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Title of Rule: Revision to the Medical Assistance Rule Concerning the Mistreatment, Abuse, Neglect, and Exploitation (MANE) of at-risk adults with intellectual and developmental disabilities, Section 8.600.4
Rule Number: MSB 17-03-08-A
Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

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 17-03-08-A, Revision to the Medical Assistance Rule Concerning the Mistreatment, Abuse, Neglect, and Exploitation (MANE) of at-risk adults with intellectual and developmental disabilities, Section 8.600.4
3. This action is an adoption of:	an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.600.4, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.600.4 with the proposed text starting at 8.600.4 through the end of 8.600.4. Replace the current text at 8.608.8 with the proposed text starting at 8.608.8.D through the end of 8.608.8.D. the effective date of this rule is December 30, 2017.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule Concerning the Mistreatment, Abuse, Neglect, and Exploitation (MANE) of at-risk adults with intellectual and developmental disabilities, Section 8.600.4
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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).

   HB16-1394 updated the definitions of Mistreatment, Abuse, Neglect, Exploitation, and Undue Influence. This bill aligned the definitions across the criminal statutes, DHS - Adult Protective Services statutes, and HCPF statutes. The Department is proposing this regulation to update the rules and remain consistent with statute.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

   N/A

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-10-204(2), C.R.S. (2017).

Initial Review	**10/13/17**	Final Adoption	**11/09/17**
Proposed Effective Date	**12/30/17**	Emergency Adoption	

DOCUMENT #01

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Title of Rule: Revision to the Medical Assistance Rule Concerning the Mistreatment, Abuse, Neglect, and Exploitation (MANE) of at-risk adults with intellectual and developmental disabilities, Section 8.600.4
Rule Number: MSB 17-03-08-A
Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

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 regulation will affect all individuals in services by clearly defining Mistreatment, Abuse, Neglect, and Exploitation. Aligning the definitions with the criminal statutes and Adult Protective Services statutes will make it easier for law enforcement and IDD professionals to identify situations requiring investigation and reporting.

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 proposed regulation should have minimal economic impact. This impact is also lessened because the Department is simply updating the rules to remain consistent with statute. The regulation should have a positive qualitative impact on reporting of MANE incidents. By clearly defining the prohibited conduct and aligning it with DHS and the criminal statutes, IDD professionals will know better what to investigate and report.

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

   This regulation simply updates definitions consistent with the HCPF statute found at C.R.S. 25.5-10-202. There should be no cost for implementation or enforcement of these definitions.

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

   To avoid conflicts with statute the definitions need to be updated. Inaction only results in confusion and hampers the ability of the Department to enforce regulations surrounding MANE incidents and investigations.

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

   This regulation is simply updating definitions to remain consistent with the statue. There should be no cost associated with this regulation.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   No alternatives were considered. The definitions in regulation need to follow the definitions in statute.

8.600.4 Definitions

As used in these rules, unless the context requires otherwise:

"Abuse," for the purpose of mistreatment, abuse, neglect and exploitation, means any of the following acts or omissions committed against a person with an intellectual or developmental disability:

A. The non-accidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;

B. Confinement or restraint that is unreasonable under generally accepted caretaking standards; or

C. The subjection to sexual conduct or contact classified as a crime under the "Colorado Criminal Code," Title 18, C.R.S.

"Algorithm" means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign clients into one of six support levels in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.

"Assistive Technology Devices" means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

"Assistive Technology Services" includes, but is not limited to, the evaluation of a person's need for assistive technology; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and, training the individual, or if appropriate a family member, to use the devices effectively.

"Authorized Representative" means an individual designated by the person receiving services, or by the parent or guardian of the person receiving services, if appropriate, to assist the person receiving services in acquiring or utilizing services and supports pursuant to section 25.5-10, C.R.S.

"Authorized Services" means those services and supports authorized pursuant to section 25.5-10-206, C.R.S., which the Department shall provide directly or purchase subject to available appropriations for persons who have been determined to be eligible for such services and supports and as specified in the eligible person's individualized plan.

"Caretaker" means a person who:

A. Is responsible for the care of a person with an intellectual or developmental disability as a result of a family or legal relationship;

B. Has assumed responsibility for the care of a person with an intellectual or developmental disability; or

C. Is paid to provide care, services, or oversight of services to a person with an intellectual or developmental disability.

"Caretaker Neglect" means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health and safety of a person with an intellectual and developmental disability is not secured for a person with an intellectual and developmental disability or is not provided by a caretaker in a timely manner and with the

degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult with an intellectual and developmental disability.

A. Notwithstanding the provisions of this subsection, the withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation, dialysis, artificial nutrition and hydration, in accordance with any valid medical directive or order, or as described in a palliative plan of care, shall not be deemed caretaker neglect.

~~A.~~B. As used in this subsection, "medical directive or order" includes a medical durable power of attorney, a declaration as to medical treatment executed pursuant to section 15-18-108, C.R.S., a medical order for scope of treatment form executed pursuant to Article 18.7 of Title 15, C.R.S., and a CPR Directive executed pursuant to Article 18.6 of Title 15, C.R.S.

"Case Management Agency" (CMA) means a Community Centered Board within a designated service area where an applicant or client can obtain case management services.

"Challenging Behavior" means behavior that puts the person at risk of exclusion from typical community settings, community services and supports, or presents a risk to the health and safety of the person or others or a significant risk to property.

"Client" means an individual who has met Long Term Care (LTC) eligibility requirements and has been offered and agreed to receive Home and Community Based Services (HCBS) in the Children's Extensive Supports (HCBS-CES) waiver, the HCBS waiver for Persons with Developmental Disabilities (HCBS-DD) or the Supported Living Services (HCBS-SLS) waiver.

"Community Centered Board (CCB)" means a private corporation, for profit or not for profit, which, when designated pursuant to section 25.5-10-209, C.R.S., provides case management services to persons with developmental disabilities, is authorized to determine eligibility of such persons within a specified geographical area, serves as the single point of entry for persons to receive services and supports under section 25.5-10, C.R.S., and provides authorized services and supports to such persons either directly or by purchasing such services and supports from service agencies.

"Comprehensive Review of the Person's Life Situation" means a thorough review of all aspects of the person's current life situation by the program approved service agency in conjunction with other members of the interdisciplinary team.

"Comprehensive Services" means habilitation services and supports that provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services include residential habilitation services and supports, day habilitation services and supports and transportation.

