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Title of Rule: Revision to the Medical Assistance Rule concerning Resident Personal Needs Accounts, Section 8.400
Rule Number: MSB 22-12-09-A
Division / Contact / Phone: Office of Community Living / Christine Bates / 303-866-5419

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 22-12-09-A, Revision to the Medical Assistance Rule concerning Resident Personal Needs Accounts, Section 8.400

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) 8.400, 8.401, 8.406, 8.408, 8.409, 8.405, 8.420, 8.424, 8.430, 8.435, 8.440, 8.441, 8.442, 8.443, 8.470, 8.482, 8.485, 8.486, 8.495, and 8.497, 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*

Remove the current text at 8.400 with the proposed text beginning at 8.400.103 through 8.400.104. Replace the current text at 8.401.182.A through the end of 8.401.182.B. Replace the current text at 8.406 with the proposed language beginning at 8.406.2 through the end of 8.406.3.A.3. replace the current text at 8.408 with the proposed text beginning at 8.408.4 through the end of 8.408.75. Replace the current text at 8.409 with the proposed text beginning at 8.409 through the end of 8.409. Replace the current text at 8.415 with the proposed text beginning at 8.415.11 through the end of 8.415.20.A.B.2. Replace the current text at 8.420 with the proposed text beginning at 8.420 through the end of 8.420. Replace the current text at 8.424 with the proposed text beginning at 8.424 through the end of 8.425. Replace the current text at

*to be completed by MSB Board Coordinator

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8.435 with the proposed text beginning at 8.435 through the end of 8.435. Replace the current text at 8.435.2 through the end of 8.435.2.E. Replace the current text at 8.440.2 with the proposed text beginning at 8.440.2.A through the end of 8.440.2.B. Replace the current text at 8.441 with the proposed text beginning at 8.441.5.C.2.a through the end of 8.441.5.C.2.a. Replace the current text at 8.441.5.F.4 with the proposed text beginning at 8.441.5.F.4 through the end of 8.441.5.F.4.d. Replace the current text at 8.441.5.I with the proposed text beginning at 8.441.5.I through the end of 8.441.5.I. Replace the current text at 8.442.1.B with the proposed text beginning at 8.442.1.B through the end of 8.442.1.B. Replace the current text at 8.443.9 with the proposed text beginning at 8.443.9.1.a through the end of 8.443.9.i. Replace the current text at 8.443.15 with the proposed text beginning at 8.443.15 through the end of 8.443.15.A.8. Replace the current text at 8.443.19 with the proposed text beginning at 8.443.19.A.2 through the end of 8.443.19.A. Replace the current text at 8.443.19 with the proposed text beginning at 8.443.19.D through the end of 8.443.19.D. Replace the current text at 8.443.19.D.2 with the proposed text beginning at 8.443.19.D.2. Remove the current text at 8.443.2 through the end of 8.443.2.E.5.e. Remove the text at 8.444 through the end of 8.448. Remove the current text at 8.461. Replace the current text at 8.470.8 with the proposed beginning 8.470.8.A. Replace the current text beginning at 8.470.8.A.5 with the proposed text beginning at 8.470.8.A.5 through the end of 8.470.8.A.5. Remove the current text at 8.481 through the end of 8.481.1. Replace the current text at 8.482.1 through the end of 8.482.1. Replace the current text at 8.482.2.F with the proposed text beginning at 8.482.2.F through the end of 8.482.2.F. Replace the current text at 8.482.2.I with the proposed text beginning at through the end of 8.482.2.I. Replace the current text at 8.482.2.K with the proposed text beginning at through the end of 8.482.2.K. Replace the current text at 8.482.3 with the proposed beginning at 8.482.3. Replace the current text at 8.482.3 with the proposed text beginning at 8.482.32 through the end of 8.482.34.D.3. Replace the current text at 8.482.42 with the proposed text beginning at 8.482.42 through the end of 8.482.42.C. Replace the current text at 8.482.42 with the proposed text beginning at 8.482.42.F through the end of 8.482.42.F. Replace the current text at 8.482.43.B.4 with the proposed text beginning at 8.482.43.B.4 through the end of 8.482.43.B.4 Replace the current text beginning at 8.482.43.C.5 through the end of 8.482.43.C.5. Replace the current text at 8.482.45 with the proposed text beginning at 8.482.45 through the end of 8.482.46.D. Replace the current text at 8.482.5 beginning at 8.482.5 through the end of 8.483. Replace the current text at 8.485.90 through the end of 8.485.90. Replace the current text at 8.486.80 beginning at 8.486.80 through the end of 8.486.80. Remove the text at 8.496. Replace the current text at 8.495.7 with the proposed text beginning at 8.495.7.1.C through the end of 8.495.7.1.C. Replace the current text at 8.495.7 with the proposed text beginning at 8.495.7.2.B through the end of 8.495.7.2.B. This rule is effective January 30, 2024.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   Section 8.482 and other sections needed to be updated to clarify nursing facility responsibilities for resident personal needs accounts and post eligibility treatment of income. Other sections of the rule needed to be updated for person-centered wording and to delete outdated wording.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

Initial Review **11/09/23** Final Adoption **12/08/23**
Proposed Effective Date **01/30/24** Emergency Adoption

DOCUMENT #

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REGULATORY ANALYSIS

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

   Nursing facilities and resident will benefit from the rule changes.

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

   There is no budget impact to this rule change.

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

   There is no budget impact to this rule change.

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

   There would be no budget impact to not making this rule change. The nursing facilities do need further clarification for handling resident personal needs accounts.

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

   N/A

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.

   N/A

8.400 LONG-TERM CARE

.10 Long-term care includes nursing facility care as part of the standard Medicaid benefit package, and Home and Community Based Services provided under waivers granted by the Federal government.

.101 Nursing facility services and Home and Community Based Services are benefits only under Medicaid. Nursing Facility Services and Home and Community Based Services are non-benefits under the Modified Medical Program.

.102 State only funding will pay for nursing facility services for October 1988 and November 1988 for clients under the Modified Medical Program who were residing in a nursing facility October 1, 1988. This is intended to give clients time to qualify for Medicaid.

~~.103 Until the implementation of SB 03-176 a legal immigrant, as defined in C.R.S. section 25.5-4-103, who received Medicaid services in a nursing facility or through Home and Community Based Services for the Elderly, Blind and Disabled on July 1, 1997, who would have lost Medicaid eligibility due to his/her immigrant status, shall continue to receive services under State funding as long as he/she continues to meet Medicaid eligibility requirements.~~

~~.104 If a nursing facility client, who is only eligible for the Modified Medical Program, is making a valid effort to dispose of excess resources but legal constraints do not allow the conversion to happen by December 1, 1988, the client may have 60 additional days to meet SSI eligibility requirements.~~

8.401.1 GUIDELINES FOR LONG TERM CARE SERVICES (CLASS I SNF AND ICF FACILITIES, *HCBS-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP*, and Long-term Home Health)

LONG-TERM CARE ELIGIBILITY ASSESSMENT

ACTIVITIES OF DAILY LIVING

B. Memory/Cognition Deficit

Definition: The age appropriate ability to acquire and use information, reason, problem solve, complete tasks or communicate needs in order to care for oneself safely.

SCORING CRITERIA

☐0= Independent no concern

☐1= The client can make safe decisions in familiar/routine situations, but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.

☐2= The client requires consistent and ongoing reminding and assistance with planning, or requires regular assistance with adjusting to both new and familiar routines, including regular monitoring and/or supervision, or is unable to make safe decisions, or cannot make ~~his/her~~their basic needs known.

☐3= The client needs help most or all of time.

SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

.182 Definitions

A. Mental Illness

~~1. [Removed per S.B. 03-088, 26 CR 7]~~

~~2~~1. A major mental disorder is defined as: A schizophrenic, mood, paranoid, panic or other severe anxiety disorder; somatoform disorder; personality disorder; other psychotic disorder; or another mental disorder that may lead to a chronic disability.

~~3~~2. An individual is considered to not have mental illness if he/she has:

a. a primary diagnosis of dementia (including Alzheimer's disease or a related disorder); or

b. a non-primary diagnosis of dementia (including Alzheimer's disease or a related disorder) without a primary diagnosis of serious mental illness, or intellectual or developmental disability or a related condition.

B. Intellectual or developmental disability and Related Conditions

~~[Removed per S.B. 03-088, 26 CR 7]~~

8.406.2 INTERMEDIATE NURSING CARE

~~[Removed per S.B. 03-088, 26 CR 7]~~

8.406.3 INTERMEDIATE NURSING CARE - INTELLECTUAL OR DEVELOPMENTAL DISABILITY 15 BEDS OR LESS

A. Intermediate nursing care is available in facilities of 15 beds or less for eligible clients who are individuals with an intellectual or developmental disability or have related conditions provided:

1. The facility holds a valid and current license from CDPHE as a residential care facility or higher classification.

~~2. [Removed per S.B. 03-088, 26 CR 7]~~

~~3~~2. Clients who are individuals with an intellectual or developmental disability or have related conditions are certified by a physician licensed to practice in the State of Colorado to be (a) ambulatory, (b) receiving active treatment, (c) capable of following directions and taking appropriate action for self-preservation under emergency conditions, and (d) not in need of professional nursing services.

8.408.4 PROFESSIONAL PERSONNEL

8.408.41 DIRECTOR OF NURSING

6. Devotes ~~his/her~~their full time to direction and supervision of the nursing services; and,

8.408.44 ANCILLARY PERSONNEL

A. Dietary - Professional planning and supervision of meal services.

2. A graduate holding at least a b~~B~~achelor's d~~D~~egree from the university program, with major study in food or nutrition; or,

8.408.75 STATE DEPARTMENT ACTION

2. Changes in classification recommended will be ~~effected~~affected prior to the next billing period.

8.409 LEVELS OF CARE DEFINED - INTERMEDIATE NURSING CARE

Intermediate nursing services in a licensed intermediate health care facility are defined as those services furnished in an institution or distinct part thereof to those clients who do not have an illness, disease, injury, or other condition that requires the degree of care and treatment which a hospital, Extended Care Facility, or Skilled Nursing Care Facility is designed to provide. Such services are provided under the supervision of a registered professional nurse or licensed practical nurse during the day shift, seven (7) days per calendar week. Covered intermediate services will be at a level less than those described as skilled nursing services and will include guidance and assistance for each client in carrying out ~~his~~ their personal health program to assure that preventive measures, treatment, and medications prescribed by the physician are properly carried out and recorded.

8.409.55 STATE DEPARTMENT ACTION

2. Changes in classification recommended will be made prior to the next billing period.

8.415 ROLE OF COUNTIES AND NURSING FACILITIES

.11 The Form AP-5615 is intended as a method for communicating the status of a resident or applicant, or actions which change that status, between nursing facility, the County Department of Social/Human Services, and the Department. Examples of such actions are admission, discharge, readmission, death or changes in resident income. Failure to complete the AP-5615, or to properly verify information reported thereon in a timely fashion, results in inappropriate reimbursement to nursing facilities, inequitable assistance payments, and the loss of documentation necessary for Department field audit staff. Upon receipt of Form AP-5615, the County Department of Social/Human Services shall be responsible for the following.

A. Verify, correct, and complete, when necessary, the client/applicant's name, State ID number, and all other identifying data:

B. Verify client/applicant income. Such verification must occur on a regular basis. All income of the client which is in excess of the amount reserved for personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, and less home maintenance allowance, ~~and less allowable expenses for medical and remedial care (see PETI deductions as defined in 10 CCR 2505-10 sections 8.100.7.T and 8.482.33)~~and any other applicable changes to patient payment per ~~10 CCR 2505-10 S~~sections 8.100.5.E. through 8.100.7.V., must be applied by the client/applicant toward ~~his/her~~their care or retained within an income trust as required under applicable regulations. Changes in income must be reflected in submission of a new eligibility reporting form and a new AP-5615.

C. Calculation of Patient Payment. Other medical and remedial expenses covered under the nursing facility PETI must be preapproved by the Department. Nursing facility PETI-approved expenses are allowed only for residents with a patient payment but do not change the patient payment amount. For nursing facility PETI, see S~~s~~ections 8.482.33 and 8.100.7.V.3.) The Department may make an exception for:

1. Hospice related PETI-IME adjustments.

2. Resolution of appeals related to patient liability or PETI-IME adjustments.

~~C~~D. Verify client payment. This amount must be calculated by per diem appropriately in all months for which Medicaid reimbursement covers less than a full month's care.

1. Client payment may be waived and zero (-0-) client payment applied only under the conditions as defined in ~~10 CCR 2505-10 s~~Section 8.482.34.D.1.

2. Client payment may not be waived (other than for the exceptions provided for in ~~10 CCR 2505-10 s~~Section 8.415.11.C.1), in the instances ~~as~~ defined in ~~10 CCR 2505-10 s~~Section 8.482.34.D.2.

3. When client payment is calculated by per diem, the amount shown on the AP-5615 will be that amount to be paid by the resident, rather than the amount to be calculated by per diem calculation.

4. Corrections to income or client payment shall be initialed and dated by the income maintenance technician from the County Department of Social/Human Services.

~~D~~E. Review the date of action, such as admission, readmission, discharge, death, or change in client payment being reported and verify as necessary;

~~E~~F. Indicate approval or denial of action being reported and effective date of that approval or denial; and

~~F~~G. Sign and date all copies~~, and distribute in accordance with instructions on the reverse side of page three of the AP-5615 form~~. Provide a copy to the facility and the D~~d~~epartment at HCPF_LTC_FinCompliance@state.co.us.

