THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revisions to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, §8.2000.

Rule Number: MSB 10-08-23-A.

Division / Contact / Phone: State Programs and Federal Financing/Nancy Dolson/3698

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 10-08-23-A., Revisions to the Medical Assistance Rule Concerning the Hospital Provider Fee Collection and Disbursement, Section 8.2000.
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) 8.2000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 10/8/10
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text from §8.2000 HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT through the end of the section at §8.2004.M.2 with the new text provided at §8.2000 HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT through §8.2004.N.2. This change is effective 12/30/2010.

Return to: Luke Huwar
Office of State Planning and Budgeting (OSPB)
State Capitol, Room 111

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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).

   Under recommendation of the Hospital Provider Fee Oversight and Advisory Board, the proposed rule revisions include changes to fees assessed upon hospital providers, payments to hospital providers, and clarification of some terms, as noted below.

   The proposed rule revisions increase payments to hospital providers to reduce uncompensated costs for services provided to Medicaid recipients and uninsured Coloradans, maximizing federal funds in accordance with the purpose of the Colorado Health Care Affordability Act, 25.5-4-402.3, C.R.S. (2010). An additional supplemental Medicaid payment for inpatient psychiatric care in general hospitals is proposed to assure access to inpatient psychiatric services to Medicaid clients. The methodology for the calculation of the High Level Neo-Natal Intensive Care Unit Supplemental Medicaid Payment has been revised to align with the purpose of the payment, i.e., to reduce uncompensated care costs for Medicaid neonates requiring specialized care.

   The proposed rule increases the fees assessed on hospital providers to fund these payments as well as funding the expansions of Medicaid and CHP+ eligibility authorized under the Act.

   Finally, the proposed rule includes clarification of some defined terms and clarification of the timing of fee collection and payment distribution.

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 Section 433.68

Initial Review		Final Adoption	**11/12/2010**
Proposed Effective Date	**12/30/2010**	Emergency Adoption	

DOCUMENT #04

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25.5-4-402.3, C.R.S. (2010)

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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.

   Colorado hospitals benefit from increased Medicaid and Colorado Indigent Care Program (CICP) reimbursements made possible through provider fee funding. Low-income persons benefit from the expanded Medicaid and Child Health Plan Plus (CHP+) eligibility.

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

   From October 2010 through September 2011, the provider fee will generate approximately $292 million in federal funds to Colorado. Hospitals will have an estimated net benefit of $159 million

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.

   While there are administrative costs associated with implementation of the Colorado Health Care Affordability Act, all such costs are covered by provider fees collected; no State General Fund is used.

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

   If no action is taken, the Department will not have the ability to fully fund Medicaid and CHP+ expansions, affected over 22,000 currently enrolled persons and up to 100,000 persons in the long run. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+ and reduce the federal revenue.

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

   The State does not currently have the resources to fund the hospital payments and coverage expansions under the hospital provider fee. The Department began collected fees from hospitals in April 2010, after the rules were established and federal approval was obtained. The Department has implemented an electronic fee and payment mechanism with the

hospitals, reducing the administrative burden on hospitals and the Department alike. For SFY 2009-10, all fees and payments were collected and disbursed efficiently and on time.

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

   The Department continues to meet regularly with stakeholders and the Hospital Provider Fee Oversight and Advisory Board and seeks their input and recommendations to maximize the benefit to the State from the Colorado Health Care Affordability Act. The first hospital provider fee expansions have been implemented and increased reimbursement has been made to hospitals. The proposed rules continue to fund the implementation of the Act to increase health care coverage and reduce uncompensated hospital costs for Medicaid and uninsured persons.

8.2000: HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3, authorizes the Department of Health Care Policy and Financing (Department) to assess a hospital provider fee, pursuant to rules adopted by the State Medical Services Board, to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program (CICP). In addition, the Act requires the Department to use the hospital provider fee to expand health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without dependent children; to provide a Medicaid buy-in program for people with disabilities; to implement twelve month continuous eligibility for Medicaid eligible children; and to pay the Department's administrative costs of implementing and administering the Act.

8.2001: DEFINITIONS

"Act" means the Colorado Health Care Affordability Act, C.R.S. 25.5-4-402.3.