"Consent" means an informed assent, which is expressed in writing and is freely given. Consent shall always be preceded by the following:

A. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

B. A description of the attendant discomforts and risks;

C. A description of the benefits to be expected;

D. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

E. An offer to answer any inquiries regarding the procedure;

F. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

G. A statement that withholding or withdrawal of consent shall not prejudice future provision of appropriate services and supports to individuals.

"Developmental Delay" means that a child meets one or more of the following:

A. A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more of the following:

1. Chromosomal conditions associated with delays in development,

2. Congenital syndromes and conditions associated with delays in development,

3. Sensory impairments associated with delays in development,

4. Metabolic disorders associated with delays in development,

5. Prenatal and perinatal infections and significant medical problems associated with delays in development,

6. Low birth weight infants weighing less than 1200 grams, or

7. Postnatal acquired problems resulting in delays in development.

B. A child less than five (5) years of age who is significantly delayed in development in one or more of the following areas:

1. Communication,

2. Adaptive behavior,

3. Social-emotional,

4. Motor,

5. Sensory, or

6. Cognition.

C. A child less than three (3) years of age who lives with one or both parents who have a developmental disability.

"Developmental Disabilities Professional" means a person who has at least a Bachelor’s Degree and a minimum of two (2) years’ experience in the field of developmental disabilities or a person with at least five (5) years of experience in the field of developmental disabilities with competency in the following areas:

A. Understanding of civil, legal and human rights;

B. Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies;

C. Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.

"Developmental Disability" means a disability that:

A. Is manifested before the person reaches twenty-two (22) years of age;

B. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria below at C, 1 and/or C, 2; and,

C. Is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in either impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.

1. "Impairment of general intellectual functioning" means that the person has been determined to have a full scale intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15).

a. A secondary score comparable to the General Abilities Index for a Wechsler Intelligence Scale that is two or more standard deviations below the mean may be used only if a full scale score cannot be appropriately derived.

b. Score shall be determined using a norm-referenced, standardized test of general intellectual functioning comparable to a comprehensively administered Wechsler Intelligence Scale or Stanford-Binet Intelligence Scales, as revised or current to the date of administration. The test shall be administered by a licensed psychologist or a school psychologist.

c. When determining the intellectual quotient equivalent score, a maximum confidence level of ninety percent (90%) shall be applied to the full scale score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the applicant being determined to have a developmental disability.

2. "Adaptive behavior similar to that of a person with mental retardation" means that the person has an overall adaptive behavior composite or equivalent score that is two or more standard deviations below the mean.

a. Measurements shall be determined using a norm-referenced, standardized assessment of adaptive behaviors that is appropriate to the person's living environment and comparable to a comprehensively administered Vineland Scale of Adaptive Behavior, as revised or current to the date of administration. The assessment shall be administered and determined by a professional qualified to administer the assessment used.

b. When determining the overall adaptive behavior score, a maximum confidence level of ninety percent (90%) shall be applied to the overall adaptive behavior score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the applicant being determined to have a developmental disability.

D. A person shall not be determined to have a developmental disability if it can be demonstrated such conditions are attributable to only a physical or sensory impairment or a mental illness.

"Division for Intellectual and Developmental Disabilities" means the unit within the Colorado Department of Health Care Policy and Financing, responsible for the administration of state sponsored services and funding for developmental disabilities for the state of Colorado.

"Emergency", as used in section 8.608.3 regarding restraint, means a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effect such bodily harm.

"Emergency Control Procedure" means an unanticipated use of a restrictive procedure or restraint in order to keep the person receiving services and others safe.

"Executive Director" means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

~~"Exploitation" means an illegal or improper action affecting a person or use of the person's resources for another person's profit or advantage.~~

"Exploitation" means an act or omission committed by a person who:

A. Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person with an intellectual or developmental disability of the use, benefit, or possession of anything of value;

B. Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person with an intellectual or developmental disability; or

C. Forces, compels, coerces, or entices a person with an intellectual or developmental disability to perform services for the profit or advantage of the person or another person against the will of the person with an intellectual or developmental disability; or

~~A.~~D. Misuses the property of a person with an intellectual or developmental disability in a manger that adversely affects the person with an intellectual or developmental disability's ability to receive health care or health care benefits or to pay bills for basic needs or obligations.

"Extreme Safety Risk to Self" means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a client's support level. This factor shall be identified when a client:

A. Displays self-destructiveness related to self-injury, suicide attempts or other similar behaviors that seriously threaten the client's safety; and,

B. Has a rights suspension in accordance with section 8.604.3 or has a court order that imposes line of sight supervision unless the client is in a controlled environment that limits the ability of the client to harm himself or herself.

"Family", as used in rules pertaining to support services, the Family Support Services Program and the Colorado Family Support Loan Fund herein, means a group of interdependent persons residing in the same household that consists of a family member with a developmental disability or a child under the age of five (5) years with a developmental delay, and one or more of the following:

A. A mother, father, brother(s), sister(s) or any combination; or,

B. Extended blood relatives such as grandparent(s), aunt(s) or uncle(s); or,

C. An adoptive parent(s); or,

D. One or more persons to whom legal custody of a person with a developmental disability has been given by a court; or,

E. A spouse and/or his/her children.

"Family Support Council" means the local group of persons within the community centered board's designated service area who have the responsibility for providing guidance and direction to the community centered board for the implementation of the Family Support Services Program.

"Family Support Plan (FSP)" means a plan which is written for the delivery of family support services as specified in section 8.613, herein.

"Functional Analysis" means a comprehensive analysis of the medical, social, environmental, and personal factors that may influence current behavior. This analysis shall also investigate the person's ability to communicate, analyze whether the current behavior is a means to communicate, and identify historical factors which may contribute to the understanding of the current behavior.

"Guardian" means a person appointed by the court, or named in a will to be the guardian or a minor child, and charged with limited, temporary, or full guardian's power and duties.

"Home and Community-Based Services Waivers (HCBS)" means HCBS waiver programs, including the Home and Community Based Waiver for the Developmentally Disabled (HCBS-DD), Supported Living Services (SLS) and Children's Extensive Support (CES). These waivers are authorized by section 25.5-6-404, C.R.S., et seq., for alternatives to long term care for the developmentally disabled by waivers to section 1915(c), 1902(a)(10)(B), and 1902(a)(1) of the Social Security Act approved by the United States Department of Health and Human Services, in accordance with section 2176 of Public Law No. 97-35 and approved for implementation by the Colorado General Assembly, and regulated by those sections of the Medical Assistance Staff Manual Volume 8 (10 C.C.R. 2505-10) of the Colorado Department of Health Care Policy and Financing, pertaining to Long Term Care and Home and Community-Based Services for the Developmentally Disabled.

