Saturday, or Sunday to Saturday).

   c. The weeks selected must be equally distributed among the months in the cost reporting period, e.g., for a 12 month period, 3 of the 12 weeks in the study must be the first week beginning in the month, 3 weeks the 2nd week beginning in the month, 3 weeks the 3rd, and 3 weeks the fourth.

   d. No two consecutive months may use the same week for the study, e.g., if the second week beginning in April is the study week for April, the weeks selected for March and May may not be the second week beginning in those months.

   e. The time study must be contemporaneous with the costs to be allocated. Thus, a time study conducted in the current cost reporting year may not be used to allocate the costs of prior or subsequent cost reporting years.

   f. The time study must be provider specific. Thus, chain organizations may not use a time study from one provider to allocate the costs of another provider or a time study of a sample group of providers to allocate the costs of all providers within the chain.

2. The salaries, payroll taxes, workers compensation payments, training and other employee benefits of medical records librarians, social workers, central or medical supplies personnel and activity personnel.

   Health Information Managers (Medical Records Librarians): Must work directly with the maintenance and organization of medical records.

Social Workers: Includes social workers, life enhancement specialists and admissions coordinators.

Central or Medical Supply personnel: Includes duties associated with stocking and ordering medical and/or central supplies.

Activity personnel: Personnel classified as “activities” must have a direct relationship (i.e., providing entertainment, games, and social opportunities) to residents. For instance, security guards and hall monitors do not qualify as activities personnel. Costs associated with security guards and hall monitors are classified as administrative and general.

3. If the provider’s chart of accounts directly identifies payroll taxes and benefits associated with health care versus administrative and general cost centers, the amounts directly identified will be appropriately allowed as either health care or administrative and general. If these costs are comingled in the chart of accounts, payroll taxes and benefits shall be allocated to the cost centers (health care and administrative and general) based on total employee wages reported in those cost centers. The reporting method for payroll taxes and benefits by cost center is required to be consistent from year to year. When a provider wishes to change its reporting method because it believes the change will result in more appropriate and a more accurate allocation, the provider must make a written request to the Department for approval of the change ninety (90) days prior to the end of that cost reporting period. The Department has sixty (60) days from receipt of the request to make a decision or the change is automatically accepted. The provider must include with the request all supporting documentation to establish that the new method is more accurate. If the Department approves the provider's request, the change must be applied to the cost reporting period for which the request was made and to all subsequent cost reporting periods. The approval will be for a minimum three year period. The provider cannot change methods until the three year period has expired.

4. Personnel licensed to perform patient care duties shall be reported in the administrative and general cost center if the duties performed by these personnel are administrative in nature.

5. Non-prescription drugs ordered by a physician that are included in the per diem rate, including costs associated with vaccinations.

    a. Pharmacies are eligible for reimbursement for administration of the COVID-19 vaccine

6. Consultant fees for nursing, medical records, registered dieticians, patient activities, social workers, pharmacies, physicians and therapies. Consultants shall be appropriately licensed and/or certified, as applicable and professionally qualified in the field for which they are consulting. The guidance provided in (1) above for employees also applies to consultants.

7. Purchases, rental, depreciation, interest and repair expenses of health care equipment and medical supplies used for health care services such as nursing care, medical records, social services, therapies and activities. Purchases, lease expenses or fees associated with computers and software (including the associated training and upgrades) used in departments within the facility that provide direct or indirect health care services to residents. Dual purpose software that includes both a health care and administrative and general component will be considered a health care service.

8. Purchase or rental of motor vehicles and related expenses, including salary and benefits associated with the van driver(s), for operating or maintaining the vehicles to the extent

that they are used to transport residents to activities or medical appointments. Such use shall be documented by contemporaneous logs if there is dual purpose. An example of the dual purpose vehicle is one used for both resident transport and maintenance activities.

