THIS PAGE NOT FOR PUBLICATION

Title of Rule: Cash Accounting, Section 8.042

Rule Number: MSB 07-08-24-D

Division / Contact / Phone: Controller's Division / Adel Soliman / 303-866-2764

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 07-08-24-D, Cash Accounting, Section 8.042
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) 8.042, 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*

Please replace current text at § 8.042 CASH ACCOUNTING with the new text provided. This change is effective 12/30/2007.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Cash Accounting, Section 8.042

Rule Number: MSB 07-08-24-D

Division / Contact / Phone: Controller's Division / Adel Soliman / 303-866-2764

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).

   To comply with SB 07-133. SB 07-133 requires the Department to utilize the cash system of accounting, regardless of the source of revenues involved, for the Old Age Pension (OAP) Health and Medical Care Programs, the Children's Basic Health Plan (CBHP), and the clawback provision of the federal Medicaid Modernization Act (MMA) of 2003 State Contribution Payment.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2006);
   SB 07-133

Initial Review **10/12/2007** Final Adoption **11/09/2007**

Proposed Effective Date **12/30/2007** Emergency Adoption

DOCUMENT #07

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Cash Accounting, Section 8.042

Rule Number: MSB 07-08-24-D

Division / Contact / Phone: Controller's Division / Adel Soliman / 303-866-2764

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.

   No clients or providers will be affected by this rule because it is only a clarification of when expenditures are counted against the State budget. There is no impact to services.

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

   No classes of persons are affected so there is no quantitative or qualitative impact.

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.

   SB 07-133 created a saving of $7.2 Million of general Fund in State Fiscal Year 07-08. This rule is a change in accounting only.

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

   The Department's Controller's Division and the Budget Division will absorb the administrative cost related to the implementation of SB 07-133.

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

   This rule implements SB 07-133 exactly as expected. There are no other less costly or less intrusive methods.

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

   This rule is a simple accounting change that is being implemented exactly as expected by the General Assembly.

8.042 UTILIZATION OF A CASH SYSTEM OF ACCOUNTING

8.042.1 PROGRAMS UTILIZING THE CASH SYSTEM OF ACCOUNTING

Effective Fiscal Year 05-06 and ongoing, The Department shall utilize the cash system of accounting regardless of the source of revenues involved, for the following appropriations:

A. Medical Services Premiums Long Bill group.

B. Medicaid Mental Health Community Programs Long Bill group.

C. Medical Programs administered by the Department of Human Services except for the administration of such programs. This includes the following Long Bill line items:

1. Child Welfare Services
2. Mental Health Community Programs, Goebel Lawsuit Settlement
3. Residential Treatment for Youth (H.B. 99-1116)
4. Mental Health Institutes
5. Alcohol and Drug Abuse Division, High Risk Pregnant Women Program
6. Community Services Adult Program Costs and CCMS Replacement – Medicaid Funding
7. Federally – matched Local Program Costs
8. Regional Centers – Medicaid Funding
9. Services for Children and Families – Medicaid Funding
10. Division of Youth Corrections – Medicaid Funding

D. Nurse Home Visitor Program Long Bill line item.

E. SB 97-101 Public School Health Services Long Bill line item.

F. University of Colorado Family Medicine Residency Training Programs Long Bill line item.

8.042.2 PROGRAMS UTILIZING THE CASH SYSTEM OF ACCOUNTING

Effective Fiscal Year 07-08 and ongoing, The Department shall utilize the cash system of accounting regardless of the source of revenues involved, for the following appropriations:

A. Services for Old Age Pension State Program Clients.

B. Children's Basic Health Plan Premium Costs and Dental Benefit Costs.

C. Medicare Modernization Act of 2003 State Contribution Payment.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Foster Care Eligibility Rules to Comply with Senate Bill 07-002
Rule Number:	MSB 07-07-18-A
Division / Contact / Phone:	Program Eligibility & Implementation / Sean-Casey King / (303) 866-5960

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 07-07-18-A, Revisions to the Foster Care Eligibility Rules to Comply with Senate Bill 07-002
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.101.2, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.101.2 through §8.101.2.F. with new text attached which that is now §8.101.2 through §8.101.2.G. This change is effective 12/30/2007.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Foster Care Eligibility Rules to Comply with Senate Bill 07-002
Rule Number:	MSB 07-07-18-A
Division / Contact / Phone:	Program Eligibility & Implementation / Sean-Casey King / (303) 866-5960

STATEMENT OF BASIS AND PURPOSE

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

   This revision to the Foster Care eligibility rules expands Medicaid benefits to individuals who are under 21 and for whom the Department of Human Services was assuming full or partial financial responsibility on their eighteenth birthday. These individuals also must have received foster care maintenance payments or subsidized adoption payments furnished by a program funded under part E of title IV of the Social Security Act at the time of their 18th birthday or emancipation. This rule is in response to SB 07-002, which revised 25.5-5-201, C.R.S. (2006). This new category of Medicaid eligibility applies only to individuals who were IV-E eligible at the time of emancipation.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. Section 1396a(a)(10)(A)(ii)(XVII) and 42 U.S.C. Section 1396d(w)(3)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2006);
   25.5-5-201(1)(n), C.R.S. (2006)
   25.5-4-104, C.R.S. (2006)

Initial Review	**10/12/2007**	Final Adoption	**11/09/2007**
Proposed Effective Date	**12/30/2007**	Emergency Adoption	

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Foster Care Eligibility Rules to Comply with Senate Bill 07-002
Rule Number:	MSB 07-07-18-A
Division / Contact / Phone:	Program Eligibility & Implementation / Sean-Casey King / (303) 866-5960

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.