8.415.20 RESPONSIBILITY OF THE NURSING FACILITY IN NURSING FACILITY PLACEMENTS

These rules set forth the administrative procedures that ~~which~~ must be followed by nursing facilities. ~~all facilities participating in the Medical Assistance Nursing Facility Program.~~ Failure of the facility to meet the requirements set forth herein will result in denial of ~~shall cause the facility to be denied~~ reimbursement.

A. Admission

When an admission to the nursing facility is proposed, it is the responsibility of the nursing facility to:

1. Determine, prior to an applicant's admission, whether or not the individual is a member ~~client of medical assistance~~ or has applied ~~made application~~ for medical assistance;

2. Complete the ULTC 100.2 prior to or on the day of admission. Based on this information, the Utilization Review Contractor will determine the level of care and assign an initial length-of-stay.

~~**8.415.21**~~

3. For purposes of this regulation, admission is defined as

a. any new admission; or

b. any change from other sources of reimbursement to the Medical Assistance p~~P~~rogram.

B. Changes in Resident Status

Form AP-5615 shall be used by the nursing facility to notify the County Department of the current or changed status of all membersclients and applicants residing within the nursing facility.

1. The nursing facility shall initiate Form AP-5615 (in accordance with instructions on the reverse side), for all admissions, readmissions, transfers from private pay or Medicare, discharges, deaths, changes in client payresident income, and leaves of absence; and shall submit three (3) copies to the responsible county and the Ddepartment at HCPF_LTC_FinCompliance@state.co.us.

2. The nursing facility is solely responsible for collecting the correct amount of client payment due from the resident, his the family, or representatives. Failure to collect client pay, in whole or in part, shall not allow the nursing facility to bill the Medical Assistance Program for the uncollected client payment.

8.420 REQUIREMENTS AND PROVISIONS FOR PARTICIPATION BY COLORADO NURSING FACILITIES

In order to receive vendor payments from the State Department for care of assistance recipients,Prior to receiving reimbursement from the Department, a nursing facility must be enrolled as a Medicaid provider. enter into a provider agreement with the Department, in such form as the Department prescribes. For the purposes of this section, the term "nursing facility" includes an intermediate care facility for individuals with intellectual disabilities (ICF/IID). The facility's provider agreement with the Department carries with it the responsibility of said nursing facility to subscribe to the terms and conditions for payment of care to recipients promulgated by the Colorado Medical Services Board in its rules and regulations set forth in this staff manual. Such nursing facilities also must adhere to all pertinent requirements of federal and state law, and to the rules, regulations, and requirements as prescribed by CDPHE in its minimum standards for nursing facilities. This means that the nursing facility must be duly and appropriately licensed, provide for the use of qualified staff and the provision of nursing care, and adhere to those regulations with respect to the number and qualifications of nursing personnel required by CDPHE in giving services to recipient patients.

All nursing facilities are required, as a condition for both initial and continuing participation, to comply with the provisions of Section 601 of Title VI of the Civil Rights Act of 1964. Annual on-site inspections for assurance of compliance will be made by CDPHE.

In addition, theN nursing facilities are ity is required to maintain proper accountings of the resident personal needs funds accounts of recipients as provided in 10 CCR 2505-10 Ssection 8.482.5.

Participation in the Colorado Medicaid program of nursing facilities and/or nursing facility beds is limited to the regulations at 10 CCR 2505-10 sections 8.430 et seq.

8.424 PERIODIC VISITS OR REQUESTS FOR DOCUMENTATION - NURSING HOME RECORDS TO BE MADE AVAILABLE

Members Staff of the county Department of Health and Human Services, the staff of the State Department of Human Services, the staff of the State Colorado Department of Public Health and Environment or specialized staff acting as agentscontractors of said Department or members of the Medicaid Fraud Control Unit,may will make periodic visits and requests for documentation to nursing facilitieshomes for purposes of determining compliance with applicable regulationsof nursing homes with the rules set forth concerning nursing home care to Medicaid recipients, for purposes concerned with theand to determine the appropriate rate to be paid for care of recipients under applicableto the facility

~~rules~~, and for ~~such~~ other purposes as may be authorized for ~~related to~~the administration of the Colorado Medical Assistance Program.

All medical and financial records and documents related to the above purposes ~~of visits or requests for documentation by the staff members mentioned~~ shall promptly be made available to the Department. ~~in Colorado to such persons by the nursing facility administrator or his delegated alternate.~~

"Closing" The Department will conduct an audit when there is a pending ~~audits also are to be made at the point of impending~~ change of ownership ~~of a nursing facility~~ in order to determine whether payment adjustments or recoveries are necessary pursuant to ~~with respect to continuing payment to the new owner or such adjustments in payments, recoveries, etc., covering former owners or sellers.~~ Refer to 10 ~~CCR 2505-10S~~ ~~s~~ection 8.443.15 Change of Ownership, Change in Tax ID or Withdrawal from Medicaid.

~~**8.425 Repealed, effective June 30, 2005**~~

8.430.3 NEW NURSING FACILITY CERTIFICATION

8.430.3.A. Procedures and Criteria for Medicaid Certification of a New Nursing Facility

5. Approval or denial of an application for Medicaid certification of a new nursing facility shall be based on all the following information from the applicant:

k.~~.~~ Documentation of whether the proposed new facility provides needed beds to an underserved geographical area, as described in Section 8.430.3.A.5.j.i., or to an underserved special population, as described in Section 8.430.3.A.5.j.ii.

ii) An application for a n~~N~~ew nursing facility to serve an underserved special population shall contain the following information and documentation:

8.435 ENFORCEMENT REMEDIES RELATED TO SURVEY DEFICIENCIES

8.435.2 GENERAL PROVISIONS

~~8.435.2.B. The following factors shall be considered by the Department~~CDPHE and/or CMS ~~in determining what remedy will be imposed on the Class I non-State-operated Medicaid-only nursing facility:~~

~~1. The scope and severity of the Deficiency(ies).~~

~~2. The most serious Deficiency in relationship to other cited Deficiencies.~~

~~3. The nursing facility's past Deficiencies and willingness to become compliant with program rules and regulations.~~

~~4. The recommendation of CDPHE p~~P~~ursuant to C.R.S. section 25-1-107.5~~ and 42 C.F.R. section 488.330~~.~~

~~5. [Expired 05/15/2016 per House Bill 16-1257]~~

8.435.2.C. ~~Enforcement Guidelines for Class I Non-State-Operated Medicaid-Only Nursing Facilities~~

~~1. At the Department's~~CDPHE and/or CMS ~~discretion, nursing facilities may be given an opportunity to correct Deficiencies before remedies are imposed or recommended for imposition except as stated below~~.

2. Nursing facilities shall not be given the opportunity to correct Deficiencies prior to a remedy being imposed or recommended for imposition under the following:

a. Nursing facilities with Deficiencies of actual harm or of greater severity on the current survey, and

i) Deficiencies of actual harm or of greater severity on the previous standard survey, or

ii) Deficiencies of actual harm or of greater severity on any type of survey between the current survey and the last standard survey.

b. Nursing facilities, previously terminated, with Deficiencies of actual harm or of greater severity on the first survey after re-entry into the Medicaid program.

c. Nursing facilities for which a determination of Immediate Jeopardy is made during the course of a survey.

d. Nursing facilities with a per instance CMP imposed due to non-compliance.

32. The Class I non-State-operated Medicaid-only nursing facility will receive a Notice of Adverse from the shall be notified by the dDepartment. The appeal procedures set forth at of any adverse action and may appeal these actions pursuant to 10 CCR 2505-10 sSection 8.050 will apply. Any other Class I nursing facilities shall be notified by CMS of any adverse action.

a. Advance notice for state monitoring is not required.

b. The advance notice requirement for other remedies is two days when Immediate Jeopardy exists and 15 days in other situations, with the exception of CMP.

c. [Expired 05/15/2016 per House Bill 16-1257]

8.435.2.D. Enforcement Actions for Class I nursing facilities

2. Denial of payment for new Medicaid admissions willshall end on the date CDPHE finds the nursing facility to be in substantial compliance with all participation requirements.

a. If substantial compliance is achieved before the denial of payment effective date, the denial of payment will be rescinded.

b. If substantial compliance is not achieved before the denial of payment effective date, the denial of payment will stop as of midnight on the date determined by CDPHE.

(1) Medicaid monies paid to the nursing facility for any resident admitted during the denial of payment effective period is subject to recoupment by the Ddepartment.

3. CMP

a. CMP amounts range in $50 increments from $50-$3,000 per day for Deficiencies that do not constitute immediate jeopardy, but either caused actual harm or caused no actual harm with the potential for more than minimal harm, and from

~~$3,050 to $10,000 per day for Deficiencies constituting immediate jeopardy, or $1,000 to $10,000 per instance as recommended by CDPHE.~~

~~b~~a. CMPs are effective on the date the non-compliance began.

~~c~~b. If the nursing facility waives its right to an appeal in writing within 60 calendar days from the date the CMP is imposed, the CMP shall be reduced by 35%, notwithstanding the provisions of ~~10 CCR 2505-10 s~~Section 8.050.

~~d~~c. The CMP shall be submitted to the ~~D~~department or CMS as defined by the adverse action notification~~check or subsequent Medicaid payment to the provider shall be withheld until the CMP is satisfied~~.

~~e. Upon notice to the Department of change in ownership or intent to terminate the Medicaid agreement, the Department shall withhold all Medicaid payments to satisfy any CMP that has not been paid in full.~~

~~f~~d. Payment of CMP shall not be an allowable cost on the nursing facility's annual Med-13 cost reports as described in ~~10 CCR 2505-10 S~~section 8.441.

8.435.2.E. Nursing Home Penalty Cash Fund

1. All CMPs collected from Class I ~~non-State-operated Medicaid-only~~ nursing facilities by the D~~d~~epartment shall be transmitted ~~by the Department~~ to the state treasurer to be credited to the Nursing Home Penalty Cash Fund.

   a. The Medicaid portions of CMPs imposed by CMS and transmitted to the State Treasurer shall be credited to the Nursing Home Penalty Cash Fund~~notification will be sent to the D.~~.

8.440.2 SERVICES AND ITEMS NOT INCLUDED IN THE PER DIEM PAYMENT

8.440.2.A. The following general categories and examples of items and services are not included in the facility's per diem rate. Items 1 – 11 may be charged to the resident's personal needs ~~funds~~ account if requested, in writing by a resident and/or the ~~resident's family~~responsible party (refer to ~~10 CCR 2505-10 s~~Section 8.482 for policy guidance on resident personal needs account):

2. ~~Gifts p~~Purchase~~d~~s on behalf of a resident if~~;~~:

   a. The resident's basic financial needs must be covered before the purchase.

   b. The resident is able to approve the purchase or in the event the responsible party is making the purchase, the purchase is in line with what the resident wants or needs.

   c. The balance in the resident's personal needs account is sufficient to cover the purchase~~s~~ and the resident's personal needs account is not depleted below one month's personal needs allowance amount.

   d. Outstanding debt due the facility related to uncollectible patient payment for room and board is an allowable~~ed~~ purchase.

   e. Reasonable funeral or burial expenses per 9 CCR 2503-5 section 3.570.43 are allowed.

3. Non-covered special care services, i.e., a private duty nurse not employed by the nursing facility or non-medical leave expenses incurred in supporting or benefitting the resident.

4. Items or services requested by the resident, including but not limited to, over the counter drugs/related items not prescribed by a physician, not included in the nursing care plan and not ordinarily furnished for effective patient care. In these instances, it is required that:

a. The resident has made an informed decision supported by a statement in the resident ~~P~~personal ~~N~~needs ~~Funds~~ account file that ~~he/she/family~~the resident/responsible party is willing to use personal needs funds.

b. The balance in the resident's ~~P~~personal ~~N~~needs ~~Funds~~ account ~~in the resident's ledger~~ is sufficient to cover the charge and does not deplete the account.

13. Prescription drugs~~, with certain specific exemptions~~.

18. Non-Medicaid laboratory, radiology, physical therapy, occupational therapy, speech therapy and respiratory therapy.

8.440.2.B. The Department's approval shall be required in order for a resident or ~~his/her~~their relatives to be billed for the following:

4. Upon approval of the Form 10013, payment for such services may be received from the resident's personal needs ~~fund~~account, relatives or others.

8.441 NURSING FACILITY COST REPORTING

8.441.5 COMPLETION OF NON-REIMBURSABLE EXPENSES AND EXPENSE LIMITATIONS AND ADDITIONS SCHEDULE

8.441.5.C. LEGAL FEES, EXPENSES AND COSTS

2. The following categories ~~shall not be~~are not deemed reasonable, necessary and patient-related:

a. Legal fees, expenses and costs incurred in connection with the appeal of a Medicaid classification or reimbursement rate, rate adjustment, resident personal needs account audit, or payment for any financial claim by or against the State of Colorado, or its agencies by a provider, in the event the State of Colorado or any of its agencies prevails in such a proceeding. In the event that each party prevails on one or more issues in litigation, allowable legal fees, expenses and costs in such cases shall be apportioned by percentage, for reimbursement purposes, by the administrative law judge rendering the final agency decision. In the event of the stipulated settlement of any such appeal, the parties shall, by agreement, determine the allowability for the provider's legal fees, expenses and costs. If a settlement agreement is silent concerning legal fees, expenses or costs, they shall not be allowable.