"Host Home Provider" is an individual (or individuals) who provides residential supports in his/her home to persons receiving comprehensive services who are not family members as defined in section 25.5-10-202(16), C.R.S. A host home provider is not a developmental disabilities service agency pursuant to section 8.602 of these rules.

"Human Rights Committee" means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and reviewing investigations of allegations of mistreatment of persons with intellectual and developmental disabilities who are receiving services or supports.

"Individual Service and Support Plan (ISSP)" means a plan of intervention or instruction which directly addresses the needs identified in the person's Individualized Plan and which provides specific direction and methodology to employees and contractors providing direct service to a person.

"Individualized Plan (IP)" means a written plan designed by an interdisciplinary team for the purpose of identifying:

A. The needs of the person receiving services or family;

B. The specific services and supports appropriate to meet those needs;

C. The projected date for initiation of service and supports; and,

D. The anticipated results to be achieved by receiving the services and supports.

"Interdisciplinary Team (IDT)" means a group of people convened by a community centered board which shall include the person receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by such person's needs and preferences, who are assembled in a cooperative manner to develop or review the individualized plan.

"Loan Fund" means the Colorado Family Support Loan Fund.

"Mechanical Restraint" means the use of devices intended to restrict the movement or normal functioning of a portion of an individual's body. Mechanical restraint does not include the use of protective devices used for the purpose of providing physical support or prevention of accidental injury.

"Mental Retardation" means substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18.

"Minimum Effective Dose" means the smallest medication dosage necessary to produce the intended effect.

~~"Mistreatment" means an act or omission, which threatens the health, safety, or welfare of a person~~

"Mistreated" or "Mistreatment" means:

A. Abuse,

B. Caretaker Neglect,

C. Exploitation,

D. An act or omission that threatens the health, safety, or welfare of a person with intellectual or developmental disability, or

~~A.~~E. An act or omission that exposes the person with an intellectual or developmental disability to a situation or condition that poses an imminent risk of bodily injury.

"Notice" means written notification hand delivered to or sent by first class mail that contains at least all of the following:

A. The proposed action;

B. The reason or reasons for that action;

C. The effective date of that action;

D. The specific law, regulation, or policy supporting the action;

E. The responsible agency with whom a protest of the action may be filed including the name and address of the director.

F. The dispute resolution procedure, including deadlines, in conformity with section 8.605 and procedures on accessing agency records:

1. For disputes involving individuals as defined in section 8.605.2, information on availability of advocacy assistance, including referral to publicly funded legal services, corporation, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under 42 U.S.C. 6012, the Developmental Disabilities Assistance and Bill of Rights Act; and,

2. For disputes involving individuals as defined in section 8.605.2 an explanation of how the agency will provide services to a currently enrolled person during the dispute resolution period, including a statement that services will not be terminated during the appeal. Such explanation will include a description of services currently received.

"Parent" means the biological or adoptive parent.

"Physical Restraint" means the use of manual methods to restrict the movement or normal functioning of a portion of an individual's body through direct physical contact by others except for the purpose of providing assistance/prompts. Assistance/prompts is the use of manual methods to guide or assist with the initiation or completion of and/or support the voluntary movement or functioning of an individual's body through the use of physical contact by others except for the purpose of providing physical restraint.

"PRN" (Pro Re Nata) means giving drugs on an "as needed" basis through a standing prescription or standing order.

"Program Approved Service Agency" means a developmental disabilities service agency or typical community service agency as defined in section 8.602, which has received program approval by the Department pursuant to section 8.603 of these rules.

"Program Services" means an organized program of therapeutic, habilitative, specialized support or remedial services provided on a scheduled basis to individuals with developmental disabilities.

"Prospective New Service Agency" means an individual or any publicly or privately operated program, organization or business that has completed and submitted an application with a community centered board for selection and approval as a service agency to provide comprehensive services.

"Public Safety Risk-Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a client's support level. This factor shall be identified when a client has:

A. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,

B. A rights suspension in accordance with section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

"Public Safety Risk-Not Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a client's support level. This factor shall be identified when a client has:

A. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,

B. A rights suspension in accordance with section 8.604.3or through parole or probation, or a court order that imposes line of sight supervision unless the client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

"Rate" means the amount of money, determined by a standardized rate setting methodology, reimbursed for each unit of a defined waiver service provided to a client by a qualified provider.

"Referral" means any notice or information (written, verbal, or otherwise) presented to a community centered board which indicates that a person may be appropriate for services or supports provided through the developmental disabilities system and for which the community centered board determines that some type of follow-up activity for eligibility is warranted.

"Referral and Placement Committee (RPC)" means an interdisciplinary or interagency committee authorized by a community centered board or the department to make referral and placement recommendations for persons receiving services.

"Regional Center" means a facility or program operated directly by the Department, which provides services and supports to persons with developmental disabilities.

"Respondent" means a person participating in the SIS assessment who has known the client for at least three months and has knowledge of the client's skills and abilities. The respondent must have recently observed the person directly in one or more places such as home, work, or in the community.

"Restrictive Procedure" means any of the following when the intent or plan is to bring the person's behavior into compliance:

A. Limitations of an individual's movement or activity against his or her wishes; or,

B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences.

"Request for Developmental Disability Determination" means written formal documentation, either handwritten or a signed standardized form, which is submitted to a Community Centered Board requesting that a determination of developmental disability be completed.

"Safety Control Procedure" means a restrictive procedure or restraint that is used to control a previously exhibited behavior which is anticipated to occur again and for which the planned method of intervention is developed in order to keep the person and others safe.

"Screening" for Early Intervention Services means a quick look at how a child is developing and learning to determine what areas of development, if any, are behind what would be expected for a child.

"Seclusion" means the placement of a person receiving services alone in a closed room for the purpose of punishment. Seclusion for any purpose is prohibited.

"Service Agency" means an individual or any publicly or privately operated program, organization or business providing services or supports for persons with developmental disabilities.

"Service Plan Authorization Limit" (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs. Purchase of services not subject to the SPAL are in accordance with the Department of Health Care Policy and Financing rules in section 8.500.102.B (10

C.C.R. 2505-10). A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of clients in each level, and projected utilization.

“Sexual contact” means the knowing touching of the victim's intimate parts by the actor, or of the actor's intimate parts by the victim, or the knowing touching of the clothing covering the immediate area of the victim's or actor's intimate parts if that sexual contact is for the purposes of sexual arousal, gratification, or abuse.