   Young adults between the ages of eighteen and twenty-one who were in the Foster Care system and received foster care maintenance payments or subsidized adoption payments under title IV-E of the social security act on their eighteenth birthday will be affected because they will be eligible to continue Medicaid until their twenty-first birthday.

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

   The qualitative impact will be that additional individuals will be eligible for Medicaid during an important transition period into adult life.

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

   The fiscal note for SB 07-002 states that the probable cost to the department for FY 2007-08 will be $8,281,730, increasing to $11,708,748 in FY 2008-09. The fiscal note for SB 07-002 also estimated a probable cost of $34,650 for system changes to be incurred by the Department of Health Care Policy and Financing, and $8,550 for system changes to be incurred by the Department of Human Services.

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

   The Department must add the rule pursuant to SB 07-002. Inaction would result in the Department's rules not being in full compliance with State law. The Department is currently complying with the statute and this rule is for clarification.

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

   The Department has determined that there are no less costly methods or less intrusive methods available to achieve the purpose of the proposed rule.

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

   There are no alternative methods for achieving the purpose of the proposed rule. The change is required by state law.

8.101.2 NEEDY PERSONS UNDER 21

Medical assistance shall be provided to certain needy persons under 21 years of age, including the following:

A. Those receiving care in an intermediate care facility eligible for Medicaid reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medicaid reimbursement.

B. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. See Colorado Department of Human Services "Social Services Staff Manual" Section 7 for specific eligibility requirements (12 CCR 2599). A child shall be the responsibility of the county, even if the child may be in a medical institution at that time.

C. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.

D. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose family income is less than the AFDC needs standard for his/her family size excluding step-parent income.

E. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.

F. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption program, including a clause in the subsidized adoption agreement to provide Medicaid for the child.

G. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments furnished under a program funded under Part E of title IV of the Social Security Act prior to the date the individual attained 18 years of age or was emancipated. Eligibility will be extended until the individual's 21st birthday.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Pediatric Hospice Waiver, Section 8.504

Rule Number: MSB 07-08-20-B

Division / Contact / Phone: Long Term Benefits / Barbara Prehmus / 303-866-2991

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 07-08-20-B, Pediatric Hospice Waiver, Section 8.504
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.504, 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*

Please insert new text (§8.504 [HOME AND COMMUNITY BASED SERVICES PEDIATRIC HOSPICE WAIVER] through §8.504.8.A.2) provided immediately after existing text at §8.503.210 [POST ELIGIBILITY TREATMENT OF INCOME (PETI)] and just preceding §8.506 (CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM). This change is effective 12/30/2007.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Pediatric Hospice Waiver, Section 8.504

Rule Number: MSB 07-08-20-B

Division / Contact / Phone: Long Term Benefits / Barbara Prehmus / 303-866-2991

STATEMENT OF BASIS AND PURPOSE

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

   This is a new rule to implement a Home and Community Based Services (HCBS) pediatric hospice waiver program approved by the federal Centers for Medicare and Medicaid Services (CMS) under the authority of Section 1915(c) of the Social Security Act. The rule defines the population eligible for enrollment, the benefits to be provided, and the provider qualifications for the waiver program..

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   An approved Home and Commuity Based Services (HCBS) Waiver CMS Control Number 0450.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2006);
   25.5-5-305, C.R.S. (2006)

Initial Review	**10/12/2007**	Final Adoption	**11/09/2007**
Proposed Effective Date	**01/01/2008**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Pediatric Hospice Waiver, Section 8.504
Rule Number:	MSB 07-08-20-B
Division / Contact / Phone:	Long Term Benefits / Barbara Prehmus / 303-866-2991

REGULATORY ANALYSIS

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

   The classes of persons directly benefiting from the program that will be implemented in accordance with the proposed rule are Medicaid-eligible children aged 0 through 18 who have a life-limiting diagnosis. Parents and/or legal guardians of such children will also benefit indirectly from the additional services allowable under this new waiver program.

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

   The qualitative impact of the proposed rule will be enhanced quality of life for enrolled children diagnosed with a life-limited, or terminal, illness for the time the child has remaining. Legislative fiscal analysis for the authorizing legislation (Senate Bill 04-206) showed cost savings of an estimated $10,283 per year per child, associated with receiving home-based care as an alternative to institutional inpatient hospital care.

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

   The following information dates back to when the original fiscal note was completed for this legislative proposal (2004). The department has not completed a revised fiscal analysis however the department plans to complete a revised analysis during the regular budget process.

   The legislative fiscal analysis estimated $75 in prior authorization requests for each qualifying child and an additional $225,000 in Medicaid Management Information System (MMIS) costs for the Department of Health Care Policy and Financing. However, implementation of the waiver program itself is estimated to save $10,283 per year per child. Based upon full waiver capacity of 200 children, the savings to cost ratio is $8.57 in cost avoidance for each $1 of investment.

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

   Inaction would result in violation of state statute, unnecessary additional reduction in quality of life for the eligible children and their families, and higher Medicaid expenditures in institutional inpatient hospital settings.

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

   No other method was considered

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

   No alternative method to achieve the implementation of this new Medicaid waiver program was considered.