9. Copier lease expense.

10. Salaries, fees, or other expenses related to health care duties performed by a facility owner or manager who has a medical or nursing credential. Note that costs associated with the Nursing Home Administrator are an administrative and general cost.

11. Related Party Management Fees and Home Office Costs

Related party management fees and home office costs shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the related party which are listed in this section, may be included in the health care cost center equal to the actual costs incurred by the related party. Documentation supporting the cost and health care licenses must be maintained. Only salaries, payroll taxes and employee benefits associated with health care personnel will be considered as allowable in the health care cost center. No overhead expenses will be included. The amount allowable in the health care cost category will be calculated in one of two ways:

a. Keeping contemporaneous time logs in 15 minute increments supporting the number of hours worked at each facility.

b. Distributing the cost evenly across all facilities as follows: the amount allowable in each health care facility's health care costs shall be equal to the total salary, payroll taxes and benefits of the health care personnel divided by the number of facilities where the health care personnel worked during the year. For example, if a nurse's total salary, payroll taxes, and benefits total $80,000, and the nurse worked on five facilities during the year, $16,000 is allowable in each of the facility's health care costs.

Auditable documentation supporting the number of facilities worked on during the year must be maintained. Even if a related party exception is granted in accordance with 10 CCR 2505-10 section 8.441.5.I.4, no mark-up or profit will be allowed in the health care cost center, only supported actual costs.

Non-Related Party Management Fees

Non-related party management fees shall be classified as administrative and general. However, costs incurred by the facility as a direct charge from the management company which are listed in this section, may be included in the health care cost center. Management contracts which specify percentages related to health care services will not be considered a direct charge from the management company.

12. Professional liability insurance, whether self-insurance or purchased, loss settlements, claims paid and insurance deductibles.

13. Medical director fees.

14. Therapies and services provided by an individual qualified to provide these services under Federal Medicare/Medicaid regulations including:

Utilization review
Dental care, when required by federal law
Audiology
Psychology and mental health services
Physical therapy
Recreational therapy
Occupational therapy
Speech therapy

15. Nursing licenses and permits, disposal costs associated with infectious material (medical or hazardous waste), background checks and flu or hepatitis shots and uniforms for personnel listed in (1) above.

16. Food Costs. Food costs means the cost of raw food, and shall not include the costs of property, staff, preparation or other items related to the food program.

8.443.7.B CLASS I HEALTH CARE STATE-WIDE MAXIMUM ALLOWABLE PER DIEM REIMBURSEMENT RATES (LIMIT)

For the purpose of reimbursing Medicaid-certified nursing facility providers a per diem rate for direct and indirect health care services and raw food, the state department shall establish an annual maximum allowable rate (limit). In computing the health care per diem limit, each nursing facility provider shall annually submit cost reports, and actual days of care shall be counted, not occupancy-imputed days of care. The health care limit will be calculated as follows:

1. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed, in accordance with these regulations, by each facility on or before December 31 of the preceding year.

2. The MED-13 cost report shall be deemed filed if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before December 31.

3. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of the limit, the Department may:

   a. Exclude part, or all, of a provider's MED-13.

   b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) published by Global Insight, Inc. measured from the midpoint of the reporting period to the midpoint of the payment-setting period.

4. The health care limit and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

5. The health care limit shall not exceed one hundred twenty-five percent (125%) of the median costs of direct and indirect health care services and raw food as determined by an array of all class I facility providers; except that, for state veteran nursing homes, the health care limit will be one hundred thirty percent (130%) of the median cost.

   a. In determining the median cost, the cost of direct health care shall be case-mix neutral.

b. Actual days of care shall be counted, not occupancy-imputed days of care, for purposes of calculating the health care limit.

c. Amounts contained in cost reports used to determine the health care limit shall be adjusted by the percentage change in the Skilled Nursing Facility Market Basket (without capital) inflation indexes published by Global Insight, Inc. measured from the midpoint of the reporting period of each cost report to the midpoint of the payment-setting period.

i). The percentage change shall be rounded at least to the fifth decimal point.

ii). The latest available publication prior to July 1 rate setting shall be used to determine the inflation indexes.