"Bad Debt" means the unpaid dollar amount for services rendered from a patient or third party payer, for which the hospital expected payment, excluding Medicare bad debt.

"Charity Care" means health care services resulting from a hospital's policy to provide health care services free of charge, or where only partial payments are expected, (not to include contractual allowances for otherwise insured patients) to individuals who meet certain financial criteria. Charity Care does not include any health care services rendered under the CICP or those classified as Bad Debt.

"Charity Care Day" means a day for a recipient of the hospital's Charity Care.

"Charity Care Write-Off Charges" means the hospital's charges for Charity Care less payments from a primary payer, less any copayment due from the client, less any other third party payments

"CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

"CICP Day" means a day for a recipient enrolled in the CICP.

"CICP Write-Off Charges" means those charges reported to the Department by the hospital in accordance with 10 CCR 2505-10, Section 8.903.C.6.

"CMS" means the federal Centers for Medicare and Medicaid Services.

"Cost-to-Charge Ratio" means the sum of the hospital's total ancillary costs and physician costs divided by the sum of the hospital's total ancillary charges and physician charges.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. 1302 Section 1820(c) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"DRG" means diagnosis related group, a cluster of similar conditions within a classification system used for hospital reimbursement. It reflects clinically cohesive groupings of inpatient hospitalizations that utilize similar amounts of hospital resources.

"DRG 801" means the DRG for neonates weighing less than 1,000 grams.

"Essential Access Hospital" means a Critical Access Hospital or General Hospital located in a Rural Area with 25 or fewer licensed beds.

"Fund" means the hospital provider cash fund described in C.R.S. 25.5-4-402.3(4).

"General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

"High Volume Medicaid and CICP Hospital" means a hospital with at least 35,000 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.

"HMO" means a health maintenance organization that provides health care insurance coverage to an individual.

"Hospital-Specific Disproportionate Share Hospital Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. 1302 Section 1102.

~~"Long Term Care Hospital" means a General Hospital that is certified as a long term care hospital by the Colorado Department of Public Health and Environment.~~

"Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

"Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

"Long Term Care Hospital" means a General Hospital that is certified as a long term care hospital by the Colorado Department of Public Health and Environment.

"Managed Care Day" means a day listed as HMO or PPO Days on the hospital's patient census.

"Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

"Medicaid Fee-for-Service Day" means a Non-Managed Care Day for which Medicaid is the primary payer. For these days the hospital is reimbursed directly through the Department's fiscal agent.

"Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.

"Medicaid NICU Day" means a Medicaid Fee-for-Service Day in a hospital's neo-natal intensive care unit, reimbursed under DRG 801, up to the average length of stay.

"Medicaid Nursery Day" means a Managed Care Day or Non-Managed Care Day provided to Medicaid newborns while the mother is in the hospital.

"Medicaid Psychiatric Day" means a Managed Care Day or Non-Managed Care Day provided to a Medicaid recipient in the hospital's sub-acute psychiatric unit.

"Medicaid Rehabilitation Day" means a Managed Care Day or Non-Managed Care Day provided to a Medicaid recipient in the hospital's sub-acute rehabilitation unit.

"Medicare Fee-for-Service Day" means a Non-Managed Care Day for which Medicare is the primary payer and the hospital is reimbursed on the basis of a ~~Diagnostic Related Group (~~DRG~~)~~.

"Medicare ~~Managed Care~~HMO Day" means a~~n~~ Managed Care Day for which the primary payer is Medicare.

"Medicare-Medicaid Dual Eligible Day" means a day for which the primary payer is Medicare and the secondary payer is Medicaid.

"Non-Managed Care Day" means a day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO or PPO.

"Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local government.

"Other Payers Day" means a day where the primary payer is not Medicaid or Medicare, which is not a CICP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care Day.

"Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges

~~"Other Payers Day" means a day where the primary payer is not Medicaid or Medicare, which is not a CICP Day, Charity Care Day, or Uninsured/Self Pay Day, and which is not a Managed Care Day.~~

"Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

"Oversight and Advisory Board" means the hospital provider fee oversight and advisory board described in C.R.S. 25.5-4-402.3(6).

"Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.

"PPO" means a preferred provider organization that is a type of managed care health plan.

"Privately-owned Hospital" means a hospital that is privately owned and operated.

"Psychiatric Hospitals" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

~~"Privately-owned Hospital" means a hospital that is privately owned and operated.~~

"Rehabilitation Hospital" means an inpatient rehabilitation facility.

"Rural Area" means a county outside a Metropolitan Statistical Area designated by the United States Office of Management and Budget.

"State-Owned Government Hospital" means a hospital that is either owned or operated by the State.

"State Teaching Hospital" means a High Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

"Third-Party Medicaid Day" means a day for which third party coverage, other than Medicare, is the primary payer and Medicaid is the secondary payer.

"Uncompensated CICP Costs" means CICP Write-Off Charges ~~(~~multiplied by the most recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment year.

"Uncompensated Charity Care Costs" means Charity Care Write-Off Charges multiplied by the most recent provider specific audited Cost-to-Charge Ratio and inflated forward to the payment year.

"Uninsured/Self Pay Day" means a day for self-pay patients and patients without third party health insurance coverage. Uninsured/Self Pay Day does not include Charity Care Days or CICP Days.

"Uninsured/Self Pay Write Off Charges" means charges for self-pay patients and those with no third party coverage less adjustments for a hospital's courtesy or uninsured or self-pay policy discounts.

"Urban Center Safety Net Specialty Hospital" means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total days, rounded to the nearest percent, equals or exceeds 65%.

8.2002: Responsibilities of the Department and Hospitals

8.2002.A. Data Reporting

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Department shall distribute a data survey to all hospitals by March 30 of each year. The Department shall include definitions and descriptions of each data element requested in the survey. Hospitals shall submit the data survey, as requested, to the Department by April 30 of each year. The Department may estimate any survey data element not provided directly by the hospital.

2. Hospitals shall submit the following data elements and any additional elements requested by the Department: (a) Managed Care Days, (b) Non-Managed Care Days, (c) Medicaid Fee-for-Service Days, (c) Medicaid Nursery Days, (e) Medicaid Managed Care Days, (f) Medicaid Psychiatric Days, (g) Medicaid Rehabilitation Days, (h) Medicare Non-Managed Care Days, (i) Medicare ~~Managed Care~~HMO Days, (j) CICP Days, (k) Charity Care Days, (l) Uninsured/Self-Pay Days, (m) Other Payers Days, (n) Total days reported on the patient census, (o) Charity Care Write-Off Charges, (p) Bad Debt, (q) Uninsured/Self Pay Write-Off Charges, (r) Medicare-Medicaid Dual Eligible Days, and (s) Third Party Medicaid Days.

3. The Department shall distribute a data confirmation report to all hospitals annually. The data confirmation report shall include a listing of relevant data elements used by the Department in calculating the Outpatient Services Fee, the Inpatient Services Fee and the supplemental payments. The data confirmation report shall clearly state the manner and timeline in which hospitals may request revisions to the data elements recorded by the Department. Revisions to the data will not be permitted by a hospital after the dates outlined in the data confirmation report.

8.2002.B. Fee Assessment and Collection

1. Establishment of Electronic Funds Process. The Department shall utilize an Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental payments in financial accounts authorized by hospitals. The Department shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

2. Fee Collection and Payment Disbursement. In state fiscal year (SFY) 2009-10 Outpatient Services Fee and Inpatient Services Fee (collectively referred to as "fee") will be assessed on an annual basis and collected in four installments on or about, April 16, 2010; April 30, 2010; May 14, 2010 and June 11, 2010.

For those hospitals that participate in the electronic funds process utilized by the Department, payments will be calculated on an annual basis and disbursed in four installments on the same date the fee is assessed.