8.504 HOME AND COMMUNITY BASED SERVICES PEDIATRIC HOSPICE WAIVER

8.504.1 DEFINITIONS

Assessment means a comprehensive face-to-face evaluation using the ULTC 100.2 conducted by the case manager with the client, family and appropriate collaterals, with supporting diagnostic information from the individual's medical professional(s), to determine the applicant's level of functioning, service needs, available resources, and potential funding sources.

Case Management means the Assessment of the client's needs, the development and implementation of the Service Plan, coordination and monitoring of service delivery, the evaluation of service effectiveness and periodic reassessment of the client's needs.

Client/Family/Caregiver Counseling means grief/loss or anticipatory grief counseling and bereavement counseling that assist the client, family or caregiver to decrease emotional suffering due to the client's health status, to decrease feelings of isolation or to cope with the client's life-limiting diagnosis.

Continued Stay Review (CSR) means a reassessment by the Single Entry Point case manager to determine the client's continued eligibility and functional level of care.

Continuous Nursing means line of sight, face-to-face skilled nursing that is more individualized and continuous, as opposed to visits or intermittent nursing care that is available under the State Plan home health benefit or is routinely provided in a hospital or nursing facility as described at 10 CCR 25050-10 Section 8.540.

Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital.

Curative Care means medical care or active treatment of a medical condition seeking to affect a cure.

Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the client to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

Intake/Screening/Referral means the SEP's initial contact with the individual and shall include, but not be limited to, a determination of the need for a comprehensive client Assessment, referral to other waivers or services and long term care services.

Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probably before the child reaches adulthood.

Palliative/Supportive Care means hospice-like care provided to manage, control, and alleviate symptoms such as pain, nausea, discomfort and anxiety related to a life-limiting diagnosis that may be provided at the same time as curative treatments.

Personal Care means services needed to meet a client's physical requirements and functional needs when such services are provided by a personal care attendant and do not require the supervision of a nurse or physician, such as assistance with activities of daily living.

Private Duty Nursing means continuous nursing different in nature and scope from the private duty nursing services in the State Plan, and does not include a requirement for the client to be technology-dependent.

Respite Care means services provided to an eligible client who is unable to care for himself/herself on a short term basis because of the absence or the need for relief of those persons normally providing care.

Respite Care is provided in the client's residence and may be provided by different levels of providers depending upon the needs of the client.

Service Plan means the document used to identify the client's needs and sets forth the services to be provided to the client including the funding source, amount, scope, duration, frequency, provider of each services, and the expected outcome or purpose of such services.

Uniform Long Term Care 100.2 Form (ULTC 100.2) means the tool used to assess the functional needs of an applicant.

Utilization Review means approving or denying admission or continued stay in the waiver based on level of care needs, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures or settings.

8.504.2 BENEFITS

8.504.2.A. Home and Community Based Services under the Pediatric Hospice Waiver (HCBS-PHW) benefits shall be provided within Cost Containment.

8.504.2.B. Benefits shall be available to eligible clients from the date of diagnosis of a life-limiting illness or condition.

8.504.2.C. Client/Family/Caregiver Counseling shall be provided in individual or group setting.

1. Client/Family/Caregiver Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

2. Client/Family/Caregiver Counseling shall be limited to 98 hours per every 365 days based on the date the client entered the program.

3. Family/Caregiver Counseling shall be available to family members for bereavement counseling for up to one year following the death of the client.

8.504.2.D. Expressive therapy includes, but is not limited to, book writing, painting, music therapy and scrapbook making.

1. Expressive therapy is limited to 39 hours per every 365 days based on the date the client entered the program.

8.504.2.E. Respite Care shall be provided in the home of an eligible client on a short term basis, not to exceed 30 days per every 365 days based on the date the client entered the program. Respite Care shall not be duplicated on the same date of service as state plan Home Health or Palliative/Supportive Care services.

1. Respite Care services include any of the following in any combination necessary according to the Service Plan.

   a. Skilled nursing.

   b. Home health aide

   c. Personal Care

   d. Private duty nursing

8.504.2.F Palliative/Supportive Care shall not require a six month terminal prognosis for the client.

1. Palliative/Supportive Care includes, but is not limited to:

a. Skilled nursing

b. Home health aide

c. Physical therapy

d. Occupational therapy

e. Speech/language pathology

f. Alternative therapies

g. Dietary/nutritional counseling or therapy

8.504.2.G. HCBS-PHW clients are eligible for all other Medicaid state plan benefits, including Curative Care and Home Health.

8.504.3 NON-BENEFIT

8.504.3.A. Case Management shall not be a benefit of the HCBS-PHW but shall be provided as an administrative activity through the SEP.

8.504.4 CLIENT ELIGIBILITY

8.504.4.A. An eligible client shall:

1. Be determined financially eligible.

2. Be at risk of institutionalization into a hospital as determined by the SEP case manager using the ULTC 100.2 and physician's statement.

3. Meet the target population criteria as follows:

a. Have a life-limiting diagnosis, as certified in writing by a physician, ~~which is in accordance with the current listed diagnosis codes by Children's Hospice International Program of All-inclusive Care for Children (CHI-PACC)~~.

b. Have not yet reached 19 years.

4. A client shall receive at least one HCBS-PHW waiver benefit per month to maintain enrollment in the waiver.

5. A client who has not received at least one HCBS-PHW waiver benefit during a month shall be discontinued from the waiver.

6. Case Management shall not satisfy the requirement to receive at least one benefit per month on the HCBS-PHW waiver.

8.504.5 WAIT LIST

8.504.5.A. The number of clients who may be served through the waiver at any one time during a year shall be limited to 200.