6. Annually, the state department shall redetermine the median per diem cost based upon the most recent cost reports filed during the period ending December 31 of the prior year.

7. The health care limit for health care reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

8.443.7.C. CLASS I HEALTH CARE PER DIEM LIMITATION ON HEALTH CARE GROWTH

For the fiscal year beginning July 1, 2009, and for each fiscal year thereafter, any increase in the direct and indirect health care services and raw food costs shall not exceed eight percent (8%) per year. The calculation of the eight percent per year limitation for rates effective on July 1, 2009, shall be based on the direct and indirect health care services and raw food costs in the as-filed facility's cost reports up to and including June 30, 2009. For the purposes of calculating the eight percent limitation for rates effective after July 1, 2009, the limitation shall be determined and indexed from the direct and indirect health care services and raw food costs as reported and audited for the rates effective July 1, 2009.

8.443.7.D. CLASS I HEALTH CARE PER DIEM REIMBURSEMENT RATES AND MEDICAID CASE MIX INDEX (CMI):

For the purpose of reimbursing a Medicaid-certified class I nursing facility provider a per diem rate for the cost of direct and indirect health care services and raw food, the State Department shall establish an annually readjusted schedule to pay each nursing facility provider the actual amount of the costs. This payment shall not exceed the health care limit described at 10 CCR 2505-10 section 8.443.7B. The health care per diem reimbursement rate is the lesser of the provider's acuity adjusted health care limit or the provider's acuity adjusted actual allowable health care costs.

The state department shall adjust the per diem rate to the nursing facility provider for the cost of direct health care services based upon the acuity or case-mix of the nursing facility provider's residents in order to adjust for the resource utilization of its residents. The state department shall determine this adjustment in accordance with each resident's status as identified and reported by the nursing facility provider on its federal Medicare and Medicaid minimum data set assessment. The state department shall establish a case-mix index for each nursing facility provider according to the resource utilization groups system, using only nursing weights. The state department shall calculate nursing weights based upon standard nursing time studies and weighted by facility population distribution and Colorado-specific nursing salary ratios. The state department shall determine an average case-mix index for each nursing facility provider's Medicaid residents on a quarterly basis

1. Acuity information used in the calculation of the health care reimbursement rate shall be determined as follows:

    a. A facility's cost report period resident acuity case mix index shall be the average of quarterly resident acuity case mix indices, carried to four decimal places, using the facility wide resident acuity case mix indices. The quarters used in this average shall be the quarters that most closely coincide with the cost reporting period.

    b. The facility's Medicaid resident acuity case mix index shall be a two quarter average, carried to four decimal places, of the Medicaid resident acuity average case mix indices. The two quarter average used in the July 1 rate calculation shall be the same two quarter average used in the rate calculation for the rate effective date prior to July 1.

    c. The statewide average case mix index shall be a simple average, carried to four decimal places, of the cost report period case mix indices for all Medicaid facilities calculated effective each July 1.

    d. The normalization ratio shall be determined by dividing the statewide average case mix index by the facility's cost report period case mix index.

    e. The facility Medicaid acuity ratio shall be determined by dividing the facility's Medicaid resident acuity case mix index by the facility cost report period case mix index.

    f. The facility overall resident acuity ratio shall be determined by dividing the facility cost report period case mix index by the statewide average case mix acuity index.

2. The annual facility specific direct health care maximum reimbursement rate shall be determined as follows:

    a. The percentage of the normalized per diem case mix adjusted nursing cost to total health care cost shall be determined by dividing the normalized per diem case mix adjusted nursing cost by the sum of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

    b. The statewide health care maximum allowable reimbursement rate (calculated at 10 CCR 2505-10 section 8.443.7B) shall be multiplied by the percentage established in the preceding paragraph to determine the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component.

    c. The facility specific maximum reimbursement rate for case mix adjusted nursing costs shall be determined by multiplying the facility specific overall acuity ratio by the amount of the statewide health care maximum allowable reimbursement rate that is attributable to the case mix reimbursement rate component as established in the preceding paragraph.