~~Payments to hospitals will be processed by the Department within two business days of receipt of a warrant (paper check) or wire transfer to pay the Outpatient Services Fee and Inpatient Services Fee from hospitals that do not participate in the ACH debit process utilized by the Department. Payments through a warrant (paper check) will be processed by the Department within two business days of receipt of the Outpatient Services Fee or Inpatient Services Fee for those hospitals that do not participate in the EFT payment process utilized by the Department to deposit supplemental payments in financial accounts authorized by hospitals.~~

3. Beginning in SFY 2010-11 the Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve monthly installments ~~on the second Friday of each month~~. Payments to hospitals will be calculated on an annual basis and disbursed in twelve monthly installments.

a.– For those hospitals that participate in the electronic funds process utilized by the Department , fees ~~Fees~~ will be assessed and payments will be disbursed on the second Friday of the month, except when State offices are closed during the week of the second Friday, then fees will be assessed and payment will be disbursed on the following Friday of the month ~~on the second Friday of each month.~~ If the Department must diverge from this schedule due to ~~State holidays, bank holidays, or~~ unforeseen circumstances, the Department ~~will~~ shall notify hospitals in writing or by electronic notice as soon as possible.

i. The Department may assess fees and disburse payments for Urban Center Safety Net Specialty Hospitals on an alternate schedule determined by the Department.

b. At no time will the Department assess fees or disburse payments prior to the state fiscal year for which they apply.

4. Payments to hospitals shall be processed by the Department within two business days of receipt of a warrant (paper check) or wire transfer to pay the Outpatient Services Fee and Inpatient Services Fee from hospitals that do not participate in the ACH debit process utilized by the Department. Payments through a warrant (paper check) will be processed by the Department within two business days of receipt of the Outpatient Services Fee or Inpatient Services Fee for those hospitals that do not participate in the EFT payment process utilized by the Department to deposit supplemental payments in financial accounts authorized by hospitals.

~~3~~5. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds

process utilized by the Department for the collection of ~~the Outpatient Services Fee and Inpatient Services Fee~~ fees and the disbursement of ~~payment of supplemental~~ payments unless the Department has approved an alternative process. A hospital requesting to not participate in the ~~ACH debit process, EFT payment process~~electronic~~,~~ fee collection process and/or payment process must submit a request in writing or by electronic notice to the Department describing an alternative fee collection process and/or payment process. The Department shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

8.2003: Hospital Provider Fee

8.2003.A. Outpatient Services Fee

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).~~).~~

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 0.~~35~~484% of total hospital outpatient charges.~~-~~ High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.2003.B. Inpatient Services Fee

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).~~-~~

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $~~60.47~~83.46 per day for Managed Care Days and $~~270.26~~374.85 per day for all other Days as reported to the Department by each hospital by April 30 with the following exceptions:

   a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $~~31.57~~43.57 per day for Managed Care Days and $~~141.10~~195.71 per day for all other Days.

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to $~~24.19~~33.38 per day for Managed Care Days and $~~108.10~~149.94 per day for all other Days.

8.2003.C. Assessment of Fee

1. The Department shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the ~~Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3~~Act. Upon receiving a favorable recommendation by the ~~Hospital Provider Fee~~

Oversight and Advisory Board ~~described in C.R.S. 25.5-4-402.3(6)~~, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Department shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed.

2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Department will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2003.D. Refund of Excess Fees

1. If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Department shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Department shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.2002.B.

2. After the close of each State fiscal year and no later than the following August 31, the Department shall present a summary of fees collected, expenditures made or encumbered, and interest earned in the Fund during the State fiscal year to the Oversight and Advisory Board.

a. If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Department has not expended or encumbered those fees at the close of each State fiscal year:

i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less four percent of the estimated expenditures for health coverage expansions authorized by the Act for the subsequent State fiscal year as most recently published by the Department.

ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the State fiscal year.

iii. The Department shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.2002.B.

8.2004: Supplemental Medicaid and Disproportionate Share Hospital Payments

8.2004.A. Conditions applicable to all supplemental payments

1. All supplemental payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Department.

2. No hospital shall receive a payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the CICP Disproportionate Share Hospital payment or the Uninsured Disproportionate Share Hospital payment exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, that hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction for the CICP Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated CICP Costs, relative to the aggregate of Uncompensated CICP Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit. The amount of the retroactive reduction for the Uninsured Disproportionate Share Hospital payment shall be retroactively distributed to the other qualified hospitals in the category based on the qualified hospital's proportion of Uncompensated Charity Care Costs relative to the aggregate of Uncompensated Charity Care Costs of all qualified providers in the category which do not exceed their Hospital-Specific Disproportionate Share Hospital Limit.