8.441.5.F. HISTORICAL COSTS

4. An initial presumption that a sale was not bona fide shall be made when any of the following factors exist:

a. The seller and purchaser are persons for whom a loss from the sale or exchange of property is not allowed under the Internal Revenue Services Code between:

viii) A fiduciary of a trust and a corporation more than 50% in value of the outstanding stock of which is directly or indirectly owned by or for the trust or a grantor of the trust. This would, for example, have the effect of denying a loss in a transaction between a corporation, more than 50% of the stock of which was owned by a ~~father~~parent, and a trust established for ~~his~~ the children. Under the constructive ownership rules (below), the children are treated as owning the stock owned by the ~~father~~parent; and

ix) A person and an exempt charitable or education organization controlled by the person or, if the person is an individual, by the individual or ~~his~~ the family.

b. The term "family" means a brother or sister (whole or half-blood relationship, spouse, ancestor, or lineal descendant, including in laws and in laws of ancestors of lineal descendants.

c. In determining stock ownership;

d. The transaction was ~~effected~~affected without significant investment on the part of the purchaser; i.e., cash or property was not transferred from the purchaser to the seller and the sales price was met by assumption of existing debt and promises to pay additional amounts or issuance of life annuities to the seller.

8.441.5.I. ITEMS FURNISHED BY RELATED ORGANIZATIONS OR COMMON OWNERSHIP

4. The charge by the related provider or organizations for the services, facilities or supplies shall be considered an allowable cost when the nursing facility demonstrates ~~all of~~all the following by clear and convincing evidence:

8.442 SUBMISSION OF COST REPORTING INFORMATION

8.442.1.B. Failure of a nursing facility to submit its MED-13 within the required ninety (90) day period shall result in the Department withholding all warrants not yet released to the provider as described below:

1. When a nursing facility fails to submit a complete and auditable MED-13 (i.e., the information represented on the MED-13 ~~can not~~cannot be verified by reference to adequate documentation as required by generally accepted auditing standards) on time, the MED-13 shall be returned to the facility with written notification that it is unacceptable.

8.443.9 FAIR RENTAL ALLOWANCE FOR CAPITAL-RELATED ASSETS

8.443.9.A. FAIR RENTAL ALLOWANCE: DEFINITIONS AND SPECIFICATIONS

1. For purposes of this section concerning fair rental allowance, the following definitions shall apply:

~~a. [Expired 05/15/2016 per House Bill 16-1257].~~

~~b~~a. Appraised value means the determination by a qualified appraiser who is a member of an institute of real estate appraisers, or its equivalent, of the depreciated cost of replacement of a capital-related asset to its current owner.

The depreciated replacement appraisal shall be based on the valuation system as determined by the Department.

The depreciated cost of replacement appraisal shall be redetermined every four years by new appraisals of the nursing facilities.

~~Appraised Value means the determination by a qualified appraiser who is a member of an institute of real estate appraisers or its equivalent, the depreciated cost of replacement of a capital-related asset to its current owner. The depreciated replacement appraisal must be based on a nationally-recognized valuation system determined by the Department available on December 31st of the year preceding the year in which the appraisals are to be performed.~~

~~c~~b. Base value means:

i) The appraised value of a capital-related asset for the fiscal year 1986-87 and every fourth year thereafter.

ii) The most recent appraisal together with fifty percent of any increase or decrease each year since the last appraisal, as reflected in the index, for each year in which an appraisal is not done pursuant to subparagraph (i) of this paragraph (b).

iii) For the fiscal year 1985-86, the base value shall not exceed twenty-five thousand dollars per licensed bed at any participating facility, and, for each succeeding fiscal year, the base value shall not exceed the previous year's limitation adjusted by any increase or decrease in the index.

iv) An improvement to a capital-related asset, which is an addition to that asset, shall increase the base value by the acquisition cost of the improvement.

~~Base Value means the value of the capital related assets as determined by the most current appraisal report completed by the Department or its designee and any additional information considered relevant by the Department. For each year in which an appraisal is not done, base value means the most recent appraisal value increased or decreased by fifty percent (50%) of the change in the Index. Under no circumstances shall the base value exceed $25,000 per bed plus the percentage rate of change referred to as the per bed limit.~~

~~d~~c. Capital-Related Asset means the land, buildings, and fixed equipment of a participating facility.

~~e~~d. Fair Rental Allowance means the product obtained by multiplying the base value of a capital-related asset by the rental rate.

~~f~~e. Fair Rental Allowance Per Diem Rate means the fair rental allowance described above, divided by the greater of the audited patient days on the provider's annual cost report or ninety percent (90%) of licensed bed capacity on file. This calculation applies to both rural and urban facilities.

~~g~~f. Fiscal Year means the State fiscal year from July 1 through June 30.

~~h~~g. Fixed equipment means building equipment as defined under the Medicare principle of reimbursement as specified in the Medicare provider reimbursement manual, part 1, section 104.3. Specifically, building equipment includes attachments to buildings, such as wiring, electrical fixtures, plumbing, elevators, heating systems, air conditioning systems, etc. The general characteristics of this equipment are:

i) Affixed to the building and not subject to transfer; and

ii) A fairly long life but shorter than the life of the building to which it is affixed.

~~i. [Expired 05/15/2016 per House Bill 16-1257]~~

~~j~~h. Index means the square foot construction costs for nursing facilities in the Means Square Foot Costs Book, which shall be the most recent publication of R.S.Means Company, Inc. that is updated quarterly (section M.450, "Nursing Home"), hereafter referred to as the Means Index.

~~k~~i. Rental Rate means the average annualized composite rate for United States treasury bonds issued for periods of ten years and longer plus two percent; except that the rental rate shall not exceed ten and three-quarters percent nor fall below eight and one-quarter percent.

8.443.15 CHANGE OF OWNERSHIP, CHANGE IN TAX ID ONLY, OR WITHDRAWAL FROM MEDICAID

8.443.15.A. A licensed nursing facility owner(s) that intends to change the ownership of a Medicaid nursing facility, change in tax ID only, or that intends to terminate its participation in the Medicaid program, shall notify the Department in writing at least 45 calendar days in advance of the proposed change or termination.

1. The advance written notice shall include a specific date for the proposed change or termination and shall be delivered to the Department.

2. The exact date of the change of ownership or termination of Medicaid participation shall be subject to approval by the Department, after consultation with the parties to the proposed transaction and CDPHE.

3. If the facility is terminating participation with the Medicaid program, and there is no successor owner, the licensed nursing facility must maintain documentation and contact with the Department until the closing audit can be performed per Section ~~10 CCR~~ 8.424.

4. If the change does not require a change in tax ID, the licensed nursing facility billing provider number and NPI will continue.

5. If the change ~~does~~ requires a change in tax ID, and maintains the same owner, the ~~licensed nursing~~ facility must submit a new enrollment application with the Department, with a new NPI number to obtain a new billing provider number.

6. If the change is to a successor owner, the transferring owner must disenroll after the change of ownership effective date, as determined by the Department under Section~~per 10 CCR~~ 8.443.15.E.

a. The successor owner must submit an enrollment application to obtain a new billing provider number.

b. The successor owner shall not bill for services using the transferring owner's billing provider number, and any such payments are subject to recoupment. ~~. Any Medicaid payments made to the successor owner shall be reversed and payment recouped by Medicaid.~~

7. A c~~C~~hange of ownership or closing audit is required ~~per 10 CCR 2505-10~~ under S~~s~~ection 8.424.

a. The Department may withhold all or part of any monies due the prior nursing facility licensee until the change of ownership or closing audit is completed.

8. The transferring owner ~~terminating provider~~ must perform a ~~closing~~ Personal Needs Account reconciliation prior to transferring funds to the successor owner per ~~10 CCR 2505-10 s~~Section 8.482.52.C.

8.443.19 PAYMENT FOR OUT OF STATE NURSING FACILITY CARE

8.443.19.A. Payments for out-of-state nursing facility care shall be made to providers when:

2. A physician has verified in the resident's medical records that ~~The nursing facility services are needed because~~ the resident's health would be endangered if ~~he/she~~they were required to travel to Colorado. ~~and the attending physician has certified to such in the resident's medical records~~.

8.443.19.D. ~~Those r~~Residents without need for rehabilitation services must ~~shall be expected to~~ meet ~~Colorado nursing facility~~ admission requirements set forth at ~~as described in 10 CCR 2505-10 S~~sections 8.402.01 through 8.402.10, and can be admitted if:

2. The resident of an out-of-state nursing facility is found ~~has been determined to be~~ eligible for Colorado Medicaid due to ~~his~~the inability to indicate ~~his/her~~their intended state of residence.

~~**8.443.22 SKILLED NURSING FACILITY ENHANCED PAYMENTS**~~

~~8.443.22.A The Department will make one-time payments to eligible Class 1 nursing facility providers, pursuant to C.R.S. § 25.5-6-210. The one-time payments will take effect only upon the passage and effective date of House Bill (H.B.) 22-1247. The payments are separated into a Medicaid enhanced payment, a workforce enhanced payment, and a hospital discharge payment.~~

~~1. The Medicaid enhanced payment will pay nursing facility providers for serving a disproportionate share of Medicaid and high-need populations.~~

~~a. The payment will equal $7,000,000, divided by the number of eligible nursing facility providers. Eligible nursing facility providers will meet all the following criteria:~~

~~i. Medicaid resident count is equal to or greater than 90% of total resident count. Medicaid resident count and total resident count determined using the most recently finalized quarterly case mix index (CMI) report.~~

~~ii. Preadmission Screening & Resident Review (PASRR) II Medicaid resident count is greater than the statewide average PASRR II Medicaid~~

resident count, plus one standard deviation. PASRR II Medicaid resident count determined using the most recently completed comprehensive minimum data set (MDS) resident assessment for calendar year 2021.

2. The workforce enhanced payment will pay nursing facility providers to support hiring new employees and increase workforce retention.

   a. The payment will equal $17,588,000, multiplied by the percentage of Medicaid patient days to total statewide Medicaid patient days.

   b. Medicaid patient days are determined using MMIS pulled data for calendar year 2021.

   c. The payment will be reported as revenue and offset against expenses on the cost report, for the cost reporting period in which the payment is received.

3. The hospital discharge payment will pay nursing facility providers to incentivize admitting Medicaid members from hospitals.

   a. The payment will equal a per-Medicaid discharge rate, multiplied by hospital Medicaid residents discharged to a nursing home provider.

      i. The per-Medicaid discharge rate will equal an amount such that the total hospital discharge payment made to all nursing facility providers will equal $2,413,000. The per-Medicaid discharge rate for complex discharges will be increased by a multiplier.

      ii. Medicaid discharges are equal to Medicaid residents discharged from a hospital to a nursing facility provider during the period May 1, 2022 through June 30, 2022 and remaining within the nursing facility provider for at least sixty (60) calendar days. Both Medicaid discharges and length-of-stay will be determined using MMIS pulled data.

      iii. A complex discharge is a discharge for a Medicaid resident with a PASRR II designation and/or a Medicaid resident deemed too difficult to place.

      iv. The PASRR II designation will be determined using the most recently completed comprehensive MDS resident assessment during the period July 1, 2021 through June 30, 2022.

4. The payments will only be made if there is available federal financial participation under the Upper Payment Limit after all other nursing facility provider MMIS and supplemental payments are considered.

5. Nursing facility providers will provide data necessary to administer and to evaluate the effectiveness of the payments.

   a. Nursing facility providers will provide:

      i. Employment and wage data within thirty (30) calendar days of request.

      ii. Quarterly financial statements will be due within thirty (30) calendar days of quarter end. Financial statements are due beginning with the quarter following the most recent cost report submission.

b. Reporting instructions will be provided to nursing facility providers before any data or financial statements are due.

c. Management companies, or other corporate structures, operating a nursing facility provider will provide quarterly financial statements will be due within thirty (30) calendar days of quarter end. Financial statements are due beginning with the quarter following the most recent cost report submission.

d. Submissions will be certified by the nursing home provider's Chief Executive Officer, Chief Financial Officer, or an individual with delegated signatory authority.

e. A skilled nursing facility provider not providing employment/wage data or financial statements may have the entirety of their payments recovered.

8.444 through 8.446 Repealed, effective June 30, 2005

8.448 Repealed, effective May 30, 2006

8.461 Repealed, effective May 30, 2006

8.407470.8 REIMBURSEMENT OF NURSING FACILITIES FOR PARTICIPATING CLIENTS WHO MEET HOSPITAL BACK UP LEVEL OF CARE

8.470.8.A Medicaid reimbursement for services provided to a hospital back up level of care nursing facility memberclient shall be based upon the Resource Utilization Group IV (RUG-IV) classification determined through the memberclient's minimum data set (MDS) resident assessment as transmitted to and accepted by the Centers for Medicare and Medicaid services (CMS).

5. If the Department determines the a memberclient's third party coverage (private insurance, LTC insurance, or Medicare) will cover the cost of the memberclient's care in either a hospital or nursing facility, the Medicaid payment under this program shall be approved only after utilization of third party benefits.

8.481 [Expired 05/15/2016 per House Bill 16-1257]

8.481.1 [Expired 05/15/2016 per House Bill 16-1257]

8.482 RESIDENT INCOME AND POSSESSIONS

8.482.1 PURPOSE AND LIMITATIONS

Resident incomePersonal needs funds, whether contributed or direct, shall be used for the care of the resident, except for 2 personal needs allowance as seet forth in 10 CCR 2505-10 sSection 8.482.5.

No person, institution, partnership, corporation or other entity shall divert resident income from the control and exclusive use of the resident, without proper legal authorization or power.

Refer to 10 CCR 2505-10 sSection 8.440.1 for services and items included in the per diem payment and 10 CCR 2505-10 to Ssection 8.440.2 for services and items not included in the per diem payment.