8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-PHW waiver, who cannot be served within the 200 client limit, shall be eligible for placement on a wait list maintained by the Department.

8.504.5.C. The SEP case manager shall ensure the applicant meets all criteria as set forth in Section ~~8.509.24~~8.504.4 prior to notifying the Department to place the applicant on the wait list.

8.504.5.D. The SEP case manager shall notify the Department by entering the ULTC 100.2 Form and Professional Medical Information Page data in the Benefits Utilization System (BUS).

8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish the order of an applicant's place on the wait list.

8.504.5.F. Within five working days of notification from the Department that an opening for the HCBS-PHW waiver is available the SEP shall:

1. Reassess the applicant for functional level of care using the ULTC 100.2 Form if the date of the last Assessment is more than six months old.

2. Update the existing ~~UTLC~~ ULTC 100.2 Form data if the date is less than six months old.

3. Reassess for the target population criteria.

4. Notify the Department of the applicant's eligibility status.

8.504.6 PROVIDER ELIGIBILITY

8.504.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-PHW waiver and enter into an agreement with the Department as set forth in 10 CCR 2505-10, Section 8.130.

8.504.6.B. Licensure and required certification for providers shall be in accordance with their specific specialty practice act and with current state licensure status and regulations.

8.504.6.C. Expressive Therapy or Client/Family/Caregiver Counseling Providers shall enroll individually with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

8.504.6.D. Client/Family/Caregiver Counseling Providers shall be one of the following:

1. Licensed Clinical Social Worker (LCSW)

2. Licensed Professional Counselor (LPC)

3. Licensed Social Worker (LSW)

4. Licensed Independent Social Worker (LISW)

5. Licensed Psychologist; or

6. Non-denominational Spiritual Counselor, if employed by a qualified Medicaid home health or hospice agency.

8.504.6.E. Expressive therapy providers shall meet any of the requirements for Client/Family/Caregiver Counseling providers and shall have at least one year of experience in the provision of Art, Music or Play therapy to pediatric/adolescent clients.

8.504.6.F. Nurses, home health aides, personal care providers, physical therapists, occupational therapists, and speech/language pathologists shall:

1. be employed by a qualified Medicaid personal care, home health or hospice provider agency pursuant to the rules for those provider types; and

2. shall meet the required license or certification standards in accordance with their specific specialty practice act and current state licensure status and regulations.

8.504.6.G. Palliative/Supportive Care Providers shall be employed by or working under a formal affiliation agreement with a qualified Medicaid hospice agency.

8.504.6.H. Respite Providers shall be employed by a qualified Medicaid home health, hospice or personal care agency.

8.504.7 PRIOR AUTHORIZATION REQUESTS

8.504.7.A. The SEP shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-PHW waiver.

8.504.7.B. All units of service requested shall be listed on the Service Plan form.

8.504.7.C. The first date for which services can be authorized shall be the later of any of the following:

1. The financial eligibility start date, as determined by the financial eligibility site.

2. The assigned start date on the certification page of the ULTC 100.2 Form.

3. The date, on which the client's parent(s) and/or legal guardian signs the Service Plan form or Intake form, as prescribed by the Department, agreeing to receive services.

8.504.7.~~G~~D. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the UTLC 100.2 Form.

8.504.7.~~H~~E. The SEP shall submit a revised PAR if a change in the Service Plan results in a change in services.

8.504.7.~~I~~F. The revised Service Plan shall list the service being changed and state the reason for the change. Services on the Revised Service Plan ~~for~~, plus all services on the original Service Plan, shall be entered on the revised PAR.

8.504.7.~~J~~G. Revisions to the Service Plan requested by providers after the end date on a PAR shall be disapproved.

8.504.7.~~K~~H. A revised PAR shall not be submitted if services on the Service Plan are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.

8.504.7.~~L~~I. If services are decreased without the client's parent(s) and/or legal guardian agreement, the SEP case manager shall notify the client's parent(s) and/or legal guardian of the adverse action and appeal rights using the LTC 803 form in accordance with the 10 day advance notice period.

8.504.8 REIMBURSEMENT

8.504.8.A. Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee scheduled as determined by the Department.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Consumer Directed Attendant Support Services, Section 8.510
Rule Number:	MSB 07-07-30-A
Division / Contact / Phone:	Long Term Care Benefits / Aggie Berens / 303-866-3358

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 07-07-30-A, Consumer Directed Attendant Support Services, Section 8.510
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.485.31 (page 1) 8.485.40 (page 2) 8.509.12 A (page 1) and 8.509.13 (page 2) , Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace existing text beginning at §8.485.30 through §8.485.40.J with new text attached from §8.485.30 through §8.485.40.K.
Please replace existing text beginning at 8.509.12 through 8.509.13.H with new text attached beginning at 8.509.12 through 8.509.13.I.
Please insert new text provided (8.510 through 8.510.15.A CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES) immediately after 8.509.40 HCBS-MI PROVIDERS and just preceding 8.515 HOME AND COMMUNITY BASED SERVICES FOR PEOPLE WITH BRAIN INJURY (HCBS-BI). This change is effective 12/30/2007.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Consumer Directed Attendant Support Services, Section 8.510
Rule Number:	MSB 07-07-30-A
Division / Contact / Phone:	Long Term Care Benefits / Aggie Berens / 303-866-3358

STATEMENT OF BASIS AND PURPOSE

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

   This rule provides regulations for the Consumer Directed Attendant Support Services, a consumer directed service model authorized by 25.5-6-1100, C.R.S. The proposed new components of the Rule define eligible clients, the consumer directed benefits, client responsibilities and rights, case management responsibilities and reimbursement.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. Section 1315

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2006);
   25.5-6-1100 et seq. : consumer directed services model, 25.5-6-307 (j) and 25.5-6-606.