"Sexual intrusion" means any intrusion, however slight, by any object or any part of a person's body, except the mouth, tongue, or penis, into the genital or anal opening of another person's body if that sexual intrusion can reasonably be construed as being for the purposes of sexual arousal, gratification, or abuse.

"Sexual penetration" means sexual intercourse, cunnilingus, fellatio, analingus, or anal intercourse. Emission need not be proved as an element of any sexual penetration. Any penetration, however slight, is sufficient to complete the crime.

"SIS Interviewer" means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department approved trainer using the Department approved curriculum. SIS Interviewers must maintain a standard for conducting SIS assessments as measured through periodic interviewer reliability reviews.

"Statewide Database" means the state web-based system that contains consumer-related demographic and program data.

"Support Coordinating Agency" means a community centered board which has been designated as the agency responsible for the coordination of support services (supported living services for adults and the children's extensive support program) within its service area.

"Supports Intensity Scale" (SIS) means the standardized assessment tool published in 2004 by the American Association on Intellectual and Developmental Disabilities. The assessment gathers information from a semi-structured interview of respondents who know the client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities. No later editions or amendments are included. Copies may be obtained or examined by contacting the Case Management Specialist, Colorado Department of Health Care Policy and Financing, Division for Intellectual and Developmental Disabilities, 1570 Grant Street, Denver, Colorado 80203; or any State Publications Depository Library.

"Support Level" means a numeric value determined using an algorithm that places clients into groups with other clients who have similar overall support needs.

“Undue Influence” means use of influence to take advantage of a person with an intellectual or developmental disability’s vulnerable state of mind, neediness, pain, or emotional distress.

"Waiver Services" means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid State Plan services.

8.608.8 ABUSE, MISTREATMENT, NEGLECT, AND EXPLOITATION

A. Pursuant to section 25.5-10-221, C.R.S., all community centered boards, service agencies and regional centers shall prohibit abuse, mistreatment, neglect, or exploitation of any person receiving services.

B. Community centered boards, program approved service agencies and regional centers shall have written policies and procedures for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any person receiving services. These policies and procedures must be consistent with state law and:

1. Definitions of abuse, mistreatment, neglect, or exploitation must be consistent with state law and these rules;

2. Provide a mechanism for monitoring to detect instances of abuse, mistreatment, neglect, or exploitation. Monitoring is to include, at a minimum, the review of:

a. Incident reports;

b. Verbal and written reports of unusual or dramatic changes in behavior(s) of persons receiving services; and,

c. Verbal and written reports from persons receiving services, advocates, families, guardians, and friends of persons receiving services.

3. Provide procedures for reporting, reviewing, and investigating all allegations of abuse, mistreatment, neglect, or exploitation;

4. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and contractors who have engaged in abuse, mistreatment, neglect, or exploitation;

5. Ensure that employees and contractors are made aware of applicable state law and agency policies and procedures related to abuse, mistreatment, neglect or exploitation;

6. Require immediate reporting when observed by employees and contractors according to agency policy and procedures and to the agency administrator or his/her designee;

7. Require reporting of allegations within 24 hours to the parent of a minor, guardian, authorized representative, and community centered board or regional center;

8. Ensure prompt action to protect the safety of the person receiving services. Such action may include any action that would protect the person(s) receiving services if determined necessary and appropriate by the service agency or community centered board pending the outcome of the investigation. Actions may include,

but are not limited to, removing the person from his/her residential and/or day services setting and removing or replacing staff;

9. Provide necessary victim supports;

10. Require prompt reporting of the allegation to appropriate authorities in accordance with statutory requirements pursuant to section 8.608.8.C of these rules;

11. Ensure Human Rights Committee review of all allegations; and,

12. Ensure that no individual is coerced, intimidated, threatened or retaliated against because the individual, in good faith, makes a report of suspected abuse, mistreatment, neglect or exploitation or assists or participates in any manner in an investigation of such allegations in accordance with section 8.608.8.D.

C. Any and all actual or suspected incidents of abuse, mistreatment, neglect, or exploitation shall be reported immediately to the agency administrator or designee. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, section 19-10-103, C.R.S., (Colorado Children's Code), section 18-8-115, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and section 26-3.1-102, C.R.S., (Social Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

D. All alleged incidents of abuse, mistreatment, neglect, or exploitation ~~by agency employees or contractors~~ shall be thoroughly investigated in a timely manner using the specified investigation procedures. However, such procedures must not be used in lieu of investigations required by law or which may result from action initiated pursuant to section C, herein.

1. Within twenty-four hours of becoming aware of the incident, a written incident report shall be made available to the agency administrator or designee and the community centered board or regional center.

2. The agency shall maintain a written administrative record of all such investigations including:

   a. The incident report and preliminary results of the investigation;

   b. A summary of the investigative procedures utilized;

   c. The full investigative finding(s);

   d. The actions taken; and,

   e. Human Rights Committee review of the investigative report and the action taken on recommendations made by the committee.

3. The agency shall ensure that appropriate actions are taken when an allegation against an employee or contractor is substantiated, and that the results of the investigation are recorded, with the employee's or contractor's knowledge, in the employee's personnel or contractor's file.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Qualified Medication Administration Person (QMAP), Section 8.603.93
Rule Number: MSB 17-07-17-A
Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

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 17-07-17-A, Revision to the Medical Assistance Rule Concerning Qualified Medication Administration Person (QMAP), Section 8.603.93
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) 8.603.9, 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).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.603.9 with the proposed text starting at 8.603.9.F through the end of 8.603.9.F. This rule is effective December 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Qualified Medication Administration Person (QMAP), Section 8.603.93
Rule Number: MSB 17-07-17-A
Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

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 Department is proposing a rule change to 8.603.9, regulating the training of Qualified Medication Administration Persons. In the past, CDPHE individually approved the curriculum for each training site. After the passage of HB16-1424, CDPHE will no longer individually approve the training curriculum. Instead, CDPHE will designate sites as Approved Training Entities (ATEs). Each ATE will then be responsible for developing a curriculum consistent with the CDPHE rules found at 6 CCR 1011-1, Section 6.

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:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   25-1.5-302(1), C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Qualified Medication Administration Person (QMAP), Section 8.603.93
Rule Number: MSB 17-07-17-A
Division / Contact / Phone: Division for Intellectual and Developmental Disabilities / James Ruden / 303-866-2016

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   This rule will directly impact all organizations and individuals who pass medications to clients. Currently, there are 52 Approved Training Entities (ATEs) that are organizations and 21 ATEs approved as individuals. The new process allows ATEs a more streamlined approach to getting their curriculum developed because they don't each have to wait on individual approval from CDPHE.