8.482.2 DEFINITIONS

F. "Personal needs allowance (PNA)" is the amount specified in ~~10 CCR 2505-10 s~~Section 8.110.4~~2~~7.V. to be deducted from resident income, ~~e~~and used for the exclusive benefit of the resident prior to application of income to nursing facility care.

I. "Responsible Party" is defined as any of the persons below, who accepts the responsibility for a resident's funds, mail or personal possessions and is willing to sign a written declaration of such responsibility:

1. a legally appointed guardian, conservator or trustee; or

2. relative or friend; or

3. the county department~~.~~; or

4. the ~~a~~ resident ~~may act as their own responsible party,~~ if they are competent to manage their own affairs.

K. "PETI-IME" is defined as nursing facility post eligibility treatment of income – incurred medical expenses, as further defined at ~~. Refer to s~~Section 8.482.33.

8.482.3 RESIDENT INCOME

The control of resident income is vested in the resident, or in such person as the resident may designate. A ~~Such~~ designee may be a conservator, administrator, family member or other representative. The resident's income is to be used by the resident, or on behalf of the resident. No ~~such~~ designee, or any other person or institution, shall convert any of these monies to their own use or use the income on behalf ~~or someone who is not the~~anyone for any reason, except the resident ~~for any reason~~. ~~Refer to section 8.482.1 above for limitations.~~

8.482.32 COLLECTION OF INCOME

C. The County or nursing facility must ~~should~~ report suspected financial exploitation to a law enforcement agency in accordance with ~~as cited in~~ C.R.S. § 18-6.5-108.

8.482.33 Nursing Facility Post Eligibility Treatment of Income – Incurred Medical Expenses (PETI-IME)

Effective April 8, 1988, with respect to the post-eligibility treatment of income of individuals who are institutionalized there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by Colorado Medicaid or third party insurance, including health insurance premiums, deductibles or co-insurance; dental care; hearing aids, supplies, and care; corrective lenses, eye care, and supplies; and other incurred expenses for medical or remedial care that are not subject to payment by a third party.

A. All PETI-IME expenses ~~in excess of $400 per calendar year~~ shall be prior authorized by the Department or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supplies, to validate that the requested expense is not a benefit of the Medicaid program, and to determine if the expenses requested are a duplication of expenses previously prior authorized.

B. Prior Authorization Request Process:

For allowable PETI-IME expenses ~~that exceed $400 per client in a calendar year,~~ costs shall be prior authorized by the Department or its designee. The process is as follows:

1. Prior authorization requests must be submitted to the Department as prescribed by the State through the Provider Web Portal. In addition to the information requested on the web portal form, the following attachments must be included:

    a. For All PETI-IME requests: The medical necessity form legibly signed by the physician (and the physician name legibly written) and resident or resident representative.

    b. For All PETI-IME requests: An itemized invoice with codes and fees for the service or supply being requested.

    c. Additionally, for ~~H~~hearing ~~A~~aids: a~~n~~ current audiogram test less than one year old.

    d. Additionally, for medical ~~H~~health Insurance: premium statement to identify the type of plan, monthly fee and copy of health Insurance card (front and back).

    e. Additionally, for Dental: Medicaid denial of coverage, verification that dental benefit has been exhausted.

2 Prior authorizations will be certified by ~~T~~the Department based on the following criteria:

    a. The request is not a benefit of the Medicaid program.

    b. The cost of the request does not exceed the basic Medicaid rate for such services or supply.

    c. The special medical service or supply is medically necessary, approved and signed by a physician.

3. The Department or its designee shall review and approve/deny the Prior Authorization Request within fifteen working days of receipt. The Provider Web Portal shall reflect the status of the request.

4. Upon receipt of the approved Prior Authorization Request (PAR), the nursing facility shall submit the PETI-IME reimbursement on the following month's Medicaid billing or on the nursing facility's next billing cycle.

    a. PETI-IME PAR requests must be submitted within the timely filing period of ~~120~~ 365 days from the date of service.

    b. For approved PETI-IME PARs requested prior to services rendered, the Department has the discretion to close the PAR if reimbursement is not requested within 12 months from the date of Department approval.

C. Private health insurance premiums, deductibles, or co-insurance as defined by state law.

1. Monthly premium payment paid by the resident for private health insurance.

    a. If premium payments exceed the patient payment amount for one month, a monthly average is calculated by dividing the total premium by the number of months of coverage. The resulting amount is to be applied as a monthly PETI-IME expense for ~~the~~ each month~~s~~ of coverage until spent.

2. Medical ~~H~~health insurance premiums will be allowed for the resident only. This does not include prescription drug, vision, dental or life insurance.

3. Private Health insurance premiums, deductibles, and coinsurance must be reviewed by the Department or its designee yearly for final approval.

   a. If duplicate coverage has been purchased, only the cost of the least expensive policy will be allowed. Premiums, deductibles and co-insurances which the Department or its designee determine to be too expensive in relation to coverage purchased shall not be allowed.

   b. Upon approval, private medical health insurance premiums are billable for 12 months.

D. The allowable expenses for special medical services are subject to the following criteria:

1. General Instructions (applies to all special medical services).

   a. If the ~~client~~ resident does not make a patient payment; then no PETI-IME will be allowed. The resident must be Medicaid approved and not in pending status for any PETI-IME service request to be approved.

   b. Costs will be allowed only if they are not a benefit of the Medicaid program, or not a benefit of other insurance coverage the resident may have.

   c. All allowable costs must be for items that are medically necessary as described in ~~10 CCR 2502-10 s~~Section 8.076.1.8, and medical necessity must be documented by the attending physician. The physician statement must be current, within one year of the authorization.

   d. The resident or resident representative must agree to the purchase of the service/equipment and related charge, with signed authorization in the resident's record.

   e. Nursing facilities or providers are not permitted to assess a surcharge or handling fee to the resident's income.

   f. The allowable costs for services and supplies may not exceed the basic Medicaid rate.

   g. In the case of damage or loss of supplies, replacement items may be requested with relevant signed documentation. If the damage or loss is due to negligence on the part of the nursing facility, the nursing facility is responsible for the cost of replacement.

   h. Costs will not be allowed if the equipment, supplies or services are for cosmetic reasons only.

   i. Monthly PETI-IME payments may not exceed the monthly patient payment. Approval for reimbursement shall only be allowed if the provider agrees to accept installment payments.

   j. For special medical services/supplies provided but not yet paid for, the encumbrance agreement and monthly payment schedule must be documented in the resident's record, as well as receipts of payment.

3. Hearing Aid Instructions

   a. All referrals for hearing aids must be authorized by the attending physician, and must include an evaluation for suitability and specifications of the appropriate appliance performed by a licensed audiologist.

   b. Purchase of new hearing aids to replace pre-existing hearing aids must include documentation of necessity of replacement of the pre-existing hearing aid. New hearing aids are a benefit after five (5) years with appropriate documentation.

   c. Documentation attached to the prior authorization request should include the signed medical necessity form, itemized invoice with codes and fees and current (within one (1) year) audiogram.

4. Corrective Lenses Instructions

   PETI-IME expenses for corrective lenses will be limited to services not covered under ~~10 CCR 2505-10, s~~DSection 8.203 Vision Services. Corrective lenses are limited to one (1) pair per twenty-four (24) month period under S~~per 10 CCR 2505-10 s~~ection 8.203.4.B. For a change in vision within twenty-four (24) months, an eye exam is required to show the change in vision.

   a. The evaluation of the need for corrective eyeglasses (lenses) must be a part of a comprehensive general visual examination conducted by a licensed ophthalmologist or optometrist.

   b. The medical necessity for prescribed corrective lenses should not be based on the determination of the refractive state of the visual system alone, but should be identified by the current procedural terminology in the Physician Current Procedures Terminology (CPT) Code as established by the American Medical Association.

      i. Documentation attached to the prior authorization request should include the signed medical necessity form and itemized invoice.

5. All documentation of the incurred expenses must be available in the client's financial and medical record for audit purposes by the Department or its designee. Lack of documentation shall cause the PETI-IME to be disallowed and shall be considered an overpayment subject to recovery by the Department. Documentation shall include:

   a. Printed copy of approved PAR.

   b. Copy of all attachments to the PAR.

   c. Yearly nursing facility tracking ~~A~~activity ~~L~~log that includes the dental, vision and PETI-IME reimbursement activity. Specifically:

      1) Member number and name receiving the service;

      2) Type of service requested;

      3) Date service was requested by the member;

      4) Date PAR was added to Provider Web Portal:

5) Date PAR was approved by the Department;

6) Date facility received payment from Medicaid for service;

7) Date service provider was paid by the facility;

8) Date service was rendered to the member;

9) When/if the member's personal needs ~~account~~ funds were used;

10) When applicable, documentation that the member's personal needs account was reimbursed;

11) Documentation that the member was still at the facility when the service was rendered;

d. All documentation shall be retained for six years and is subject to audit by the D~~d~~epartment or its designee.

8.482.34 THE "STATUS OF NURSING FACILITY CARE" FORM, AP-5615

A. Responsibilities of the Nursing Facility

1. The AP-5615 form is to be completed by the nursing facility~~, in duplicate,~~ for all admissions, readmissions, transfers from private pay or Medicare, discharges, deaths, changes in income and/or patient payment, and leaves of absence.

2. Each form must include~~carry~~ the date completed and the actual signature of the nursing facility administrator or ~~his/her~~their authorized representative.

3. All copies of the AP-5615 must be ~~mailed~~ submitted to the appropriate county department and the D~~d~~epartment at HCPF_LTC_FinCompliance@state.co.us within five working days of the action which is being reported, or in the case of a change in resident income, within five working days of the time the change becomes known, in order to expedite reimbursement.

4. The nursing facility will be responsible for assuring that the patient payment, as shown on the AP-5615 and approved by the County Department, is identical to that claimed on the monthly nursing facility, billing form. Failure to enter the latest patient payment data on the billing form will render the nursing facility liable for any discrepancies.

B. Responsibilities of the County Department

On receipt of Form AP-5615, the county department will, within five working days:

1. For an admission, a readmission or a transfer from/to private pay or Medicare:

a. Verify and correct, if necessary, data entered by the ~~nourishing~~ nursing facility.

b. List and/or verify the resident's monthly income; and compute patient payment. ~~Distribute completed form as instructed on back of form.~~

c. Verify and ~~C~~correct the automated system to indicate the nursing facility name and provider number and to reflect the current distribution of income. Submit the

AP-5615 to the nursing facility and the Department at HCPF_LTC_FinCompliance@state.co.us.

(1) The CBMS system shall be updated to reflect the resident's current nursing facility name and provider number to ensure residential placement is accurately reported in the system.

(2) Any report generated by the county reflecting a current list of residents residing in a single facility shall be accurate. This includes, but is not limited to, the yearly cost of living adjustment (COLA) report generated by the county.

2. For change in patient payment with respect to changes in resident income:

a. Verify changes in resident income~~,~~ and correct if necessary. All such corrections must be initialed,

b. Correct ~~eligibility reporting form~~the AP-5615 and submit to the nursing facility and ~~state~~ the department at HCPF_LTC_FinCompliance@state.co.us.

3. For change in patient payment with respect to the ~~post-eligibility treatment of income~~Medicare p~~P~~remium deduction allowance, the county department shall:

a. Review the AP-~~-~~5615 for Medicare premium deduction allowances for the first two months of admission of readmission.

b. If the member is enrolled in ~~client is already on~~ the Medicare Buy-In program, do not: adjust patient payment on Form 5615 for the Medicare premium deduction. If member~~client~~ is not on the Buy-In program, adjust Form 5615 for the Medicare premium deduction for the first two months of nursing facility eligibility.

5. For discharge or death of resident:

a. Verify the date of death or discharge~~,~~ and verify the correct patient payment (or resident's monthly income) for the discharged month, and the amount calculated by per diem. All corrections must be initialed.

b. Note if the resident entered another nursing facility and, if so, provide the name of the new nursing facility. This information is needed to assure that duplicate payment will not be made.

c. In the event the resident may return to the same facility, the AP-5615 may be completed at the end of the month for discharges due to hospitalization.

d. Make necessary changes on the automated system to reflect the appropriate circumstances. Submit the AP-5615 to the nursing facility and the Department at HCPF_LTC_FinCompliance@state.co.us.

(1) The Colorado Benefits Management System (CBMS) system must be updated with the resident's current nursing facility name and provider number to ensure the yearly COLA report for the county includes all residents residing in nursing facilities located in their county.

6. Failure to submit the correct form may result in the refusal of the Department to reimburse such nursing facility care.

7. General Instructions:

a. The AP-5615 form must be verified and the original returned to the nursing facility and the Dd~~d~~epartment at HCPF_LTC_FinCompliance@state.co.us.

b. The AP-5615 form must be signed and dated by the director of the County Department, or by ~~his/her~~their designee.

c. AP-5615 forms may be initiated by either the nursing facility or County Department. If the County Department is aware of information requiring a change in financial arrangements of a resident, and a new AP-5615 form is not forthcoming from the nursing facility, the County Department may initiate the revision to the AP-5615. In such case, one copy of the AP-5615 showing the changes, will be sent to the nursing facility and the Dd~~d~~epartment at HCPF_LTC_FinCompliance@state.co.us.

C. Calculating Partial Month Payments

1. Whenever a resident is in the nursing facility on the first day of the month, and remains a resident for each day of the month, ~~and continues to be is still a resident on the first day of the next month,~~ the total resident income~~.~~ in excess of the amount reserved for personal needs allowance, less adjusted earned income ~~(if appropriate)~~, less spousal, and dependent care allowance, less home maintenance allowance, ~~and less allowable expenses for medical and remedial care (see PETI deductions as defined in 10 CCR 2505-10 sections 8.110.49 and 8.482.33)~~ will be used as the patient payment~~,~~. ~~regardless of the actual number of days in that month.~~ If the resident is in the facility less than this period, the rate is computed using the calculation below.