Initial Review	**10/12/2007**	Final Adoption	**11/09/2007**
Proposed Effective Date	**01/01/2008**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Consumer Directed Attendant Support Services, Section 8.510

Rule Number: MSB 07-07-30-A

Division / Contact / Phone: Long Term Care Benefits / Aggie Berens / 303-866-3358

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.

   Individuals who are eligible for the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS- EBD) and Home and Community Based Services for Persons with Major Mental Illness (HCBS- MI) waivers and are interested in directing their attendant support services or having an authorized representative direct the care on their behalf will benefit from this rule.

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

Clients will have the ability to control the quality of care they receive by selecting, training, and supervising their attendants and setting wages for those attendants. This ability may enhance clients' ability to have their care needs met either through a wider array of caregivers or in a manner more desirable to the client.

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

The service is designed to be cost neutral relative to either the historical costs of providing care through an agency model or if the client's care needs as reflected by the Service Plan were provided by an enrolled Medicaid Provider agency.

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

   Inaction would result in failure to comply with state law.

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

None

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

None

8.485.30 SERVICES PROVIDED

.31 HCBS EBD services provided as an alternative to nursing facility placement include:

A. Adult day services; and

B. Alternative care facility services, including homemaker and personal care services in a residential setting; and

C. Electronic monitoring; and

D. Home modification; and

E. Homemaker services; and

F. Non-medical transportation; and

G. Personal care; and

H. Respite care.

I. In-Home Support Services.

J. Community Transition Services

K. Consumer Directed Attendant Support Services

.32 Case management is not a service of the HCBS-EBD waiver program, but shall be provided as an administrative activity through Single Entry Point Agencies.

.33 HCBS-EBD clients are eligible for all other Medicaid state plan benefits, including the Home Health program.

8.485.40 DEFINITIONS OF SERVICES

A. Adult day services shall be as defined at Section 8.491.

B. Alternative care facility services shall be as defined at Section 8.495.

C. Electronic monitoring shall be as defined at Section 8.488.

D. Home modification shall be as defined at Section 8.493.

E. Homemaker services shall be as defined at Section 8.490.

F. Non-medical transportation shall be as defined at Section 8.494.

G. Personal care shall be as defined at Section 8.489.

H. Respite shall be as defined at Section 8.492.

I. In-Home Support Services shall be as defined at Section 8.552.

J. Community Transition Services (CTS) shall be as defined at Section 8.553.

K. Consumer Directed Attendant Support Services (CDASS) shall be defined at Section 8.510.

8.509.12 SERVICES PROVIDED

A. HCBS-MI services provided as an alternative to nursing facility placement include:

1. Adult day services, and

2. Alternative care facility services, including homemaker and personal care services in a residential setting, and

3. Electronic monitoring, and

4. Home, modification, and

5. Homemaker services, and

6. Non-medical transportation, and

7. Personal care; and

8. Respite care; and

9. Consumer Directed Attendant Support Services; and

B. Case management is not a service, of the HCBS-MI program, but shall be provided as an administrative activity through case management agencies.

C. HCBS-MI clients are eligible, for all other Medicaid State plan benefits.

8.509.13 DEFINITIONS OF SERVICES

A. Adult Day Services shall be as defined at Section 8.491, ADULT DAY SERVICES.

B. Alternative Care Facility services means, services as defined at Section 8.495, ALTERNATIVE CARE FACILITY.

C. Electronic Monitoring services shall be as defined at Section 8.488, ELECTRONIC MONITORING.

D. Home Modification shall be as defined at Section 8.493.

E. Homemaker Services shall be as defined at Section 8.490.

F. Non-Medical Transportation shall be as defined at Section 8.494.

G. Personal Care shall be as defined at Section 8.489.

H. Respite shall be as defined at Section 8.492.

I. Consumer Directed Attendant Support Services shall be defined at Section 8.510.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

Attendant means the individual who provides Consumer Directed Attendant Support Services as set forth in § 8.510.3.

Attendant Support Services Management Training means the required training, including a final, comprehensive assessment, provided by the Department or its designee to a client and/or Authorized Representative who is interested in directing CDASS.

Authorized Representative means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to assist the client in acquiring and utilizing Consumer Directed Consumer Directed Attendant Support Services.

Case Manager ~~means~~ is defined at~~, as defined under the Long Term Care Program at~~ 10 C.C.R. 2505-10. § 8.390.1 C.

Consumer Directed Attendant Support Services (CDASS) means services that assist an individual in accomplishing activities of daily living including Health Maintenance Activities, Personal Care, Homemaker activities and Protective Oversight.

~~Fiscal~~ Financial Management Services organization (FMS) ~~means~~is the entity or entities under contract with the Department, which entity is the employer of attendants, and which provides ~~to provide personnelfiscal~~personnel~~-~~ management services, fiscal management and skills training to a client receiving CDASS and/or Authorized Representative.

Health Maintenance Activities ~~, as defined under the Long Term Care Program~~ is defined at 10 C.C.R. 2505-10, § 8.552.1.

Homemaker services~~, as defined the Long Term Care Program~~is defined ~~-~~at 10 C.C.R. 2505-10, §8.490.

Inappropriate Behavior means offensive behavior which includes, documented verbal, sexual and/or physical abuse. Verbal abuse is defined as consistent verbal threats, insults or offensive language from the client and/or Authorized Representative over a period of time.