3. The annual facility specific indirect health care maximum allowable reimbursement shall be determined as follows:

    a. The percentage of the indirect health care per diem cost to total health care cost shall be determined by dividing the indirect health care per diem cost by the sum

of the normalized per diem case mix adjusted nursing cost and other health care per diem cost.

b. The facility specific in direct health care maximum reimbursement rate shall be determined by multiplying the statewide health care maximum allowable reimbursement rate by the percentage established in the preceding paragraph.

4. The case mix reimbursement rate component shall be determined as follows:

a. The case mix reimbursement rate component shall be established using the facility Medicaid resident acuity ratio.

b. This ratio shall be multiplied by the lesser of the facility's allowable case mix adjusted nursing cost or the facility specific maximum reimbursement rate for case mix adjusted nursing costs. The resulting calculation shall the case mix reimbursement rate component.

5. The indirect health care reimbursement rate shall be the lesser of the facility's allowable other health care cost or the facility specific other health care maximum reimbursement rate.

8.443.7.E DETERMINATION OF THE HEALTH CARE SERVICES MAXIMUM ALLOWABLE RATE (LIMIT) FOR CLASS II AND IV FACILITIES

1. For class II facilities, one hundred twenty-five percent (125%) of the median actual costs of all class II facilities;

2. For non-state administered class IV facilities, one hundred twenty-five percent (125%) of the median actual costs of all class IV facilities.

3. State-administered class IV facilities shall not be subject to the health care limit. The Med-13s of the state-administered class IV facilities shall be included in the health care limit calculation for other class IV facilities.

4. The determination of the reasonable cost of services shall be made every 12 months.

5. Determination of the health care limit beginning on July 1 each year shall utilize the most current MED-13 cost report filed in accordance with these regulations, by each facility on or before May 2.

6. The MED-13 cost report shall be deemed submitted if actually received by the Department's designee or postmarked by the U.S. Postal Service on or before May 2nd.

7. If, in the judgment of the Department, the MED-13 contains errors, whether willful or accidental, that would impair the accurate calculation of reasonable costs for the class, the Department may:

a. Exclude part, or all, of a provider's MED-13; or

b. Replace part, or all, of a provider's MED-13 with the MED-13 the provider submitted in its most recent audited cost report adjusted by the change in the "medical care" component of the Consumer Price Index published for all urban consumers (CPI-U) by the United States Department of Labor, Bureau of Labor Statistics over the time period from the provider's most recent audited cost report.

8. State-administered class IV facilities shall not be subject to the maximum reasonable rate ceiling. The Med-13s of the state-administered class IV facilities shall be included in the maximum rate calculation for other class IV facilities.

9. The maximum reasonable rate and the data used in that computation shall be subject to administrative appeal only on or before the expiration of the thirty (30) day period following the date the information is made available.

10. The maximum rate for reimbursement shall be changed effective July 1 of each year and individual facility rates shall be adjusted accordingly.

COLORADO
Department of Health Care Policy & Financing
Medical Services Board

OCTOBER 2022 EMERGENCY JUSTIFICATION FOR MEDICAL ASSISTANCE RULES ADOPTED AT THE OCTOBER 14, 2022 EMERGENCY MEDICAL SERVICES BOARD MEETING

MSB 22-10-06-A, Revision to the Medical Assistance Act Rule concerning Novel Corona Virus Disease (COVID-19) Rules, Section 8.6000

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary for the preservation of public health safety, and welfare.