2. In figuring the number of days for payment, the day of admission is included, but not the day of discharge (i.e., the resident dies or leaves the facility).

3. In order to calculate the patient payment:

a. ~~d~~Determine the amount of available resident income for the month (see subsection 1. above).

b. ~~s~~Subtract the cost of the care provided to the resident during that month (computed by multiplying the number of days in the facility times the per diem cost of care).

4. If the cost of care exceeds the available resident income, Medicaid will pay the difference. If the available resident income exceeds the cost of care, the excess income is the property of the resident (~~10 CCR 2505-10 s~~Section 8.482.3) and must be refunded to the resident or the legal guardian/designated responsible party.

5. When patient payment is calculated by per diem, the final amount shown on the AP-5615 will be that amount to be paid by the resident, not the amount to be returned to the resident.

6. If, at the time the resident is discharged or dies, the patient payment for that month is greater than the properly computed per diem patient payment, the following rules apply:

a. If the resident is discharged to another nursing facility, or to the resident's own home, the excess patient payment and personal needs ~~monies~~ fund must be

forwarded to the resident in ~~his/her~~their own home or in the transferred nursing facility, within 45 working days of the date of discharge.

b. If the resident is discharged to a hospital, other medical institution, or if the resident dies, the excess patient payment must be immediately ~~transferred from the nursing care account~~refunded to the resident's personal needs account. These funds should be disbursed ~~then are to be disposed of~~ as detailed in ~~10 CCR 2505-10 s~~Section 8.482.52.F. If the nursing facility does not handle the resident~~''~~s personal needs funds, the excess patient payment must be immediately returned to the responsible party.

1) However, if the resident is discharged from the nursing facility to a hospital or other medical institution and is admitted with Medicaid as the primary source of funding, the patient payment in excess of the amount due to the discharging nursing facility may be due to the hospital or medical institution. Any excess patient payment should be sent to the hospital at the end of the month (see S~~10 CCR 2505-10 s~~ection 8.3~~58~~00.10). If the resident discharged to a hospital or other medical institution is not readmitted to the nursing facility, the resident's personal needs funds, either excess patient payment or resident personal needs funds, must be lawfully disposed of as indicated in ~~10 CCR 2505-10 s~~Section 8.482.52.F.

2) If the resident dies in the nursing facility or is discharged to a hospital or other medical institution where ~~he/she~~they subsequently die~~s~~, the resident's funds entrusted to the nursing facility must be transferred as indicated in ~~10 CCR 2505-10 s~~Section 8.482.52.F.

(3) If resident personal needs funds are unable to be transferred due to an uncashed check after ninety (90) days, the resident personal needs funds must be submitted to the Department with a copy of the cancelled check as indicated in ~~. Refer to 10 CCR 2505-10 s~~Section 8.482.52.F.3.

D. Zero Patient Payment

1. Patient payment may be waived, and zero $0.00 patient payment applied only under the following conditions:

a. A resident's income is equal to or less than the personal needs allowance (see ~~10 CCR 2505-10 S~~section ~~8.110.42~~8.100.7.V.3.); or

b. A resident's income is equal to or less than the personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, or less home maintenance allowance, or less allowable expenses for Medicare premiums ~~(see PETI deductions as defined in 10 CCR 2505-10 sections 8.110.49 and 8.482.33)~~as defined in ~~10 CCR 2505-10 s~~Section 8.100.7.V.3.; or

c. A resident is admitted to the nursing facility from ~~his/her~~their home and the resident's funds are committed elsewhere for that month; or

d. The resident is admitted from ~~his/her~~their home, where ~~his/her~~their funds were previously committed, to the hospital, and subsequently to the nursing facility, in the same calendar month; or

e. The resident is discharged to ~~his/her~~their home, and the county department determines that the income is necessary for living expenses; or

f. The resident is admitted from another nursing facility or from private pay within the facility and has committed the entire patient payment for the month in payment of care already provided in the month of admission.

2. Patient payment may not be waived (other than for the exceptions provided for in ~~10 CCR 2505-10 s~~Section 8.482.34.D.1.) in the following instances:

a. A resident with income in excess of the personal needs allowance, less earned income (if appropriate), less spousal and dependent care allowance, or less home maintenance allowance, or less allowable expenses for Medicare premiums ~~(see PETI deductions~~ as defined in ~~10 CCR 2505-10 s~~Section~~s 8.110.49 and 8.482.33)~~8.100.7.V.3., except as provided in the Colorado Department of Human Services Income Maintenance Staff Manual Volume 3, concerning increased personal needs allowance; or

b. Transfers between nursing facilities; or

c. Discharges from nursing facility to a hospital or other medical institution; or

d. Changes from private pay within the facility and patient payment not already committed for care provided; or

e. The death of the resident.

3. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.

8.482.42 ADDITIONAL PAYMENTS

A. "Additional payments" are defined as payments made by the resident, or by a resident's family, conservator or administrator for items which are not a benefit of the Medicaid program, such as:

1. Items covered in ~~1S0 CCR 2505-10 s~~ection 8.44~~2.10~~2.A., Services and items not included in the Per Diem Rate (chargeable to ~~Patient Trust Funds~~resident personal needs account).

2. Room reservations for medical leave in accordance with ~~10 CCR 2505-10 s~~Section 8.482.43.

3. Room reservations for non-medical and/or programmatic leave days in excess of 42 days per calendar year in accordance with ~~10 CCR 2505-10 s~~Section 8.482.44.

~~4. Limitations covered in 10 CCR 2505-10 section 8.462.~~

B. Additional payment for resident care and services which are to be furnished within the nursing facility per diem rate (Section 8.440.1) are specifically prohibited ~~(10 CCR 2505-10 sSection 8.442)~~. The nursing facility can neither solicit additional funds for such care and services nor accept voluntary monetary contributions for them, from residents or responsible parties. Any such monies collected or accepted by the nursing facility shall render such facility liable for the penalties set forth in ~~10 CCR 2505-10 s~~Section 8.482.~~48~~45.

C. Additional payments may be charged for:

1. Services and items not included in the per diem rate, as specified in ~~10 CCR 2505-10 s~~Section 8.44~~2.1~~0.2. These items may be billed to the resident, to the resident's estate or other responsible party, subject to the restrictions set forth in ~~10 CCR 2505-10 s~~Section 8.44~~2.1~~0.2.

F. Additional payments may not be deducted from the resident's personal needs ~~funds~~account, nor may they be applied to a PETI deduction as described in ~~10 CCR 2505-10 s~~Section 8.482.33, unless authorized by the~~such~~ resident or the party responsible for the~~such~~ resident. The~~Such~~ authorization must be a separate written authorization for each billing from the nursing facility.

8.482.43 MEDICAL LEAVE FROM NURSING FACILITY

4. The resident, or the responsible party ~~if the resident is unable to respond~~, must be advised, in writing, that payment for holding the nursing facility room cannot be made by Medicaid. In addition, ~~he/she~~~~they~~ the resident must give written consent to the additional charge, including ~~both~~ the daily rate ~~thereof~~ and the anticipated number of days. If the resident is absent from the facility longer than the anticipated number of days shown on the consent form, the nursing facility must obtain agreement on another consent form before continuing to charge for medical leave. The consent form(s) must be retained with the resident's ~~other resident~~ records and be subject to audit.

C. Room reservation charges for Medical leave:

5. If no other funds are available, the room reservation charges may be deducted from the resident's personal needs ~~funds~~account, subject to the restrictions in ~~10 CCR 2505-10 s~~Section 8.482.42. However, the resident's personal needs account must retain at least $10 at all times, if used for room reservations payment. In case of death of the resident, the entire resident personal needs account may be used, if necessary.

8.482.45 ~~PENALTIES~~ENFORCEMENT BY THE DEPARTMENT

The Department shall assess, enforce, and collect penalties for noncompliance with regulations, in accordance and as authorized under C.R.S. § ~~25-1-107.5~~25.5-6-205(1)(a), including but not limited to the following:

A. Obtaining vendor payments fraudulently, as outlined in C.R.S. §~~section~~ ~~26-1-127~~25.5-4-305 ~~(1995 Supp)~~.

B. Obtaining additional payments from residents, or resident's families, as outlined in C.R.S. §~~section~~ 25.5-4-301.

C. License ~~may be revoked~~revocation or provisional license according to the provisions of C.R.S. §~~section~~ 25-3-103.

D. ~~Falsification of reports~~Fraudulent acts to assist any person in obtaining public assistance, vendor payments, medical assistance, or child care assistance to which the person is not entitled to as outlined in C.R.S. §~~section~~ ~~26-1-127~~25.5-4-301.

E. Overpayments or ~~i~~incorrect payments due to omission, error or fraud ~~may be recovered~~ as outlined in C.R.S. § ~~section~~ 25.5-4-301(2).

F. Duty of resident to report changes in income ~~and penalties for non compliance,~~ as outlined in C.R.S. §~~section~~ 26-2-128.

~~G. In addition to all penalties imposed above, the Department may also require the reimbursement of the entire amount of any benefits unlawfully obtained.~~

G. Crimes against at-risk persons as outlined in C.R.S. § 18-6.5-103

H. Illegal retention and use of resident personal needs account as outlineds in C.R.S. § 25.5-6-206.

I. Rules as defined in this section 8.400 through 8.482.

8.482.46 UTILIZATION OF MEDICARE BENEFITS

~~A. [Expired 05/15/2016 per House Bill 16-1257]~~

~~B~~A. Part "B" deductible and co-insurance amounts for Medicare-eligible Medicaid recipients will be reimbursed by Medicaid. Reimbursement will be made for any service covered by Part "B" of the Medicare program, as described in 42 CFR §~~sections~~ 405.~~230-252~~ Subpart B, even though that service is not ordinarily covered under the medical assistance program. The services paid ~~for~~ by Medicare cannot be included in costs for calculation of the nursing home provider's daily reimbursement rate. If Medicare Part "B" type services are provided by the facility and the facility has a provider number which it used to bill Medicare, then the following entries must be made to the cost report (MED-13):

1. The cost of the care reimbursed by Medicare and/or Medicaid crossover for residents who are Medicaid recipients may be deducted from Schedule "C" of the MED-13 Schedule "B" if the costs for providing that care are determinable and auditable; or

2. The Medicare and/or Medicaid crossover revenue for residents who are Medicare eligible will be deducted from Schedule "C" on Schedule "A".

~~C~~B. When the facility provides Medicare Part "B" type services to non-residents of the facility, the following entries must be made to the cost report (MED-13):

1. Cost of the care reimbursed by Medicare and/or Medicaid crossover for non-residents of the facility must be deducted from Schedule "C" of the MED-13 on Schedule "B" if the costs for providing that care are determinable and auditable; or

2. The Medicare and/or Medicaid crossover revenue for non-residents of the facility must be deducted from Schedule "C" on Schedule "A".

~~D~~C. Co-insurance and deductible costs for the following services (which are covered by Medicare Part "B") may be billed to the Medicaid program without prior authorization:

1. Laboratory Services

2. Medical Supplies

3. Durable Medical Equipment

4. Speech Therapy

5. Occupational and Physical Therapy

6. Practitioner Services

~~E~~D. Facilities or their suppliers when billing the Medicaid program for those services reimbursed by Medicare, must~~are to~~ use the Medicare/Medicaid crossover system of billing. The facility, in order to bill through the Medicare/Medicaid crossover system, needs ~~only~~ to complete a Medicare billing form and indicate on that form that they wish to "accept assignment." A Medicare claim form for a Medicare/Medicaid patient, indicating acceptance of assignment, will cross over to Medicare, and co-insurance and/or deductibles will be paid on a Medicaid remittance advice.

8.482.5 RESIDENT'S PERSONAL NEEDS ~~FUNDS~~ACCOUNTS

8.482.51 STATEMENT OF POLICY

A. All residents receiving nursing facility care are allowed to retain the amount of income specified in ~~10 CCR 2505-10 s~~Section ~~8.110.42~~8.100.7.v.3. as personal needs funds, to purchase necessary clothing or incidentals as specified in ~~10 CCR 2505-10 s~~Section 8.440.2.A.. These funds may not be used to supplement the Medicaid nursing facility payment, and such funds cannot be used for any other purpose whatsoever by the nursing facility.

B. Personal needs ~~money is~~funds are for the exclusive use of the resident as ~~he/she~~they desire~~s~~. The resident or relatives may not be charged for such items as Chux, tripads, toilet paper, or other nursing facility maintenance items because~~since~~ these items are included in the audited cost described in ~~10 CCR 2505-10 s~~Section 8.442. Other charges which could be disallowed are as follows:

1. Nursing facility maintenance items and nursing care supplies and services.

2. Charges without the following documentation:

   a. vendor receipts;

   b. signed cash receipts; or

   c. statement signed by the resident for any specifically requested over-the-counter drug.

3. Charges which constitute a duplicate payment as defined in~~10 CCR 2505-10 s~~Section 8.482.41.

4. Charges which constitute an additional payment as defined in ~~10 CCR 2505-10 s~~Section 8.482.42.

5. Handling charges, such as personal needs ~~trust~~ account bank service fees.

C. Items not covered by Medicaid, as described ~~noted~~ in ~~10 CCR 2505-10 s~~Section 8.440.2.A.,such as personal items, clothing, ~~private room,~~ etc., may be charged to the resident's personal needs account ~~of the resident~~. However, all of the restrictions in ~~of 10 CCR 2505-10 s~~Section 8.442.1 apply. In addition, only those items actually requested by the resident may be charged to ~~his/her~~the personal needs funds, and there must be a signed, dated receipt for each ~~such~~ item or service signed by the resident, the resident's conservator, guardian or relative, or by a responsible party, retained in the resident's personal needs accounts file.