Individual Allocation means the funds made available by the Department to clients receiving CDASS and administered by the FMS.

Personal Care services ~~, as defined the Long Term Care Program~~ is defined at 10 C.C.R. 2505-10, §8.489.

Protective Oversight is supervision of the client to prevent at risk behavior that may result in harm to the client.

8.510.2 ELIGIBILITY

8.510.2.A. To be eligible for CDASS, an individual shall:

1. Meet medical assistance eligibility requirements.

2. Be eligible for the Consumer Directed Care model as defined at 25.5-6-1101 C.R.S et seq.

3. Demonstrate a current need for Attendant support.

4. Document a pattern of stable health, which is a condition of health that necessitates a predictable pattern of Attendant support, allowing for variation that is consistent with medically predictable progression or variation of disability or illness. The documentation may include the individual's history of utilization of Medicaid funded Attendant support.

5. Provide a statement from his or her primary care physician that indicates the client has sound judgment and the ability to direct his or her care or has an Authorized Representative who has the ability to direct the care on the client's behalf.

6. Demonstrate the ability to handle the financial aspects of CDASS, through completion of Attendant Support Services Management Training or have an Authorized Representative who is able to handle the financial aspects of CDASS. Ability to handle the financial aspects of CDASS means:

   a. The ability to determine how the Individual Allocation should be spent to ensure that the individual receives necessary Attendant support, both in quantity and quality, and to ensure that Attendants receive appropriate compensation; and

   b. The ability to verify the accuracy of financial and personnel records as provided by the FMS.

7. Demonstrate the ability to manage the health aspects of his or her ~~lif~~care, ~~either~~ through ~~prior experience or through~~ completion of Attendant Support Services Management Training or have an Authorized Representative who is able to manage the health aspects of his or her ~~life~~care. Managing the health aspects of one's ~~life~~care includes the ability to understand principles and monitor conditions of basic health and the knowledge of how, when, and where to seek medical help of an appropriate nature.

8. Demonstrate the ability to supervise Attendants, through completion of Attendant Support Services Management Training or have an Authorized Representative who is able to supervise Attendants. Ability to supervise Attendants means the knowledge and ability:

   a. To recruit and hire Attendants;

   b. To communicate expectations;

   c. To provide training, guidance and review for accomplishment of the Attendant tasks;

   d. To manage necessary paperwork; and

   e. To dismiss Attendants when necessary.

9. Complete the Attendant Support Services Management Training and pass the post training assessment.

8.510.3 BENEFITS

Covered benefits shall be for the benefit of the client and not for the benefit of other persons living in the home.

8.510.3.A. Benefits include:

1. Personal Care Tasks, as provided under the Long Term Care Program at 10 C.C.R.2505-10, §8.489.30, including Protective Oversight.

2. Homemaker Services, as provided under the Long Term Care Program at 10 C.C.R.2505-10, §8.490.3 (B).

3. Health Maintenance Activities as defined under the Long Term Care Program at 10 C.C.R. 2505-10, §8.552.1.

8.510.4 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES MANAGEMENT PLAN

8.510.4.A. The client and/or Authorized Representative shall develop a written CDASS management plan which shall be reviewed and approved by the Case Manager. The plan shall describe the individual's:

1. Current status;

2. Needs and requirements for CDASS;

3. Plans for securing CDASS;

4. Plans for handling emergencies;

5. Assurances and plans regarding direction of Health maintenance Activities, as described at 10 CCR 2505 -10, §8.510.5, if applicable;

6. Plans for using the Individual Allocation.

8.510.5 DIRECTION OF HEALTH MAINTENANCE ACTIVIITES

8.510.5.A. A client, who needs Consumer Directed Attendant Support Services for Health Maintenance Activities, shall direct or have an Authorized Representative direct the Attendant in such activities under each the following conditions:

1. The client and/or Authorized Representative indicates on the CDASS management plan that he or she has received adequate instruction from health professionals, and is therefore qualified and able to train Attendants in specified Health Maintenance Activities.

2. The client and/or Authorized Representative list the specific Health Maintenance Activities on his or her CDASS management plan for which he or she will be providing training.

3. The client and/or Authorized Representative verifies on the CDASS management plan the Attendants who will perform Health Maintenance Activities have had or will receive necessary training, either from the client and/or Authorized Representative or from appropriate health professionals.

8.510.6 CLIENT AND/OR AUTHORIZED REPRESENTATIVES RESPONSIBILITES

8.510.6.A. As a supervisor of Attendants, a client and/or Authorized Representative shall:

1. Determine wages for each Attendant;

2. Determine what credentials, if any, individuals must have to be employed as Attendants;

3. Train Attendants to meet his or her own particular needs;

4. Dismiss Attendants who are not meeting his or her needs;

5. Establish hiring agreements, in the form provided by the FMS with each Attendant, outlining wages, services to be provided (limited to Personal Care, Homemaker or Health Maintenance Activities), schedules and working conditions;

6. Follow all relevant laws and regulations applicable to client's supervision of Attendants with the exception of those responsibilities set out at § 8.510.13.D as the responsibility of the FMS~~regarding the employment of Attendants, with the exception of those which are the responsibility of FMS~~;

7. Explain the role of the FMS to the Attendant;

8. Budget for Attendant care within the established monthly allocation.

9. Communicate with the FMS regarding the hiring of Attendants, including wage, services to be provided and scheduling information for each Attendant;