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 simplifies the process for ATEs in developing their curriculum. By not having CDPHE individually review and approve the curriculum for each program, ATEs can more quickly develop their programs and train new QMAPs.

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

   This change should not affect state revenues. CDPHE will likely benefit from this change because they won't need dedicated employees to review each individual QMAP program.

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

   This rule is necessary because of statutory changes made by HB16-1424. The Department needs to update their rules to stay consistent with the changes at CDPHE. There will not be any cost to the Department.

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

No. This is a minor rule change and simply aligns the Department rules with statute.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Department briefly considered administering the program itself, essentially having the Department become the Approved Training Entity and requiring all QMAPs to attend Department sponsored training. This approach however was abandoned because of the cost of hiring trainers, the liability, and difficulty traveling to provide training to all service agencies across both LTSS and DIDD.

8.603.9 PERSONNEL AND CONTRACTOR ADMINISTRATION

A. Community centered boards and program approved service agencies shall establish qualifications for employees and contractors (Host Home and other providers) and maintain records documenting the qualifications and training of employees and contractors who provide services pursuant to these rules and regulations.

B. The community centered board or service agency may, in accordance with section 27-90-110, C.R.S., conduct background checks and reference checks prior to employing staff providing supports and services and contracting with Host Home and other providers.

C. The community centered board in its role as support coordinating agency, as defined in section 8.609.1, shall have screening procedures for individual providers who are not agency employees and for other entities providing services and supports.

D. The community centered board and program approved service agency shall have an organized program of orientation and training of sufficient scope for employees and contractors to carry out their duties and responsibilities efficiently, effectively and competently. The program shall, at a minimum, provide for:

1. Extent and type of training to be provided prior to employees or contractors providing supports and services having unsupervised contact with persons receiving services;

2. Training related to health, safety and services and supports to be provided within the first ninety (90) days for employees and contractors; and,

3. Training specific to the individual(s) for whom the employees or contractors will be providing services and supports.

E. Community centered boards shall ensure that individuals who are hired to fulfill the duties of case management services have at least a bachelor's level degree of education, five (5) years of experience in the field of developmental disabilities, or some combination of education and experience appropriate to the requirements of the position.

F. All employees and contractors, not otherwise authorized by law to administer medication, who assist and/or monitor persons receiving services in the administration of medications or the filling of medication reminder systems shall have passed a competency evaluation ~~approved by the Colorado Department of Public Health and Environment.~~ offered by an approved training entity, as defined in 6 CCR 1011-1, Chapter 24, *et seq*.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number: MSB 17-07-28-A
Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

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 17-07-28-A, Revision to the Medical Assistance Rule Concerning Outpatient Hospital Reimbursement, Section 8.300.6
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) 8.300.6.A, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	7/1/2017
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.6.A with the proposed text beginning at 8.300.6 through the end of 8.300.6.A.2. This rule is effective December 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number: MSB 17-07-28-A
Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

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).

   On May 26, 2017, Governor Hickenlooper signed Senate Bill 17-254, which set the Colorado state budget for FY 2017-18. After much debate by the General Assembly, the signed budget includes reimbursement increases for Medicaid providers, including hospitals. As a result, Medicaid hospitals are receiving a 1.4% increase in their reimbursement rate for outpatient services. This outpatient reimbursement rate change requires a new rule since it adds an additional step in the reimbursement rate calculation to accommodate the 1.4% increase, representing the payment increase of 1.4% as required by Senate Bill 17-254.

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 purpose of this rule is to comply wih state law, specifically the mandates of Senate Bill 17-254.

3. Federal authority for the Rule, if any:

   42 U.S.C. 1396a(a)(30)(A);

   42 C.F.R. 447.321

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   24-4-103(6), C.R.S., (2016); 10 CCR 2505-10 8.300.6; SB 17-254

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Outpatient Hospital Reimbursement, Section 8.300.6
Rule Number: MSB 17-07-28-A
Division / Contact / Phone: Payment Reform / Andrew Abalos / 2130

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.

   Hospitals will receive increased reimbursement for outpatient services provided to Medicaid clients. These costs have already been accounted for in the state budget for FY 2017-18 through Senate Bill 17-254.

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

   Reimbursement to hospitals for outpatient services is estimated to increase by $7,507,001 for FY 2017-18 as a result of the 1.4% rate increase. The increase contained in this rule will allow hospitals to continue providing services to Medicaid clients and potentially provide improved services to more recipients.

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

   This would cost the Department approximately $7,507,001 in FY 2017-18 for the increased reimbursement to hospitals. These costs have already been accounted for in the state budget for FY 2017-18 through Senate Bill 17-254. There are no additional costs to the Department or any other agency due to the implementation and enforcement of the proposed rule.

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

   The proposed rule will allow the Department to increase reimbursement to hospitals for outpatient services provided to Medicaid clients as required in Senate Bill 17-254. Hospitals will receive a 1.4% rate increase, which will be funded by both state and federal dollars. Inaction would leave the Department out of compliance with state legislation, and Hospitals would continue to receive reimbursement at current levels.

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

DO NOT PUBLISH THIS PAGE

Senate Bill 17-254 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2017. There are no methods for achieving the purpose of the proposed rule that are less costly or less intrusive.

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.

Senate Bill 17-254 mandates across-the-board rate increases for most Medicaid providers effective 7/1/2017. There are no methods for achieving the purpose of the proposed rule that are less costly or less intrusive.

8.300.6 Payments For Outpatient Hospital Services

8.300.6.A Payments to DRG Hospitals for Outpatient Services

1. Payments to In-Network Colorado DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges multiplied by the Medicare cost-to-charge ratio less 28%. When the Department determines that the Medicare cost-to-charge ratio is not representative of a Hospital's Outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited Medicaid cost less 28% or billed charges less 28%.

Effective September 1, 2009, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.1 percent (29.1%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 29.1 percent (29.1%) or billed charges less 29.1 percent (29.1%).

Effective January 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30 percent (30%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30 percent (30%) or billed charges less 30 percent (30%).

Effective July 1, 2010, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 30.7 percent (30.7%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 30.7 percent (30.7%) or billed charges less 30.7 percent (30.7%).

Effective July 1, 2011, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 31.2 percent (31.2%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 31.2 percent (31.2%) or billed charges less 31.2 percent (31.2%).

Effective July 1, 2013, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 29.8 percent (29.8%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective

adjustment is made to bring reimbursement to the lower of actual audited cost less 29.8 percent (29.8%) or billed charges less 29.8 percent (29.8%).

Effective July 1, 2014, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28.4 percent (28.4%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28.4 percent (28.4%) or billed charges less 28.4 percent (28.4%).