1. Acceptable signed consent formats:

   a. Petty cash receipt form signed by the resident, responsible party or two facility witnesses, if the resident is unable to sign.

b. Email from the responsible party on file for the resident.

2. Copy or original itemized receipt for purchase obtained at time purchased item(s) is/are delivered to the resident. Receipt must be attached to the signed consent form.

3. Disallowed consent forms include text messages and~~,~~ verbal approvals.~~, etc.~~

D. Facility is responsible to document and maintain procedures for handling resident personal needs accounts and reporting fraud and/or financial exploitation

E. Facility is responsible to report to a law enforcement agency any suspected mistreatment of at-risk elders as described ~~cited~~ in C.R.S. § 18-6.5-108.

F. Resident personal needs accounts are subject to audit by the Department or its designee. Any deficiencies identified may result in corrective action plans, recoupment of funds, including interest, to the Department from the facility, forfeiture of the surety bond, or any penalty listed in ~~10 CCR 2505-10 s~~Section 8.482.45.

1. Any instances of insufficient documentation or misuse of funds identified during an audit may be referred to the County Department's ~~of the County Office~~.

8.482.52 RESPONSIBILITIES OF NURSING FACILITIES

A. General Accounting Practices

1. Nursing facilities must administer a resident personal needs ~~fund~~ account for those residents who are unable to or have no desire to handle their own personal needs ~~monies~~funds. The nursing facility is obligated to exercise due care in the handling of resident funds per federal regulations.

2. If a resident elects to have the nursing facility handle ~~his/her~~their personal needs ~~monies~~funds, a resident personal needs ~~trust~~ account agreement must be entered into and signed by the resident or the resident's legal personal representative. This agreement creates a fiduciary relationship between the nursing facility and the resident which includes the legal rights and responsibilities provided for in C.R.S. ~~s~~§~~ection~~ 15-1-101. As a condition of the ~~trust~~ resident personal needs account agreement, the nursing home is allowed to return the personal needs allowance portion of the resident's income. (See ~~10 CCR 2505-10 s~~Section ~~8.110.42~~8.100.7.V.3.).

3. If the resident or responsible party does not elect to have the facility handle the personal needs ~~monies~~funds, the resident or responsible party must enter into and sign a resident personal needs account exclusion agreement with the facility.

4. If the total personal needs ~~trust~~ fund balance is less than $50.00, the resident's personal needs ~~trust~~ fund ~~monies~~ may be held in either an interest or non-interest-bearing account with a depository institution or in cash at the facility as described at ~~indicated in~~ 42 C.F.R. § 483.10(f)(10)(ii)(B).

5. If the total personal needs ~~trust~~ fund balance is $50.00 or more, the resident's personal needs funds must be kept in an interest-bearing account. The account can be a checking account, a savings account, or a certificate of deposit as described at ~~indicated in~~ 42 C.F.R. § 483.10(f)(10)(ii)(B).

6. The bank account must be designated as "resident ~~trust funds~~personal needs account."

7. The funds in the depository institution (most often a bank) must be insured (bonded) per Part B below.

8. The personal needs ~~trust monies~~funds must not be commingled with either the operating funds of the facility or with any other individual's fund who is not a resident of the facility.

9. The personal needs ~~monies~~ funds of more than one resident~~:~~ can be commingled in the same bank account as long as separate accounting records (i.e., subsidiary ledgers) are maintained.

10. No charge for handling such ~~trust~~ accounts may be made to the recipient or to the estate of the recipient at any time. Such expenses should be included as a part of the audited costs as determined in ~~10 CCR 2505-10 s~~Section 8.440.

11. A subsidiary ledger, as specified by the Department, must be kept for each resident for recording resident personal needs account transactions.

12. A reconciliation of the sum of the ledger balances to the bank balance (plus petty cash, if applicable) must be performed on a monthly basis.

13. Deposits and disbursements from the resident personal needs ~~trust~~ account must be recorded in an accurate amount and in accordance with ~~10 CCR 2505-10 s~~Section 8.482.51.B for purchases and ~~10 CCR 2505-10 s~~Section 8.482.52.F for refunds.

14. Any interest income must be recorded on the ledgers. If the resident ~~trust~~ personal needs account funds are pooled in one interest - bearing account, the interest earned on the accounts must be allocated to each resident's account proportionately (i.e., by dividing the individual resident's account balance by the total personal needs ~~trust~~ account fund balance then multiplying that quotient times the amount of interest income).

15. The resident shall be notified when ~~his/her~~their personal needs ~~trust~~ account fund balance reaches $200 less than the SSI resource limit. ~~as provided in 10 CCR 2505-10 sSection 8.110.53. A~~

16. This accounting system must be adequate for audit by the ~~representative of~~ the Department, and in accordance with generally accepted accounting principles.

17. All such accounts, original bank statements, and supporting documentation must be available for audit by any authorized employee of the county department, ~~, State~~ Department, or agent of the ~~State~~ Department at any time.

18. Personal needs ~~money is~~funds are the property of the residents and all accounting records, bank accounts and other documents must remain with the nursing facility when ownership is transferred.

B. Bonding Requirements

1. An additional condition of nursing facility participation in the Medicaid program is the purchase of a surety bond as required by C.R.S. §~~section~~ 25.5-6-206(3)(c). The sum of the surety bond must not be less than the resident's personal needs ~~trust~~ accounts funds liability as computed quarterly during interest proration, or the licensed operator ("licensee") shall otherwise demonstrate to the satisfaction of the Department that the security of the residents' ~~personal needs~~ funds is assured. State owned/operated facilities are bonded separately under the risk management program up to $100,000 and are exempt from this requirement.

2. The effective dates of the surety bond shall be from January of each calendar year through December 31 of the following calendar year. ~~The nursing facility licensee's Medicaid participation shall be terminated immediately upon lapse of such bond.~~

3. A copy of the Surety Bond Patient Needs ~~Trust~~ Fund (Form MED-181), or the Certificate of Insurance (Surety Bond), fully executed, signed and sealed, shall be filed each year with the Department within 15 days prior to the effective date thereof.

   a. Each year, upon surety bond renewal, a copy of the renewed surety bond shall be filed with the Department within thirty (30) calendar days of the renewal date at HCPF_LTC_FinCompliance@state.co.us.

4. Upon the termination of Medicaid participation of a nursing facility provider for any reason, either voluntarily or through Departmental action, the bond must be kept in effect until the final audits of resident personal needs account funds and ~~resident~~ nursing facility ~~care~~ billing accounts can be completed by the Department, and until any adjustments required by such audits have been made.

C. Change ~~of~~ in Licensed Operator, Change in Ownership - Requirements

1. When the licensed operator ("licensee") of a nursing facility is changed, as described in ~~10 CCR 2505-10 s~~Section ~~8.441.5~~8.443.15, it shall be the duty of the new licensee~~Medicaid provider~~:

   a. To execute a new resident personal needs account agreement on behalf of Medicaid residents, as required by this section. The new licensee~~provider~~ shall furnish proof to the Department that it has properly established resident's personal needs accounts and carried forward the proper balance remaining in each resident's ledger.

   b. To post a surety bond as required by C.R.S. §~~section~~ 25.5-6-206 (3)(c)~~.,~~ and ~~10 CCR 2505-10 s~~Section 8.482.52.B., or ~~above, or~~ to otherwise demonstrate to the satisfaction of the Department that the security of residents' personal needs ~~funds~~ accounts is assured.

   c. Upon notice to the Department that a nursing facility's licensed operator will change or Medicaid participation will be terminated as required in ~~10 CCR 2505-10 s~~Section ~~8.441.5~~8.443.15, the Department may withhold all or part of any monies due the prior nursing facility licensee until the resident personal needs accounts ~~of the residents~~ have been determined to be correct. If such accounts are found to be deficient, the amount of the bond established by the prior licensee shall be forfeited to the Department~~, and any additional deficit shall be deducted from such monies due to the prior licensee of fee nursing facility. (See also 10 CCR 2505-10 section 8.444.)~~ The Department will, in such cases, assume the responsibility for proper distribution of such monies to the deficient resident accounts.

2. It shall be the duty of the prior licensee to provide the new licensee written verification, by a public accountant, of the amount of personal needs ~~money~~ funds being transferred for each resident's personal needs ~~fund~~account. This verification shall include a statement that this amount corresponds to the total of the balances shown on the resident's individual ledger

D. New Admission

When a patient is admitted to a nursing facility for the first time, ~~,~~ or transferred from Medicare or private pay, the nursing facility shall set up a new account for personal needs funds, which lists a beneficiary or beneficiaries (with percentages), as specified in A. of this subsection.

E. Readmissions, Transfers from Another Nursing Facility.

1. Upon readmission or transfer of a resident, the nursing facility shall determine the amount of personal needs funds currently in the resident's account in the previous facility, make every effort to obtain such funds, and show this amount as a balance forward in the current ledger. Reconfirmation of the listed beneficiary or beneficiaries shall also be done at this time.

2. Failure to make such effort shall be considered a breach of ~~trust~~ agreement, and may be cause for cancellation of the participation agreement.

3. If, upon making every effort, the current nursing facility is unable to obtain the balance of funds from the resident's previous facility, the current nursing facility should notify the Department immediately. Failure to do so may be construed as a failure to make every effort.

F. Discharge from a Nursing Facility

1. Upon discharge of a resident to the resident's home, to another nursing facility or to the care of a responsible party, the nursing facility shall determine the amount remaining in the resident's personal needs account within 45 days, and make payment of this amount to the resident, responsible party, or transfer these funds to the current nursing facility, if appropriate. Failure to so dispose of the resident's personal needs funds shall render the nursing facility liable for cancellation of the participation agreement or to the penalties as set forth in ~~10 CCR 2505-10 s~~Section 8.482.45, or both. All patient's personal possessions shall also be relinquished, as required by ~~10 CCR 2505-10 s~~Section 8.482.6.

2. At the end of the month in which a resident is discharged to a hospital, the nursing facility shall:

a) set aside the personal needs allowance ~~of $50~~ amount for the resident;

b) apply the balance of any ~~monies~~ patient liability amount to the established Medicaid rate for the number of days the resident lived in the facility; and

c) if there is still a balance, transfer the funds to the receiving hospital, if Medicaid is the primary funding source.

If the resident returns to the same nursing facility, no additional accounting is necessary. If the resident does not return to the same facility, however, disposition of the personal needs funds shall be made as specified in this section.

3. Death of a resident.

a. The nursing facility shall distribute the balance of the resident personal needs account in the following order ~~is required to determine if~~:

(1) Pay outstanding debt due the facility related to uncollectible patient payment for room and board;

(2) Transfer the personal needs amount and a final accounting of the funds to the person responsible for settling the resident~~'~~'s estate. The responsible party may be a Public Administrator or other interested or appointed person. The facility can accept the Collection of Personal Property by Affidavit pursuant to C.R.S. §~~section~~ 15-12-1201 if the estate assets are under the published threshold for that year, the Letters Testamentary, or Letters of Administration. Transfer of funds shall occur within 60 days from the date of death. The facility shall provide written notice to the Department that funds were transferred to the person responsible for settling the resident's estate. Notice shall include the patient's name, Medicaid State ID, amount transferred, name of person that received the funds, and the contact information for the person that received the funds. Upon receipt of the notice, the Department may initiate action to recover the funds pursuant to C.R.S. §~~section~~ 25.5-4-302.

(3) Pay remaining funds to the Public Administrator of the county according to the provisions of C.R.S. §~~section~~ 15-12-620(4). The Clerk of the District Court should be contacted to obtain the name of the current Public Administrator appointed for the county. The facility shall provide written notice to the Department that funds were transferred to the Public Administrator for settling the resident's estate. Notice shall include the patient's name, Medicaid State ID, amount transferred, county, and the name of the Public Administrator.

(4) The facility shall have defined policies and procedures to determine whether the balance of a resident's personal needs account should be remitted to a burial or funeral service provider for outstanding costs. The facility shall follow the burial assistance rules of the Colorado Department of Human Services per 9 CCR 2503-5 §~~section~~ 3.570.43. The facility should ensure that the value of the member's estate, including any cash or property, is identified and subtracted from the burial grant per 9 CCR 2503-5 §~~ section~~ 3.570.43.D.2 and that payments from the decedent's estate are paid directly to the service provider per 9 CCR 2503-5 §~~section~~ G;

(5) If the facility is unable to properly disposition the deceased resident's personal needs funds in any of the means described in the above provisions, the facility may transfer the funds to the Department for collection to offset the medical assistance paid on the member's behalf.

~~1) The nursing facility resident dies intestate (i.e., without a will) with known relatives, or a listed beneficiary, for whom current addresses are known; or~~

~~2) The nursing facility is unsure of the existence of a will or whether there are known relatives and there is no listed beneficiary; or~~

~~3) There is a public administrator in the county in which the death occurred. If not, the nursing facility shall, within ten days from the date of death, contact the Department. It shall then be the responsibility of the~~

Department to turn the funds over to the Colorado State Treasurer for inclusion in the next Great Colorado Payback listing.