10. Review all Attendant timesheets for accuracy and completeness;

11. Submit completed timesheets to FMS by the timelines established by the FMS;

12. Ensure that timesheets are signed by the client and/or Authorized Representative and the Attendant in order for the FMS to issue paycheck to the Attendant; and

13. Authorize the FMS to make any changes in the Attendant wages.

8.510.6.B. To receive CDASS each client and/or Authorized Representative shall sign a responsibilities form acknowledging full responsibility for:

1. Completing training.

2. Developing a CDASS management plan.

3. Budgeting for CDASS within the established monthly allocation.

4. Recruiting, hiring, firing and managing Attendants.

5. Completing reference checks on Attendants.

6. Reviewing background checks on Attendants, if applicable.

7. Determining wages for Attendants, within the range established by the FMS.

8. Determining work schedules.

9. Training and supervising Attendants.

10. Following all applicable laws and rules applicable to client's supervision of Attendants with the exception of those responsibilities set out at § 8.510.13.D as the responsibility of the FMS.

~~on employing Attendants, with the exception of those which are the responsibility of FMS.~~

11. Completing and managing all paperwork.

8.510.7 START DATE FOR SERVICES

8.510.7.A. The start date ~~of eligibility for CDASS services~~ shall not occur until all of the requirements defined at 10 C.C.R. 2505-10, § 8.510.2 and 8.510.6 ha~~s~~ve been met.

8.510.7.B. The Case Manager shall approve the management plan and establish a start date before a client can begin CDASS.

8.510.8 SERVICE SUBSTITUTION

8.510.8.A. Once a start date has been established for CDASS, the Case Manager shall disenroll the individual from any other Medicaid-funded Attendant support effective as of the start date of CDASS.

8.510.8.B. In accordance with 25.5-6-1101 (4), C.R.S., while a client is participating in the Consumer Directed Care model, that client shall be ineligible to receive Home Care Allowance as provided in § 8.484. Once an individual has a start date for CDASS, the Case Manager shall disenroll him or her from Home Care Allowance program prior to the start date for CDASS.

8.510.8. C. Case Managers shall not authorize payments for CDASS and Personal Care services, Homemaker services, and Health Maintenance Activities for the same individual.

8.510.9 CLIENT AND AUTHORIZED REPRESENTATIVE RIGHTS

8.510.9.A. A client receiving or requesting CDASS whose Attendant Support Services management plan is disapproved by the Case Manager has the right to review that disapproval. The client shall submit a written request to the SEP stating the reasons for requesting the review and justifying the proposed management plan. The client's most recently approved Attendant Support Services management plan shall remain in effect while the review is in process.

8.510.9. B. Clients receiving CDASS have the right to transition back to Personal Care, Homemaker, and Home Health Aide and Nursing services provided by an agency at any time. A client who wishes to transition back to an agency-provided services shall contact the Case Manager. The Case Manager shall coordinate arrangements for the services.

8.510.9.C. A client and/or Authorized Representative may request a re-assessment, as described at §8.390.1 (N), if he or she believes that his or her level of service needs to be adjusted.

8.510.9.D. A client and/or Authorized Representative may revise his or her CDASS management plan at any time, as long as the Case Manager approves the revised plan.

8.510.10 INVOLUNTARY TERMINATION

8.510.10.A. A client may be terminated from CDASS for any one of the following reasons:

1. The client and/or Authorized Representative fail to comply with CDASS program requirements;

2. The client and/or Authorized Representative demonstrates an inability to manage Attendant support;

3. A client's and/or Authorized Representative's physical or cognitive condition deteriorates to the point that he or she no longer meet program criteria and the client refuses to designate an Authorized Representative to direct services on his/her behalf;

4. The client and/or Authorized Representative continue to spend the monthly allocation in a manner indicating premature depletion of funds;

5. The client and/or Authorized Representative exhibits Inappropriate Behavior toward Attendants, and the Department has determined that the FMS has made adequate attempts ~~in~~to assist~~ing~~ the client and/ or Authorized Representative to resolve the Inappropriate Behavior, and resolution has failed.

6. The client's medical condition that causes an unsafe situation for the client, as determined by the treating physician; and/or

7. Documented misuse of the monthly allocation by client and/or Authorized Representative as documented by the Case Manager or FMS.

8.510.11 DISCONTINUATION OF CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.11.A. A client may be discontinued from CDASS when the Case Manager has secured equivalent care in the community.

8.510.11.B. The Case Manager shall notify the client and/or Authorized Representative in writing at least twenty (20) calendar days prior to the termination, that he or she is no longer eligible for CDASS, and that the client and/or Authorized Representative should contact his or her Case Manager for assistance in obtaining other home care services. The notice shall provide the client and/or Authorized Representative with the reasons for termination and with information about the client's rights to fair hearing and appeal procedures, in accordance with 10 C.C.R. 2505-10, § 8.057. Exceptions may be made to the twenty (20) day advance notice requirement when the Department has documented that there is danger to the client or to the Attendant(s), the Case Manager shall notify the FMS of the date on which the client is being terminated from CDASS.

8.510.12 CASE MANAGEMENT FUNCTIONS

8.510.12.A. The Case Manager shall review and approve the CDASS management plan completed by the client and/or Authorized Representative. The Case Manager shall notify the client and/or Authorized Representative of the approval and establish a start date.

8.510.12.B. If the Case Manager determines that the CDASS management plan is inadequate to meet the client's CDASS needs, the Case Manager shall assist the client and/or Authorized Representative with further development of the CDASS management plan.