3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2004.B. Outpatient Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals and Critical Access Hospitals shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals and Long Term Care Hospitals shall not receive this payment.

3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado Medicaid Management Information System (MMIS) are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient Hospital Payment Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for managed care enrollment, utilization and inflation~~, multiplied~~, multiplied by ~~29.4~~30.7%. If the hospital qualifies as a Pediatric Specialty Hospital this payment equals hospital-specific outpatient billed costs adjusted for managed care enrollment, utilization and inflation, multiplied by ~~16.8~~30.7%. If the hospital qualifies as an Urban Center Safety Net Specialty Hospital, this payment equals hospital-specific outpatient billed costs adjusted for managed care enrollment, utilization and inflation, multiplied by 25%.

8.2004. C. Outpatient High-Volume Small Rural Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals located in a Rural Area, with 20 or fewer licensed beds, where at least 80% of total Medicaid payments are for outpatient hospital services shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals and Long Term Care Hospitals shall not receive this payment.

3. Calculation methodology for payment. This payment shall equal ~~46~~50% of inflated annual hospital-specific Medicaid outpatient billed costs.

8.2004.D. CICP Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. There will be three categories for qualified hospitals: State-Owned Government Hospitals, Non-State-Owned Government Hospitals, and Private-Owned Hospitals. State-Owned Government Hospitals shall receive ~~5.06~~7.25~~.~~% of the State's annual Disproportionate Share Hospital Allotment, Non-State-Owned Government Hospitals shall receive ~~40~~45.00% and Private-Owned Hospitals shall receive ~~35~~25.00%.

   A qualified hospital's annual payment shall equal its share of the percent of Uncompensated CICP Costs of all qualified hospitals in the category divided by the State's annual Disproportionate Share Hospital allotment allocated to the category.

8.2004.E. Uninsured Disproportionate Share Hospital Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that report charges for services provided to low-income uninsured persons to the Department in a manner as prescribed by the Department shall receive this payment.

2. Excluded hospitals. Hospitals that participate in the CICP, Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. Beginning in FY 2009-10, ~~19.94~~22.75% of the State's annual Disproportionate Share Hospital allotment shall be allocated to the Uninsured Disproportionate Share Hospital Payment. A qualified hospital's annual payment shall equal its share of the percent of Uncompensated Charity Care Costs of all qualified providers divided by the State's annual Disproportionate Share Hospital allotment allocated to the Uninsured Disproportionate Share Hospital Payment.

8.2004.F. CICP Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals that participate in the CICP shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals and hospitals that do not participate in the CICP shall not receive this payment.

3. Calculation methodology for payment.

a. Qualified hospitals shall receive an annual payment, such that, when combined with the CICP Disproportionate Share Hospital Payment, shall total to a percentage of Uncompensated CICP Costs. The percentage applied to Uncompensated CICP Costs shall be:

i. ~~Seventy-five~~Sixty-four percent (~~75~~64%) for High Volume Medicaid and CICP Hospitals,

ii. One hundred percent (100%) for Rural Hospitals, or

iii. ~~Ninety percent~~Seventy-five percent (~~90~~75%) for all other qualified hospitals.

8.2004.G. Inpatient Hospital Base Rate Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals, Rehabilitation Hospitals, Long Term Care Hospitals and Critical Access Hospitals with an established Medicaid inpatient base rate shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this annual payment equals the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate with increases as follows:

a. Pediatric Specialty Hospitals shall have a ~~13.76~~16.8% increase.

b. ~~Urban Center Safety Net Specialty~~State Teaching Hospitals shall have a ~~5.8~~16.0% increase.

c. Other General Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and Critical Access Hospitals shall have an ~~18.1~~35.0% increase.

8.2004.H. High Level Neo-natal Intensive Care Unit (NICU) Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals and Critical Access Hospitals certified level IIIb or IIIc neo-natal intensive care unit (NICU) shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $~~450~~ 2,100 per Medicaid NICU Day.~~Nursery Day~~

~~3. High Volume Medicaid and CICP Hospitals shall not receive this payment.~~

8.2004.I. State Teaching Hospital Supplemental Medicaid Payment

1. Qualified hospitals. State Teaching Hospitals shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $~~75~~ 125 per Medicaid Day.