Within 60 days after a resident's death, the facility shall transfer the resident's personal needs funds and a final accounting of the funds to the person responsible for settling the resident's estate or, if there is none, to the resident's heirs in accordance with the provisions of C.R.S. sections 15-1-101 et seq. Within 15 days after receiving the funds, the executor, administrator, or other appropriate representative of the resident's estate shall provide written notice to the Department regarding the receipt of the funds. Upon receipt of the notice, the Department may initiate action to recover the funds pursuant to the provisions of this article.

b. When a nursing facility resident dies intestate (i.e., without a will) and is known to be without relatives or a listed beneficiary, the nursing facility is required to pay any funds remaining in the personal needs account to the Public Administrator of the county in which the nursing facility resident died. C.R.S. section 15-12-620(4) specifically requires that whenever a person without known heirs dies intestate on the premises of another, the personnel in possession of such premises must give immediate notice thereof to the public administrator or incur liability for any damages that may be sustained through neglect. The Clerk of the District Court should be contacted to obtain the name of the current Public Administrator appointed for the county.

c. In those instances in which the nursing facility resident dies testate (i.e., with a will) the funds in his personal needs account must be transferred to the executor of the estate, unless another person or persons are listed as beneficiaries, in which case the funds can be passed outside the will. Other personal property of the deceased should be given to the executor. C.R.S. section 15-12-711 provides that a personal representative or executor has the same power over the title of the property of the estate as an absent owner.

d. If the proper disposition of the deceased resident's personal needs funds and/or personal property cannot be made, the nursing facility may elect to use the following provisions of the Colorado Small Estate Act to be discharged from further liability.

1) In accordance with C.R.S. sections 15-12-1201 et seq. after ten or more days following the death of a nursing facility resident, a person claiming to be the successor or acting on behalf of all successors of the deceased resident may present an affidavit (Form CPC-40, Rev. 6/81) stating that:

a) The fair market value of the property owned by the decedent and subject to disposition by will or intestate succession, less liens and encumbrances, does not exceed $27,000;

b) At least ten days have elapsed since the death of the decedent;

c) No application or petition for the appointment of a personal representative is pending or has been granted in any jurisdiction; and

d) The claiming affiant(s) and successor (s) are entitled to payment of all monies due and to delivery of all tangible personal property.

~~2) In accordance with C.R.S. section 15-12-1202, the nursing facility administrator is discharged and released from further responsibility once funds or personal property have been released to an individual presenting an affidavit as referenced above. The nursing facility need not inquire as to the truth of the affidavit or of any successor's right to succeed to the deceased resident.~~

~~e. The nursing facility shall also require a signed and dated receipt listing all the resident's personal property items released to a successor, as required by 8.482.6.C.~~

4. Any failure of the nursing facility to properly dispose of the resident~~'s~~ personal needs ~~funds~~ account within 90 days of death or discharge will be considered a breach of ~~trust~~resident personal needs account agreement~~,~~ and may be cause for cancellation of the participation agreement, forfeiture of the required surety bond, and prosecution under the penalties provided in ~~10 CCR 2505-10 S~~section 8.482.45.

8.482.53 RESPONSIBILITIES OF COUNTY DEPARTMENT

A. It shall be the responsibility of the county department, to explain to the resident the various options for handling the personal needs ~~monies~~funds, as well as the resident's rights to such funds. If the resident chooses to allow the nursing facility to hold such funds in ~~trust~~a resident personal needs account, the county department is responsible for assuring that the resident assigns all income to the nursing facility. See ~~10 CCR 2505-10 s~~Section 8.482.52.A.2.

~~B. It shall be the responsibility of the county department, to assure that the nursing facility properly transfers or disposes of the resident's personal needs funds within 45 days of discharge from the nursing facility, or transfer to another nursing facility.~~

~~C. The county department shall notify the State Department if they become aware that a nursing facility has retained personal needs funds more than 90 days after the death of a resident.~~

8.482.54 RESPONSIBILITIES OF THE STATE DEPARTMENT

A. It shall be the responsibility of the ~~State~~ Department to accept and to properly dispose of residual personal needs funds, upon the death of the resident, in any of the following conditions:

1. The resident dies intestate (i.e., without a will), but with known relatives or a listed beneficiary for whom current addresses are unknown;

2. There is no Public Administrator in the county and there are no listed relatives or beneficiaries;

3. The nursing facility is unsure of the existence of a will, or whether there are known relatives.

B. The facility shall be obligated to provide explanation for withholding personal needs funds beyond 90 days after the death of a resident. The Department may apply any or all of the following remedies:

1. Demand immediate return of such funds,-

2. Order an audit of all resident personal needs accounts;

3. Cancel the participation agreement of such nursing facility.

C. Perform periodic audits of nursing facility accounts. Audits may be performed at such intervals as determined necessary by the Department. Audits will always be performed when a nursing facility is discontinued from the Medicaid program for any reason and when a change of ownership or management occurs.

D. If an audit of a resident personal needs account~~s~~ reveals discrepancies the Department, on behalf of the resident, may take administrative action as outlined in ~~Volume 8~~10 CCR 2505-10 S~~s~~ections 8.~~,~~040 and 8.482.45, Recoveries from Providers~~; or the Executive Director may refer the case to the appropriate legal authorities. See 10 CCR 2505-10 section 8.482.45~~.

E. If the nursing facility cannot offer proof that any apparent discrepancies identified in an audit ~~in personal needs accounts~~ have been corrected the Department may withhold payment of nursing care costs in the amount shown due and payable by the audit.

8.482.55 MANAGEMENT OF PERSONAL NEEDS FUNDS BY OTHER THAN RESIDENT

A. For residents unable to manage their own funds due to a physical or mental condition, a conservator, guardian ~~trustee~~, or other responsible person may carry out these acts for the resident.

B. Personal needs funds shall not be turned over to persons other than ~~a duly accredited agent or guardian of the resident~~the resident's authorized agent ~~responsible party the resident authorized~~ when establishing the resident personal needs account.

1. With ~~the~~ resident's written consent ~~of the resident (is the resident is~~ (if able and willing to give such consent~~)~~ the administrator may authorize ~~turn over personal needs funds belonging to said resident to a close relative or friend to~~for the purchase ~~a particular~~of specific items for ~~to~~ a close relative or friend.

2. ~~However, a~~An ~~signed,~~ itemized, dated, and signed receipt ~~will be~~is required for the purchase.

3. A copy or original itemized receipt must be submitted to facility at the time the purchase is delivered to the resident.

4. The facility must ~~will~~ verify purchased items were delivered to the resident.

5. The Facility will only reimburse the responsible party for items the resident requested.

C. Refer to S~~s~~ection 8.482.51 for the account management policy and S~~s~~ection 8.440.2.A.2 for the acceptable purchases policy.

8.482.6 PATIENT'S PERSONAL POSSESSIONS

A. The Department's rules and regulations are designed to insure that clothing and other property of each resident shall be properly safeguarded and reserved for personal use, and to comply with standards established by CDPHE.

B. The nursing facility shall be responsible for safeguarding personal possessions (including money) and to:

1. Provide a method of identification of the resident's suitcases, clothing, and other personal effects, listing the items on an appropriate form attached to the resident's nursing facility record at the time of admission. Such listings are to be kept current. Any personal effects

released to a relative or designated representative of a resident must be delineated in a signed receipt.

2. Provide adequate storage facilities for the resident's personal effects.

3. Exercise careful ~~j~~Judgment in the release of resident's personal property to anyone other than the actual owner, and to secure an itemized statement of release, the signature of the resident, duly authorized agent, or responsible party.

4. ~~I~~Ensure that all mail is delivered unopened to the resident to whom it is addressed, except for those residents who have a legal guardian or conservator, other legal arrangement, or have voluntarily given written consent to allow opening such mail, in which case the mail is held, unopened, until delivered to the resident.

C. In the event of death of a resident in the nursing facility, or in a medical institution or on medical leave from a nursing facility, the following rules apply:

1. The nursing facility shall provide the deceased resident's executor, administrator or successor claiming under the Small Estates Act (See ~~10 CCR 2505-10 s~~Section 8.482.52.F.3.d) with a copy of the resident's personal needs account ledger.

2. The nursing facility shall turn over to the ~~such~~ responsible party all of the deceased resident's personal property in its possession. All items shown by the resident personal needs account ledger as purchased by or in behalf of the resident must be returned to the responsible party.

3. The responsible party claiming the possessions must sign a dated, itemized receipt for all such items before removal of the items from the nursing facility.

D. In the event of discharge of a resident, all personal possessions and a copy of the resident personal needs account ledger signed and dated by the administrator shall be turned over to the patient, or to the responsible party, as is required for a deceased patient in C above.

8.482.7 NURSING FACILITY RESPONSIBILITY FOR ESTABLISHING RESIDENT PERSONAL NEEDS ACCOUNT

Many nursing facility residents are either unable or unwilling to manage their personal funds and the residents or their families or guardians wish this responsibility to be assumed by the nursing facility. Because ~~Also, since~~ nursing facility residents who are ~~recipients of~~ Medicaid members~~benefits~~ often have income from Social Security, Supplemental Security Income, Railroad Retirement, or other sources, it is necessary for participating nursing facilities to maintain a system of accounting for Medicaid funds, resident income, and resident's personal needs ~~funds~~accounts. This ~~Such~~ system shall be maintained in accordance with standards required by the Department, and subject to audit.~~adequate for audit by representatives thereof.~~ The following sections outline a standard system of accounting to be used by participating nursing facilities for these purposes. Any deviation from this system must have written approval of the Department.

8.482.71 REQUIRED ITEMS

A. Book of money receipts in triplicate.

B. Cash receipts journal including columns for nursing facility operating and resident ~~trust cash~~personal needs accounts.

C. Checking accounts for nursing facility operating and resident ~~trust~~ personal needs accounts.

D. Cash Disbursements Journal including columns for nursing facility operating and resident ~~trust cash~~personal needs accounts.

E. General Ledger accounts as follows:

1. Cash-General or Operating account

2. Cash-Patient ~~Trust Fund~~Resident Personal Needs Account

3. Cash-Patient ~~Trust~~ Petty Cash (Resident Personal Needs Imprest Fund)

4. Accounts Receivable - Nursing Care (Control Account.)

5. Accounts Payable - Personal Needs Liability (Control Account)

(Note: This is not a complete listing of every account which would normally appear in a General Ledger, but includes the accounts necessary for purposes of this system of accounting.)

F. Subsidiary Ledger for Accounts Receivable-Nursing Care sub-classified by resident name.

G. Subsidiary Ledger for Personal Needs sub-classified by resident name.

H. Personal Needs Cash Paid Out and Personal Needs Cash Request Slips for use with Personal Needs Imprest Fund.

I. Forms for Certificate of no responsibility for resident's personal needs funds and Appointment of Agent and authorization to handle resident's personal needs funds.

J. Cash box or other secure place for petty cash used in Personal Needs Imprest Fund.

K. Reconciliation personal needs bank statement with personal needs account records.

8.482.72 GLOSSARY

A. Basic Bookkeeping Terms

14. ~~IMPREST~~ PETTY CASH FUND (Also called ~~PETTY CASH~~IMPREST FUND) -- A fund set up for the purpose of control over cash transactions; most often used when a large number of small transactions must be made. The balance of an imprest fund is constant, and must consist of either cash or receipts or other documentation showing the use of the cash. An imprest fund is “replenished” periodically when the cash in the fund reaches a low point by removing the receipts, totalling them, and replacing them with the amount of cash spent. An imprest fund is sometimes called a “revolving fund”.

15. LIABILITY -- An “obligation” or “debit” of an individual or business enterprise to pay a sum of money at some future time. Examples of liabilities are accounts payable, notes payable, bonds payable, monies held in a fiduciary ~~or trust~~ capacity, such as the personal ~~trust~~ needs funds.

B. Terms Related to Nursing Facility Bookkeeping

1. BENEFICIARY -- The listed person/persons/charitable institution or other agency a resident has elected to receive the balance of ~~his/her~~the resident personal needs ~~trust monies~~account in the event of death.

5. GENERAL (OR OPERATING) ACCOUNT -- May describe either an account in the general ledger (as Cash-Genera~~l~~ l or Operating) or a bank account. Used to record monies due to the nursing facility for care or services provided to the resident, are recorded in this account (as distinguished from a ~~Personal Needs or Resident Trust~~resident personal needs account, which is used to account for personal needs funds belonging to residents of a facility).

10. PERSONAL NEEDS ALLOWANCE (PNA) - ~~A nursing facility resident's monthly allowance for spending money and personal items~~is the amount specified in ~~10 CCR 2502-10 s~~Section 8.100.7.V. to be deducted from resident income and used for the exclusive benefit of the resident prior to application of income to nursing facility care.

14. ~~RESIDENT TRUST FUND - Same as "Patients' or Resident's Personal Needs Account".~~RESIDENT PERSONAL NEEDS ACCOUNT – An account in a subsidiary resident ledger used to record personal needs fund transactions of a resident. Most often used as a title for a bank account for residents' personal needs funds.

15. RESIDENT OR PATIENT PAYMENT - The portion of a nursing facility resident's income which is applied toward ~~his/her~~their care at the facility (according to state department regulations, all income received by a resident, with the exception of the monthly personal needs allowance, or the allowable cost with respect to the post -eligibility treatment of income as defined in 10 CCR 2505-10 section ~~8.110.49~~8.100.7.V.1., shall be applied toward the resident's care, with the balance paid by Medicaid). A resident's income may be from Social Security, Veterans' Administration, Railroad Retirement, government pensions, an estate or trust, or other sources. The amount of SSI benefits received by a person who is institutionalized is not considered when calculating patient payment.