Effective July 1, 2015, Outpatient Hospital Services are reimbursed on an interim basis at actual billed charges times the Medicare cost-to-charge ratio less 28 percent (28%). When the Department determines that the Medicare cost-to-charge ratio is not representative of a hospital's outpatient costs, the cost-to-charge ratio may be calculated using historical data. A periodic cost audit is done and any necessary retrospective adjustment is made to bring reimbursement to the lower of actual audited cost less 28 percent (28%) or billed charges less 28 percent (28%).

Effective October 31, 2016, DRG Hospitals will be reimbursed for Outpatient Hospital Services based on a system of Enhanced Ambulatory Patient Grouping and a Hospital-specific Medicaid Outpatient base rate. The reimbursement for Outpatient Hospital Services shall be referred to as the EAPG Payment.

a. The EAPG Payment will be equal to the EAPG Weight multiplied by the Hospital-specific Medicaid Outpatient base rate for that hospital as calculated in 10 CCR 2505-10, Section 8.300.6.A.1.k. If the EAPG Weight is modified due to any action impacting payment as described in sections 8.300.6.A.1.d-j, the modified EAPG Weight will be referred to as the EAPG Adjusted Weight. EAPG Payment will then be equal to the EAPG Adjusted Weight multiplied by the Hospital-specific Medicaid Outpatient base rate. If the billed amount is less than the EAPG Payment, reimbursement will be the billed amount.

b. The EAPG Payment is calculated for each detail on the claim. Claim details with the same dates of service are grouped into a visit. Claims containing details describing charges for emergency room, treatment room services or patients placed under observation will have all its details grouped into a single visit.

c. Each detail on a claim is assigned an EAPG. EAPGs can have the following types:

    (1) Per Diem

    (2) Significant Procedure. Subtypes of Significant Procedures Are:

        (a) General Significant Procedures

        (b) Physical Therapy and Rehabilitation

        (c) Mental Health and Counseling

        (d) Dental Procedure

        (e) Radiologic Procedure

(f) Diagnostic Significant Procedure

(3) Medical Visit

(4) Ancillary

(5) Incidental

(6) Drug

(7) Durable Medical Equipment

(8) Unassigned

d. A detail will be subject to EAPG Consolidation when it is assigned the same Significant Procedure EAPG as a detail not already subjected to EAPG Consolidation for that visit. EAPG Consolidation will also occur for details assigned EAPGs considered to be clinically similar to another EAPG during the visit. Details subject to EAPG Consolidation will have an EAPG Payment calculated using an EAPG Weight of 0.

e. A detail will be subject to EAPG Packaging when its assigned EAPG is considered an ancillary service to a Significant Procedure EAPG or Medical Visit EAPG present on the claim for that visit. Details describing additional undifferentiated medical visits and services will be exempt from EAPG Packaging. A detail is also subject to EAPG Packaging when it is assigned a Medical Visit EAPG while a Significant Procedure EAPG is present on the claim for that visit. Details assigned Significant Procedure EAPGs that are of subtypes Physical Therapy and Rehabilitation and Radiologic Significant Procedure do not cause details with Medical Visit EAPGs to be subject to EAPG Packaging. Details subject to EAPG Packaging will be calculated using an EAPG Weight of 0.

f. A detail will qualify for Multiple Significant Procedure Discounting when a Significant Procedure of the same subtype is present on the claim for that visit. Details qualifying for Multiple Significant Procedure Discounting are ordered by their EAPG Weight, by visit. Per visit, the qualifying detail with the greatest EAPG Weight will have its EAPG Payment calculated at 100 percent (100%) of its EAPG Weight. The qualifying detail for that visit with the next greatest EAPG Weight will have its EAPG Payment calculated at 50 percent (50%) of its EAPG Weight. All other qualifying details for that visit will have its EAPG Payment calculated at 25 percent (25%) of its EAPG Weight.

g. Details assigned the same Ancillary EAPG on the same visit will qualify for Repeat Ancillary Discounting. EAPG Payment for the first occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 100 percent (100%) of its EAPG Weight. EAPG Payment for the second occurrence of a detail qualifying for Repeat Ancillary Discounting for that visit and EAPG is calculated using 50 percent (50%) of its EAPG Weight. EAPG Payment for all other details qualifying for Repeat Ancillary Discounting for that visit and EAPG will be calculated using 25 percent (25%) of their EAPG Weights.

h. Details describing terminated procedures will be subject to Terminated Procedure Discounting. EAPG Payment for a detail subject to Terminated Procedure Discounting is calculated using 50 percent (50%) of the EAPG Weight. Terminated procedures are not subject to other types of discounting.

i. Details describing bilateral services will have EAPG Payment calculated using 150 percent (150%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

j. Details describing 340B Drugs will have an EAPG Payment calculated using 50 percent (50%) of the EAPG Weight or the EAPG Payment not resulting from Terminated Procedure Discounting.

k. The Hospital-specific Medicaid Outpatient base rate for the year of the methodology implementation for each hospital is calculated using the following method.

(1) Assign each hospital to one of the following peer groups based on hospital type and location:

(a) Pediatric Hospitals

(b) Urban Hospitals

(c) Rural Hospitals

(2) Process Medicaid outpatient hospital claims from state fiscal year 2015, known as the Base Year, through the methodology described in 8.300.6.A.1.a-j using Colorado's EAPG Relative Weights. For lines with incomplete data, estimations of EAPG Adjusted Weights will be used.

(3) Calculate costs from hospital charge data using the computation of the ratio of costs to charges from the CMS-2552-10 Cost Report. After the application of inflation factors to account for the difference in cost and caseload from state fiscal year 2015 to the implementation period, costs and EAPG Adjusted Weights are aggregated by peer group and are used to form peer group base rates. Each hospital is assigned the peer group base rate depending on their respective peer group assigned in 8.300.6.A.1.k.(1).

(4) For each hospital, calculate the projected EAPG payment by multiplying its peer group base rate by its hospital-specific EAPG Adjusted Weights as calculated in 8.300.6.A.1.k.(2). If the projected payment exceeds a +/- 10% difference in payment from the prior outpatient hospital reimbursement methodology, the hospital will receive an adjustment to their base rate to cap its resulting gains or losses in projected EAPG payments to 10%.

(5) Effective July 1, 2017, hospitals will receive a 1.4% increase to the rate calculated in sections 8.300.6.A.1.k.(1)-(4).