8.2004.J. Acute Care Psychiatric Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $150 per Medicaid Psychiatric Day.

8.2004.~~J~~K. Large Rural Hospital Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in a Rural Area with 26 or more licensed beds shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis at $~~315~~ 600 per Medicaid Day.

8.2004.~~K~~L. Denver Metro Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in Adams County, Arapahoe County, Boulder County, Broomfield County, Denver County, Jefferson County or Douglas County shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, ~~or~~ and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment.

   a. For each qualified hospital located in Adams County or Arapahoe County, this payment is calculated on an annual basis at $~~400~~ 675 per Medicaid Day.

   b. For each qualified hospital located in Boulder County, Broomfield County, Denver County or Jefferson County, this payment is calculated as $~~510~~ 700 per Medicaid Day.

8.2004.~~L~~M. Metropolitan Statistical Area Supplemental Medicaid Payment

1. Qualified hospitals. General Hospitals located in El Paso County, Larimer County, Mesa County, Pueblo County or Weld County shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, Rehabilitation Hospitals, ~~or~~ and High Volume Medicaid and CICP Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital this payment is calculated on an annual basis at $~~310~~ 600 per Medicaid Day.

8.2004.~~M~~N. Pediatric Specialty Hospital Provider Fee Payment

1. Qualified hospitals. Hospitals qualified to receive the Pediatric Major Teaching Hospital Payment in 10 CCR 2505-10 Section 8.903.C.6 shall receive this payment.

2. Calculation methodology for payment. For each qualified hospital, this payment is calculated on an annual basis and shall equal $~~5~~ 3 million.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Children with Autism Waiver Section 8.519.
Rule Number:	MSB 10-09-01-A
Division / Contact / Phone:	Long Term Care Benefits Division / Michelle Rogers /3895

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 10-09-01-A, Revision to the Medical Asseistance Rule Concerning Home and Community Based Services for Children with Autism Waiver Section 8.519.
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) Long Term Care Benefits Division, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance 8.519(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 §8.519 HOME AND COMMUNITY BASED SERVICES FOR CHILDREN WITH AUTISM WAIVER through §8.519.11.B.2 with the new text provided. Two separate redline documents are submitted for clarity only as the November document did not include the majority of the track changes that were included in the October Initial version.

This change is effective 12/30/2010.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Children with Autism Waiver Section 8.519.
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STATEMENT OF BASIS AND PURPOSE

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

   The rule changes the language from Community Centered Board (CCB) to Case Management Agency to accommodate the change in 25.5-6-804 implemented by SB 10-129 that allows the Department to cotnract with other Department Approved Case Management Agencies if the CCBs are unwilling or unable to contract with the Department.

   The rule updates the specific name of the Universal Long Term Care (ULTC) 100.2 assessment to the Universal Long Term Care (ULTC) Instrument and more clearly defines the Assessment process.

   There are changes to the format of the Case Management section of the rule to improve the order and flow of the rule.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

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

   Explain:

   n/a

3. Federal authority for the Rule, if any:

   CMS HCBS-CWA Waiver Control Number CO-0454.01

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25.5-6-801 through 25.5-6-805

Initial Review	**10/08/2010**	Final Adoption	**11/12/2010**
Proposed Effective Date	**12/30/2010**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Children with Autism Waiver Section 8.519.
Rule Number:	MSB 10-09-01-A
Division / Contact / Phone:	Long Term Care Benefits Division / Michelle Rogers /3895

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.

Case Management Agencies will be affected by the proposed rule. There is no cost associated with the rule change.

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

None, the rule amendment is only a change in terminology.

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 rule does not have an effect on state revenues.

The Department will establish a protocol for contracting with another Case Management Agency if the CCB is unwilling or unable to contract with the department per SB 10-129.

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

None, the rule amendment is only a change in terminology.