16. "Responsible Party" is ~~defined as~~ any of the persons below, who accepts the responsibility for a resident's funds, mail or personal possessions and is willing to sign a written declaration of such responsibility:

    a. a legally appointed guardian, or conservator;

    b. relative or friend;

    c. the county department; or

    d. a resident may act as their own responsible party, if they are managing their own affairs.

    ~~RESPONSIBLE PARTY -- A party who is responsible for a nursing facility resident's financial affairs. A nursing facility, a friend or designated representative, or a county department may be a responsible party, or a resident may act as his/her own responsible party, if he/she is managing his/her own affairs.~~

17. TESTATE -- A person who dies leaving a will is said to have died "testate."

18. ~~UB92~~ UB04 CLAIM FORM -- Form utilized by providers to bill nursing facility services.

~~8.483 ADULT FOSTER CARE - REPEALED~~

~~[Repealed effective April 2, 2007]~~

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

~~Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.~~

8.486.80 COST CONTAINMENT

~~Sections 8.486.90 - 8.486.98 deleted by the Medical Services Board February 9, 2001.~~

8.495.7 REIMBURSEMENT

~~**8.496 (Repealed effective March 30, 2014)**~~

8.497 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

~~8.497.1.C. [Expired 05/15/2016 per House Bill 16-1257]~~

8.497.2 ENROLLMENT

~~8.497.2.B. [Expired 05/15/2016 per House Bill 16-1257]~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Unilateral Cochlear Implants, Section 8.200.3.D.1.2.e.iii-iv
Rule Number: MSB 23-05-05-A
Division / Contact / Phone: Health Policy Office / Erica Schaler / 303-866-5927

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-05-05-A, Revision to the Medical Assistance Act Rule concerning Unilateral Cochlear Implants, Section 8.200.3.D.1.2.e.iii-iv

3. This action is an adoption of: an amendment

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

   Sections(s) 8.200.3.D.1.2.e.iii-iv, 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
   Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.200.3.D with the proposed text beginning at 8.200.3.D.2.e.iii through the end of 8.200.3.D.2.e.iv.h. This rule is effective January 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Unilateral Cochlear Implants, Section 8.200.3.D.1.2.e.iii-iv
Rule Number: MSB 23-05-05-A
Division / Contact / Phone: Health Policy Office / Erica Schaler / 303-866-5927

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The proposed rule adds unilateral cochlear implants to the list of covered cochlear implants in the speech, language, and hearing section of the physician services rule for pediatric members that meet Federal Drug Administration (FDA)-approved age guidelines. The current rule covers bilateral cochlear implants for pediatric members, but not unilateral cochlear implants. Bilateral and unilateral cochlear implants are covered under Early and Periodic Screening, Diagnosis and Treatment (EPSDT) for pediatric members aged 20 and under, the proposed rule references the EPSDT authority for this coverage.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 440.110(c) (2023)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);

   Section 25.5-5-202(l)(I), C.R.S. (2023)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Unilateral Cochlear Implants, Section 8.200.3.D.1.2.e.iii-iv
Rule Number: MSB 23-05-05-A
Division / Contact / Phone: Health Policy Office / Erica Schaler / 303-866-5927

REGULATORY ANALYSIS

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

   Pediatric members benefit from the proposed rule. The Department will bear the cost of the proposed rule.

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

   Pediatric members aged have access to unilateral cochlear implants.

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.

   Budget reviewed the proposed rule and has estimated the annual cost to be $3,040,000

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

   The probable cost of the proposed rule is provided in the response to question #3 above. The benefit of the proposed rule is expanding access to unilateral cochlear implants for pediatric members. The cost of inaction is restricting access to unilateral cochlear implants for pediatric members. There is no benefit to inaction.

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

   There are no less costly methods or less intrusive methods to expand coverage of unilateral cochlear implants to pediatric members.

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.

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There are no alternative methods for expanding coverage of unilateral cochlear implants to pediatric members.

8.200 PHYSICIAN SERVICES

8.200.3. BENEFITS

8.200.3.D Physician Services

Note: 8.200.3.D.1 Podiatry Services was moved to §8.810 01/2015.

2. Speech – Language and Hearing Services

e. COVERED SERVICES

iii. Audiology Services

1. Audiological benefits include identification, diagnostic evaluation and treatment for ~~children~~ members 20 and under with hearing loss, neurologic, dizziness/vertigo, or balance disorders. Conditions treated may be either congenital or acquired.

2. Assessment – Service may include testing or clinical observation or both, as appropriate for chronological or developmental age, for one or more of the following areas, and must yield a written evaluation report.

a. Auditory sensitivity (including pure tone air and bone conduction, speech detection and speech reception thresholds).

b. Auditory discrimination in quiet and noise.

c. Impedance audiometry (tympanometry and acoustic reflex testing).

d. Hearing aid evaluation (amplification selection and verification).

e. Central auditory function.

f. Evoked otoacoustic emissions.

g. Brainstem auditory evoked response.

h. Assessment of functional communicative skills to enhance the activities of daily living.

i. Assessment for cochlear implants (for ~~clients~~ members age~~s~~ 20 and under).

j. Hearing screening.

k. Assessment of facial nerve function.

l. Assessment of balance function.

m. Evaluation of dizziness/vertigo.

3. Treatment – Service may include one or more of the following, as appropriate:

a. Auditory training.

b. Speech reading.

c. Augmentative and alternative communication training including training on how to use cochlear implants for members~~clients~~ ages 20 and under. Adults with chronic conditions may qualify for augmentative and alternative communication services when justified and supported by medical necessity to allow the individual to achieve or maintain maximum functional communication for performance of Activities of Daily Living.

d. Purchase, maintenance, repairs and accessories for approved devices.

e. Selection, testing and fitting of hearing aids for ~~children~~ members 20 and under with bilateral or unilateral hearing loss; and auditory training in the use of hearing aids.

f. Purchase and training on Department approved assistive technologies.

g. Balance or vestibular therapy.

iv. Cochlear Implants – ~~Unilateral~~

1. Bilateral and unilateral ~~C~~cochlear implants ~~may be indicated~~are covered for ~~clients~~ members aged ~~12 months through~~ 20 years and under in accordance with Section 8.280. ~~t~~The following prior~~e~~-authorization criteria must be met:

a. ~~Six months of age or older~~Food and Drug Administration ~~(FDA)-approved cochlear implant guidelines for age.~~The proposed use of the device must be in accordance with FDA guidelines applicable to the member's age.

~~b. Limited benefit from appropriately fitted binaural hearing aids (with different definitions of "limited benefit" for children 4 years of age or younger and those older than 4 years) and a 3-6 month hearing aid trial.~~

b~~c~~. Bilateral and unilateral hearing loss with unaided pure tone average thresholds of 6~~7~~0 dB or greater.

c~~d~~. Minimal speech perception may be measured using recorded standardized stimuli-speech discrimination scores of 50-60% or below with optimal amplification at 1000, 2000 and 4000 Hz.

d~~e~~. Family support and motivation to participate in a post-cochlear aural, auditory and speech language rehabilitation program.

e~~f~~. Assessment by an audiologist and otolaryngologist experienced in cochlear implants.

f~~g~~. ~~Bi lateral~~, unilateral, ~~and hybrid/Electric Acoustic Stimulation cochlear implantation considered on a case-bycase basis.~~

f~~g~~h. No medical contraindications.

g~~h~~i. Up-to-date-immunization status as determined by the Advisory Committee on Immunization Practices (ACIP).

h.

~~ij.~~Replacement of an existing cochlear implant for all ages is a benefit ~~when the currently used component is no longer functional and cannot be repaired~~ when the currently used internal or external component is no longer functioning and cannot be repaired. For members age 20 and younger, please see 8.280 for additional guidance. ~~Age 20 and younger, please see 8.280 for additional guidance.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Rural Sustainability Payments, Section 8.8500.
Rule Number: MSB 23-06-05-A
Division / Contact / Phone: External Relations / John Kennedy / john.kennedy@state.co.us

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 23-06-05-A, Revision to the Medical Assistance Rule concerning Rural Sustainability Payments, Section 8.8500.

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) 8.8500, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Insert the newly proposed at 8.8500 beginning at 8.8500 through the end of 8.8500.4.b. This rule is effective January 30, 2024.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Rural Sustainability Payments, Section 8.8500.
Rule Number: MSB 23-06-05-A
Division / Contact / Phone: External Relations / John Kennedy / john.kennedy@state.co.us

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).

    1. A Sustainability Payment of $100,000 per Critical Access Hospital and $20,000 per Rural Health Center will be issued March 1, 2024 and each subsequent year on August 1st annually for all qualified rural providers participating in the state's Rural Connectivity Program.

2. An emergency rule-making is imperatively necessary

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

    Explain:

3. Federal authority for the Rule, if any:

    42 CFR Sec 440.20

    42 CFR 405 and 491

    According to the Centers for Medicare and Medicaid Services (CMS), RHCs are clinics that are located in areas designated by the Bureau of the Census as rural and by the Secretary of the Department of Health and Human Services (DHHS) or the State as medically underserved. An RHC is a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of 42 CFR 405 and 491

4. State Authority for the Rule:

    Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
    Sections C.R.S. § 25.5-5-202(1)(b)
    Sections C.R.S. § 25.5-5-102(1)(a-b), (i)

Initial Review	**11/09/23**	Final Adoption	**12/08/23**
Proposed Effective Date	**01/30/24**	Emergency Adoption	

DOCUMENT #

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Initial Review	**11/09/23**	Final Adoption	**12/08/23**
Proposed Effective Date	**01/30/24**	Emergency Adoption	

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Rural Sustainability Payments, Section 8.8500.
Rule Number: MSB 23-06-05-A
Division / Contact / Phone: External Relations / John Kennedy / john.kennedy@state.co.us

REGULATORY ANALYSIS

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

   Those served by Rural Health Clinics, Critical Access Hospitals, and providers themselves benefit by receiving the sustainability payment

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 supports three of the Department's six strategic pillars that were established to ensure customer focused performance management in Rural Health Clinics and Critical Access Hospitals

   Care Access – Improve member access to affordable, high-quality care.

   Member Health – Improve member health outcomes and reduce disparities in care.

   Operational Excellence & Customer Service – Provide excellent service to members, providers, and partners with compliant, efficient, effective person- and family centered practices

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.

   A Sustainability Payment of $100,000 per Critical Access Hospital and $20,000 per Rural Health Center will be issued March 1, 2024 and each subsequent year on August 1st annually for all qualified rural providers participating in the state's Rural Connectivity Program

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

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The Proposed Rule would increase payments for rural providers through an incentive payment for rural providers that participate in OeHI's Rural Connectivity Program. Currently, the Office of eHealth Innovation (OeHI) and the Department will make a one-time only investment into rural providers through OeHI's Rural Connectivity Program. Once the rural providers are participating in the OeHI Program, the Department requests to incentivize those providers to maintain participation. Since the OeHI funding is a one-time investment, providers must find the funding to support their long-term IT investments. Rural providers may drop out of the program overtime if there is not sustainability funding to support their internal IT investments and participation in the program. OeHI will have ongoing operational funding to support the contracted services related to the program, but there is no funding to incentivize providers to maintain their participation. The ability to capture savings and make investments to maintain their participation can be difficult due to their limited revenue sources.

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

   There is no less costly or intrusive method for implementing this sustainability payment

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 is no alternative method for implementing this sustainability payment

8.8000 Rural Provider Access and Affordability Stimulus Grant Program

8.8500 Rural Sustainability Payments

1. A Sustainability Payment of $100,000 per Critical Access Hospital and $20,000 per Rural Health Center will be issued March 1, 2024 and each subsequent year on August 1st annually for all qualified rural providers participating in the state's Rural Connectivity Program.

    a. Critical Access Hospitals (CAH) are Centers for Medicare and Medicaid Services (CMS)-designated hospitals with <25 beds which are >35 miles from the nearest hospital.

    b. Rural Health Clinics (RHC) are Centers for Medicare and Medicaid Services (CMS)-designated primary care clinics that operate in rural counties.

        i. According to the Centers for Medicare and Medicaid Services (CMS), RHCs are clinics that are located in areas designated by the Bureau of the Census as rural and by the Secretary of the Department of Health and Human Services (DHHS) or the State as medically underserved. An RHC is a clinic that is located in a rural area designated as a shortage area, is not a rehabilitation agency or a facility primarily for the care and treatment of mental diseases, and meets all other requirements of 42 C.F.R. 447.371.

2. At minimum, to qualify this payment or a partial payment, a participating rural provider must be connected to one of the state's Health Information Exchanges (HIEs) and the Community Analytics Platform (CAP) established by the Office of eHealth Innovation.

    a. The participating rural provider must have a signed agreement with one of the Colorado Health Information Exchanges (HIEs) so the participating rural provider can view medical records contained within the HIE.

    b. The participating rural provider must have a signed agreement with the vendor managing the Community Analytics Platform (CAP) so the participating rural provider is accessing the CAP and authorizing the vendor managing the CAP to capture data on its behalf.

3. To continue receiving the full amount each year, providers will make continuous efforts to maintain or increase their level of connectivity between the provider and one of the state's HIEs and the CAP.

    a. Each year the Office of eHealth Innovation, and the Department will present the criteria for a participating provider to receive a payment or partial payment to the eHealth Commission.

    b. The eHealth Commission will approve any changes to the criteria. The eHealth Commission will provide a public forum for any changes to the criteria.

4. Following the criteria approved by the eHealth Commission, the Office of eHealth Innovation, and the Department will review all participating rural providers to determine the payment or partial payment.

a. A participating rural provider will be notified if they are qualified to receive a payment or partial payment.

b. If a participating provider is not qualified to receive a payment or will receive only a partial payment, the notification will explain the criteria that the participating rural provider did not fulfill.