MSB 22-10-06-B, Revision to the Medical Assistance Rule concerning Provider Enrollment, Sections 8.125.11, 8.125.12, 8.125.13

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The purpose of this emergency rule is to temporarily change regulatory requirements for Department of Health Care Policy and Financing rules to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic. The temporary changes to regulatory requirements in order to provide enhanced flexibility, reduction to programmatic limitations, and alignment with existing federal guidance related to processes under the COVID-19 pandemic is imperatively necessary fo the preservation of public health safety, and welfare.

MSB 22-10-06-C, Revision to the Medical Assistance Act Rule concerning Emergency Medical Transportation, Sections 8.018.1.F. and 8.018.4.D.1

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. Under the Department's current rule, ambulance trips may only be taken to a limited set of medical facilities, the "closest, most appropriate Facility." CMS recently issued an expanded list of allowable destinations for

ambulance trips that qualify for Medicare reimbursement during the COVID-19 public health emergency. This rule will align the Department with that new CMS Medicare guidance by expanding our definition of Facility. The goal is to allow EMT providers to take members to a wider range of medical facilities that are appropriate to the member's condition but that are not necessarily hospitals. This will help prevent hospital overcrowding while also getting members the most appropriate medical care, and will allow utilization of temporary and alternative care sites.
The second change relates to interfacility transportation, which is ambulance transportation from one facility to another, provided the member requires basic or advanced life support en route. This revision suspends the life support requirement. This will allow for members to be moved from one facility to another if they need continued COVID-19-related care, but do not require life support en route. This is imperatively necessary for the preservation of public health safety, and welfare.

MSB 22-10-06-D, Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.1.N, 8.014.3.C.2, 8.014.3.D.1, 8.014.4.A, 8.014.6.A.3

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. Permitting NEMT trips to non-covered places of service will prevent hospital overcrowding while ensuring that members receive treatment for COVID-19. The change allows flexibility and takes advantage of newly established alternative care sites that may be temporary in nature and thus not enrolled in the Colorado Medical Assistance Program. If members with COVID-19 can only receive care at covered places of service, those sites may become overcrowded and may see a shortage of available beds.
Suspending multi-loading will ensure compliance with social distancing guidelines by limiting a vehicle's occupants. It is imperatively necessary for the preservation of public health safety, and welfare.

MSB 22-10-06-E, Revision to the Medical Assistance Act Rule concerning Nursing Facility Immunization Administration, Sections 8.443 and 8.815

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. This rule revision will allow the Department to reimburse pharmacies for administration of the COVID-19 vaccine in Long-term Care Facilities through the Centers for Disease Control and Prevention's (CDC's) Pharmacy Partnership for Long-term Care Program or other partnership between an LTC and a pharmacy. These revisions are required to facilitate administration of the forthcoming COVID-19 vaccine to nursing home facility residents and is imperatively necessary for the preservation of public health safety, and welfare.

MSB 22-10-06-F, Revision to the Medical Assistance Rule concerning Medical Assistance program rule updates, Sections 8.100.1,8100.3, 8.100.4, 8.100.5 and 8.100.6
For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. The proposed rule change will amend 10 CCR 2505-10 sections 8.100.1,8.100.3, 8.100.4, 8.100.5 and 8.100.6 based on the Coronavirus Aid, Relief, and Economic Security (CARES) Act, the Families First Coronavirus Response Act (FFCRA) and the Affordable Care Act(ACA), which includes the Maintenance of Effort (MOE) provision. All policy revisions will align with federal regulations for the state to be in compliance during the federal Coronavirus (COVID-19) Public Health Emergency. These changes will impact all Medical Assistance categories and these policy changes will stay in place until the end of the federal Coronavirus (COVID-19) Public Health Emergency. The following policy changes are: Self-attestation for most verifications will be acceptable to be in compliance with the Maintenance of Effort (MOE) provision to ensure the continuance of health coverage for all eligible members. When a member is not reasonable compatible based off income a member self-attests, documentation will not be required, and the member will remain eligible for Medical Assistance. Self-attestation of resources will be acceptable for Non-MAGI programs. Premiums for the Buy-In program will be waived. Required through the Federal CARES Act for the Maintenance of Effort (MOE), members who had a loss of employment will remain in the Buy-In program. Newly enrolled members will still need to meet the work requirements. For applicants who are not eligible for Medical Assistance but have been exposed or who are potentially infected by the COVID-19, will be eligible for Medical Assistance for related COVID testing. The economic stimulus relief package designed to provide direct assistance to individuals to help offset the financial impacts of the COVID-19 Public Health Emergency will be exempt for MAGI and Non-MAGI eligibility determinations. The economic stimulus will not be a countable resource for 12 months for any Non-MAGI financial eligibility determinations that include a resource test. Lastly, the Federal Pandemic Unemployment Compensation (FPUC) program which provides an extra $600.00 a week is not countable unearned income for Medical Assistance categories. This rule change is crucial for the preservation of public health, safety, and welfare.