8.510.12.C. The Case Manager shall calculate the initial Individual Allocation for each client who chooses CDASS as follows:

1. Calculate an average monthly payment using prior utilization expenditures for Personal Care, Homemaker, and Home Health Aide and Nursing services, or

2. Calculate the number of Personal Care, Homemaker, and Health Maintenance Activities hours needed on a monthly basis as defined on the Care Plan and multiply by the Departments established rate for Personal Care, Homemaker, and Health Maintenance Activities services for clients who have insufficient utilization history.

8.510.12.D. The Case Manager shall provide written notification of the Individual Allocation to each client.

8.510.12.E. A client and/or Authorized Representative who believes that he or she needs more CDASS than the existing Individual Allocation will cover, may request the Case Manager to perform a reassessment. If the reassessment indicates that more CDASS are justified, the client and/or Authorized Representative shall amend the Attendant Support Services management plan and the Case Manager shall complete a Prior Authorization Request (PAR) revision indicating the increase and submit it to the Department's fiscal agent.

8.510.12.F. In approving an increase in the Individual Allocation, the Case Manager shall consider:

1. Any change in the client's condition.

2. Discrepancies between the client's utilization history and current needs for CDASS.

3. The appropriateness of Attendant wages.

4. The quality and quantity of services provided by Attendants for the wages they receive.

5. Revisions in the client's budgeting of the current Individual Allocation to more effectively pay for needed services.

8.510.12.G. In reducing an Individual Allocation, the Case Manager shall consider:

1. Improvement or changes in the condition.

2. Reasons for unspent allocated funds.

8.510.12.H. Case Managers shall notify the state fiscal agent to cease payments for all existing Medicaid-funded Personal Care, Homemaker, Health Maintenance Activities and/or Long Term Home Health as defined under the Home Health Program at 10 C.C.R. 2505-10, § 8.520 et seq. as of the clients CDASS start date.

8.510.12.I. For effective coordination, monitoring and evaluation of clients receiving CDASS, the Case Manager shall:

1. Contact the client receiving CDASS and/or Authorized Representative twice a month during the first three months to assess their CDASS management, their satisfaction with care providers and the quality of services received.

2. Contact the client quarterly, after the first three months to assess their implementation of service plans, CDASS management issues, and quality of care, CDASS expenditures and general satisfaction.

3. Conduct a face-to-face visit with the client and/or Authorized Representative when a change in Authorized Representative occurs and contact the client and/or Authorized Representative twice a month for three months after the change takes place.

4. Review monthly reports to monitor client spending patterns and service utilization to ensure appropriate budgeting and follow up with the client and/or Authorized Representative when discrepancies occur.

5. Contact the FMS quarterly to determine the status of each client's financial management activities.

8.510.12.J. Reassessment:

For clients receiving CDASS, the Case Manager shall conduct a face-to-face interview with each client and/or Authorized Representative every six months. The interview shall include review of the CDASS management plan and documentation from the physician that the client and/or Authorized Representative have the ability to direct the care.

8.510.13 ATTENDANTS

8.510.13.A. Attendants shall be at least 16 years of age and demonstrate competency in caring for the client to the satisfaction of the client and/or Authorized Representative.

8.510.13.B. Attendants shall not represent himself or herself to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse.

8.510.13.C. Attendants shall not have had his or her license as a nurse or certification as a nurse aide suspended or revoked or his application for such license or certification denied.

8.510.13.D. The FMS shall be the employer of record for all Attendants. The FMS shall be responsible for worker's compensation insurance, unemployment compensation insurance, withholding of all federal and state taxes, compliance with federal and state laws regarding overtime pay and minimum wage requirements and compliance with any other relevant federal, state, or local laws.

8.510.13.E. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the client and/or Authorized Representative. The FMS shall make all payments from the client's Individual Allocation under the direction of the client and/or Authorized Representative.

8.510.14 LIMITATIONS ON PAYMENT TO FAMILY AND/ OR LEGAL GUARDIANS

8.510.14.A. Family members and/ or legal guardians may be employed by the FMS to provide CDASS, subject to the conditions below. For the purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption, or common law.

1. The family member and/or legal guardian shall be employed by the FMS and be supervised by the client and/or Authorized Representative if providing CDASS.

2. The family member and/ or legal guardian providing Personal Care, Homemaker, and/or Health Maintenance Activities shall be reimbursed at an hourly rate by the FMS which employs the family member and/or legal guardian, with the following restrictions:

    a. A family member and/or legal guardian shall not be reimbursed for more than forty (40) hours of CDASS in a seven day period.

    b. A spouse may only be paid to furnish extraordinary care as determined by the Case Manager. Extraordinary care is determined by assessing whether the care to be provided exceeds the range of care that a spouse would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which are necessary to assure the health and welfare of the client and avoid institutionalization. Extraordinary care shall be documented on the service plan.

3. A client and/or Authorized Representative must provide a planned work schedule to the FMS a minimum of two weeks in advance of beginning CDASS, and variations to the schedule shall be noted and supplied to the FMS when billing.

4. ~~A married individual shall be offered a choice of providers.~~ A client and/or Authorized Representative who choose a spouse as a care provider, shall document the choice on the Attendant Support Services management plan.

8.510.15 ATTENDANT REIMBURSEMENT

8.510.15.A. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the client and/or Authorized Representative hiring the Attendant. The Fiscal Management Services organization shall make all payments from the client's Individual Allocation under the direction of the client and/or Authorized Representative.