2. Payments to Out-of-Network DRG Hospitals

Excluding items that are reimbursed according to the Department's fee schedule, border-state Hospitals and out-of-network Hospitals, including out-of-state Hospitals, shall be

paid 30% of billed charges for Outpatient Hospital Services. Consideration of additional reimbursement shall be made on a case-by-case basis in accordance with supporting documentation submitted by the Hospital.

Effective October 31, 2016, Out-of-Network ~~PPS~~ DRG Hospitals will be reimbursed for Outpatient Hospital Services based the system of Enhanced Ambulatory Patient Grouping described in 10 CCR 2505-10 Section 8.300.6.A.1. Such hospitals will be assigned to a Rural or Urban peer group depending on hospital location and will receive a base rate of 90% of the respective peer group base rate as calculated in 8.300.6.A.1.k.(3).

Effective July 1, 2017, Out-of-Network DRG Hospitals will have their rates increased by 1.4% from their rates effective October 31, 2016.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Adding the Asset Verification Program as a Valid Verification Source for Certain Liquid Assets. Section 8.100.5.B.1.e
Rule Number: MSB 17-08-21-B
Division / Contact / Phone: Eligibility Policy / Eric Stricca / 303-866-4475

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 17-08-21-B, Revision to the Medical Assistance Rule Concerning Adding the Asset Verification Program as a Valid Verification Source for Certain Liquid Assets. Section 8.100.5.B.1.e

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) 8.100.5.B.1.e, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.5.B.1 with the proposed text beginning at 8.100.5.B.1 through the end of 8.100.5.B.1. This rule is effective December 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Adding the Asset Verification Program as a Valid Verification Source for Certain Liquid Assets. Section 8.100.5.B.1.e
Rule Number: MSB 17-08-21-B
Division / Contact / Phone: Eligibility Policy / Eric Stricca / 303-866-4475

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).

   Section 1940 of the Social Security Act set forth the requirement that states implement a federally mandated electronic interface that will verify assets held in depository institutions, such as checking and savings accounts. This rule adds the Asset Verification Program as the electronic data source and as a valid way to verify liquid assets.

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 U.S.C. 1396w

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   25.5.1.101(4) C.R.S. (2017)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Adding the Asset Verification Program as a Valid Verification Source for Certain Liquid Assets. Section 8.100.5.B.1.e
Rule Number: MSB 17-08-21-B
Division / Contact / Phone: Eligibility Policy / Eric Stricca / 303-866-4475

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   The classes of persons who will be affected are those whose eligibility for Medical Assistance includes an asset test. These are groups that are referred to as Non-MAGI. When certain assets are able to be verified by an electronic data source, such as the Asset Verification Program, the burden to provide physical verifications of those assets will be reduced which will decrease the time in which eligibility determinations can be completed.

2. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   The Department received administrative resources through FY 2017-18 R-7 "Oversight of State Resources" to implement the Asset Verification Program in compliance with federal law. The Department does not anticipate that verifying resources through this program would result in a change to the number of clients determined eligible for medical assistance; rather, it would allow the verification to happen through an electronic mechanism rather than through supplemental paper verifications.

3. Compare the probable costs and benefits of the proposed rule to the probable costs and benefits of inaction.

   Using the Asset Verification Program to verify resources with an electronic data source is federally mandated, inaction would jeopardize Federal Matching.

4. 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.

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5. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   The Asset Verification Program is the only electronic data source that verifies resources. There are no other alternatives methods.

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. A Social Security Number shall be provided for each individual on the application for whom Medical Assistance is being requested, or proof shall be submitted that an application for a Social Security Number has been made. Members of religious groups whose faith will not permit them to obtain Social Security Numbers shall be exempt from providing a Social Security Number.

   b. Verification of citizenship and identity as outlined in the section 8.100.3.H under Citizenship and Identity Documentation Requirements.

   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.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Persons Requesting Long Term Care through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE) for individuals that are in the Working Adults with Disabilities category to be able to access Supported Living Services Waiver Services at 8.100.7. B.1
Rule Number: MSB 17-08-23-A
Division / Contact / Phone: Eligibility / Beverly Hirsekorn / 6320

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 17-08-23-A, Revision to the Medical Assistance Eligibility Rules Concerning Persons Requesting Long Term Care through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE) for individuals that are in the Working Adults with Disabilities category to be able to access Supported Living Services Waiver Services at 8.100.7. B.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) 8.100.7.B.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)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.7.B.1 with the proposed text starting at 8.100.7.B.1.c through the end of 8.100.7.B.1.c. This rule is effective December 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Persons Requesting Long Term Care through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE) for individuals that are in the Working Adults with Disabilities category to be able to access Supported Living Services Waiver Services at 8.100.7. B.1
Rule Number: MSB 17-08-23-A
Division / Contact / Phone: Eligibility / Beverly Hirsekorn / 6320

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 will amend 10 CCR 2505-10 8.100.7.B.1 to incorporate changes that implement HB 16-1321 which directs the Department to allow individuals who are financially eligible under the Working Adults with Disabilities Buy-In category to receive Home and Community Based Services (HCBS) under the Supported Living Services waiver (SLS).

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 USC § 1396n

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   25.5-6-1405, C.R.S. (2016)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning Persons Requesting Long Term Care through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE) for individuals that are in the Working Adults with Disabilities category to be able to access Supported Living Services Waiver Services at 8.100.7. B.1
Rule Number: MSB 17-08-23-A
Division / Contact / Phone: Eligibility / Beverly Hirsekorn / 6320

REGULATORY ANALYSIS

1. Describe the classes of persons who will be affected by the proposed rule, including classes that will bear the costs of the proposed rule and classes that will benefit from the proposed rule.

   Colorado Medicaid currently has a buy-in program for working adults with disabilities. The existing buy-in program allows adults with a qualifying disability who earn incomes of less than 450 percent of the Federal Poverty Level to obtain Medicaid coverage by paying a premium (i.e., to buying into Medicaid) based on a sliding payment scale. This bill extends the Medicaid buy-in program to adults that are eligible to receive home- and community-based services under the Supported Living Services waiver. The Supported Living Services Waiver provides services to persons with Intellectual and Developmental Disabilities, with the goal of allowing clients to remain in their homes. To participate, adults must meet certain financial and program criteria.

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 addition of SLS Waiver services to the Working Adults with Disabilities Medicaid Buy-In program allows working people with disabilities, who have incomes between the Medicaid limit and up to 450 percent of the Federal Poverty Level, and who also meet the functional level for the Supported Living Waiver, to get their necessary services while earning more income or having more resources than allowed under regular Medicaid. This would benefit individuals on the waiver who would like to work but fear losing services if additional work would raise their income above the limit for regular Medicaid. This also affects individuals who cannot currently access the SLS waiver because they do not meet the income or resource requirement by allowing them to buy in to Medicaid with HCBS-SLS services.