MSB 22-10-06-H, Revision to the Medical Assistance Act Rule concerning Subacute Care, Section 8.300

For the preservation of public health, safety and welfare

Emergency rule-making is imperatively necessary. Addition of subacute care to the list of the covered services for inpatient hospitals, and associated alternate care facilities, increases access to such care for the duration of the COVID-19 public health emergency and is imperatively necessary for the preservation of public health, safety, and welfare.

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Office of the Attorney General

Tracking number: 2022-00647

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 10/14/2022

10 CCR 2505-10

MEDICAL ASSISTANCE - STATEMENTS OF BASIS AND PURPOSE AND RULE HISTORY

The above-referenced rules were submitted to this office on 10/18/2022 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.

November 02, 2022 09:08:36

Philip J. Weiser
Attorney General
by Eric R. Olson
Solicitor General

Terminated Rulemaking

Department

Department of Regulatory Agencies

Agency

Passenger Tramway Safety Board

CCR number

3 CCR 718-1

Tracking number

2022-00632

Termination date

11/15/2022

Reason for termination

The Permanent Rulemaking Hearing will be delayed until the next Board meeting on February 1, 2023. This postponement will allow further time for stakeholders to review the proposed changes and provide additional feedback prior to the Permanent Rulemaking Hearing.

Terminated Rulemaking

Department

Department of Local Affairs

Agency

SAR Advisory Board

CCR number

8 CCR 1307-1

Tracking number

2022-00548

Termination date

11/15/2022

Reason for termination

Exceeded 20 day deadline for filing adopted rules after rules were adopted and AG's opinion was filed.

Calendar of Hearings

Hearing Date/Time	Agency	Location
12/15/2022 10:00 AM	Taxation Division	Virtual Hearing See Comments
12/15/2022 10:00 AM	Taxation Division	Virtual Hearing See Comments
12/15/2022 10:00 AM	Taxation Division	Virtual Hearing See Comments
12/15/2022 10:00 AM	Taxation Division	Virtual Hearing See Comments
12/15/2022 11:00 AM	Liquor and Tobacco Enforcement Division	1881 Pierce Street, Conference Room #110, Lakewood, CO 80214; Meeting ID meet.google.com/ewc-pvvb-myk, Phone +1 386-603-3236, PIN 882 456 156#
12/15/2022 09:15 AM	Division of Gaming - Rules promulgated by Gaming Commission	1707 Cole Blvd, Redrocks Conference Room, Lakewood, CO 80401, and virtually
12/15/2022 09:15 AM	Division of Gaming - Rules promulgated by Gaming Commission	1707 Cole Blvd, Redrocks Conference Room, Lakewood, CO 80401, and virtually
12/16/2022 01:00 PM	Division of Professions and Occupations - Colorado Podiatry Board	Webinar Only: https://us06web.zoom.us/webinar/register/WN_CWu8jONSSk2qW_-gZbunUA
01/19/2023 09:00 AM	Public Utilities Commission	By video conference using Zoom at a link in the calendar of events on the Commissions website: https://puc.colorado.gov/