   Approximately 20 clients are expected participate in the new HCBS-SLS buy-in program in FY 2017-18 and 38 clients will participate in FY 2018-19. Out of these participating clients, 3 clients in FY 2017-18 and 5 clients in FY 2018-19 will be new

clients, the remainder (31 in FY 2017-18 and 32 in FY 2018-19) will be existing waiver clients that transition from the regular waiver program to the buy-in program

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.

   Addition of the HCBS-SLS buy-in option increases net costs to HCPF by $306,821 in FY 2017-18, and $606,865 in FY 2018-19. In addition, for clients shifted from regular waiver programs to the Medicaid buy-in, costs will be shifted from the General Fund to the Hospital Provider Fee Cash Fund. This shift, and the collection of client premiums will increase the cash fund revenue to HCPF by $159,275 and by $312,232 in FY 2018-19.

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

   Without implementing this rule, the Department will be out of compliance with state law; therefore, inaction is not possible

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.

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.

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), ~~and~~ 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.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Consideration of Trusts in Determining Medical Assistance Eligibility
Rule Number: MSB 17-08-31-A
Division / Contact / Phone: Legal / David L. Smith / 3247

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 17-08-31-A, Revision to the Medical Assistance Rule Concerning the Consideration of Trusts in Determining Medical Assistance Eligibility
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) 8.100.7.E.6.b.i.c, 8.100.7.E.6.b.i.f, and 8.100.7.E.6.c.i.h , 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:	12/30/17
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.7.E with the proposed text beginning at 8.100.7.E.1.b through the end of 8.100.7.E.1.c. This rule is effective December 30, 2017.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Consideration of Trusts in Determining Medical Assistance Eligibility
Rule Number: MSB 17-08-31-A
Division / Contact / Phone: Legal / David L. Smith / 3247

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 21st Century Cures Act signed on December 13, 2016 by President Obama permits a disabled individual to establish their own disability trust. Previously, the law required a disability trust to be established by the individual's parent, grandparent, legal guardian, or by the court. Colorado's General Assembly addressed the change in federal law by passing H.B. 17-1280 which amended section 15-14-412.8, C.R.S. of the Colorado Probate Code to permit disabled individuals to establish disability trusts on their own behalf. The Department is making this change to its rules to comply with the General Assembly's direction. See also, CMS State Medicaid Director Letter, Implications of the Cures Act for Special Needs Trusts (Aug. 2, 2017).

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 U.S.C 1396p(d)(4)(A).

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   15-14-412.8, C.R.S.

Initial Review — Final Adoption **11/09/17**
Proposed Effective Date **12/30/17** — Emergency Adoption

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Consideration of Trusts in Determining Medical Assistance Eligibility
Rule Number: MSB 17-08-31-A
Division / Contact / Phone: Legal / David L. Smith / 3247

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.

   Disabled individuals seeking to remain or become eligible for medical assistance who have excess resources that prevent financial eligibility.

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 change eliminates a potential burden for disabled individuals seeking to establish a disability trust by allowing them to establish such trusts on their own behalf.

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

   This rule change is not anticipated to increase or decrease state revenues; rather, it eliminates a potential barrier for individuals and may decrease their legal costs of establishing disability trusts.

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

   Inaction could potentially cause regulatory risk from the Centers for Medicare & Medicaid (CMS) as well as individuals seeking to establish disability trusts.

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

   This rule amendment potentially makes it less costly for individuals seeking to establish disability trusts.

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

This proposed amendment was chosen based upon the language provided by Congress and the General Assembly.

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.

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~~a~~ 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-~~403~~ 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 ~~26~~25.5-4-~~403~~301(~~45~~), 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.

DO NOT PUBLSIH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Consideration of Trusts in Determining Medical Assistance Eligibility
Rule Number: MSB 17-08-31-A
Division / Contact / Phone: Legal / David L. Smith / 3247

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 17-08-31-A, Revision to the Medical Assistance Rule Concerning the Consideration of Trusts in Determining Medical Assistance Eligibility

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) 8.100.7.E.6.b.i.c, 8.100.7.E.6.b.i.f, and 8.100.7.E.6.c.i.h , 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: 11/10/2017
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.7.E.1.b with the proposed text beginning at 8.100.7.E.1.b through the end of 8.100.7.E.1.c. This rule is effective December 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLSIH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Consideration of Trusts in Determining Medical Assistance Eligibility
Rule Number: MSB 17-08-31-A
Division / Contact / Phone: Legal / David L. Smith / 3247

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 21st Century Cures Act signed on December 13, 2016 by President Obama permits a disabled individual to establish their own disability trust. Previously, the law required a disability trust to be established by the individual's parent, grandparent, legal guardian, or by the court. Colorado's General Assembly addressed the change in federal law by passing H.B. 17-1280 which amended section 15-14-412.8, C.R.S. of the Colorado Probate Code to permit disabled individuals to establish disability trusts on their own behalf. The Department is making this change to its rules to comply with the General Assembly's direction. See also, CMS State Medicaid Director Letter, Implications of the Cures Act for Special Needs Trusts (Aug. 2, 2017).

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 U.S.C 1396p(d)(4)(A).

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   15-14-412.8, C.R.S.

Initial Review — Final Adoption **11/09/17**
Proposed Effective Date **12/30/17** — Emergency Adoption

DOCUMENT #06

DO NOT PUBLSIH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Consideration of Trusts in Determining Medical Assistance Eligibility
Rule Number: MSB 17-08-31-A
Division / Contact / Phone: Legal / David L. Smith / 3247

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.

   Disabled individuals seeking to remain or become eligible for medical assistance who have excess resources that prevent financial eligibility.

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 change eliminates a potential burden for disabled individuals seeking to establish a disability trust by allowing them to establish such trusts on their own behalf.

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

   This rule change is not anticipated to increase or decrease state revenues; rather, it eliminates a potential barrier for individuals and may decrease their legal costs of establishing disability trusts.

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

   Inaction could potentially cause regulatory risk from the Centers for Medicare & Medicaid (CMS) as well as individuals seeking to establish disability trusts.

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

   This rule amendment potentially makes it less costly for individuals seeking to establish disability trusts.

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 PUBLSIH THIS PAGE

This proposed amendment was chosen based upon the language provided by Congress and the General Assembly.

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.

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~~a~~ 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-~~403~~ 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 ~~26~~25.5-4-~~403~~301(~~45~~), 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.