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

None, the rule amendment is only a change in terminology.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Community Based Services for Children with Autism Waiver Section 8.519.
Rule Number:	MSB 10-09-01-A
Division / Contact / Phone:	Long Term Care Benefits Division / Michelle Rogers /3895

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, the rule amendment is only a change in terminology.

*****Redline Version submitted to MSB for Initial Approval in October*****

8.519 HOME AND COMMUNITY BASED SERVICES FOR CHILDREN WITH AUTISM WAIVER

8.519.1 DEFINITIONS

Assessment means a comprehensive and uniform process using the ULTC Instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, including ADLs and Instrumental Activities of Daily Living, health status and other factors relevant to determine the client's level of functioning. Assessment process includes collecting information from the client and appropriate collaterals pertaining to service needs, available resources, potential funding sources and includes supporting diagnostic information from a licensed medical professional.~~Assessment means a comprehensive face-to-face evaluation using the ULTC-100.2 conducted by the case manager with the client 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.~~

Autism means the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests as set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000. No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000 is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

Benefits Utilization System (BUS) means the web based data system maintained by the Department for recording case management activities associated with Long Term Care (LTC) services.

Care 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 service and the expected outcome or purpose of such services.

Case Management means the evaluation of functional eligibility and other activities which may include assessment, service plan development, service plan implementation and service monitoring, the evaluation of service effectiveness, and the periodic reassessment of such client's needs. Case Management activities may also include assistance in accessing waiver, State Plan, and other non-Medicaid services and resources and ensuring the right to a Fair Hearing.~~Case Management means the Assessment of a client's needs, the development and implementation of the Care Plan, coordination and monitoring of service delivery, the evaluation of service effectiveness and periodic reassessment of the client's needs.~~

Case Management Agency (CMA) means an agency contracted by the Department to furnish case management services to applicants and clients within a designated service area. CMAs may include Single Entry Point (SEP) agencies, Community Centered Boards (CCB), and private case management agencies.

~~Community Centered Board (CCB) means an agency contracted by the Department to conduct Assessments, develop the Care Plan and provide Case Management and Utilization Review.~~

Continued Stay Review (CSR) means a periodic face to face review of a client's condition and service needs performed in the client's residence, by a case manager to determine a client's continued eligibility for LTC services[A1].[JES2]~~Continued Stay Review (CSR) means a reassessment by the CCB case manager to determine the client's continued eligibility and functional level of care.~~

~~Corrective Action Plan means a plan from the CCB written on a Department approved form that includes the actions the CCB shall take to correct non-compliance with regulatory standards and stipulates the date by which each action shall be completed.~~

Cost Containment means the cost of providing care in the community is less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services, Long Term Home Health services and Home Care Allowance.

Department means the Department of Health Care Policy and Finacing.

Functional Eligibility means an applicant or client meets the criteria for LTC services as determined by the Department's ULTC instrument.

Functional Needs Assessment means a component of the Assessment process which includes a comprehensive face-to-face evaluation using the ULTC Instrument to determine if the client meets the appropriate Level of Care (LOC).~~Cost Containment means the determination that, on an individual client basis, the cost of providing care in the community is less than or the same as the cost of providing care in an Intermediate Care Facility for the Mentally Retarded (ICF/MR).~~

Intake/Screening/Referral means the initial contact with an individual by the CMA and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services, referral to other programs or services and the need for the Assessment.

~~Intake/Screening/Referral means the CCB's initial contact with an 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.~~

Lead Therapist means a qualified Medicaid provider ~~who assesses the client's need for behavioral therapies and prescribes the treatment plan.~~~~as defined~~according[JES3] to criteria at 10 C.C.R. 2505-10, § 8.519.6.

Line Staff means a qualified Medicaid provider ~~as defined~~according to criteria at 10 C.C.R. 2505-10, § 8.519.6.
~~who works directly with the client using behavioral therapies.~~

Senior Therapist means the qualified Medicaid provider ~~as defined~~according to criteria at 10 C.C.R. 2505-10, § 8.519.6.~~who is responsible for training the Line Staff in proper application of prescribed therapies and providing on-going supervision and implementation of the treatment plan, including documentation of client progress.~~

Plan of Correction (POC) means a written plan submitted to and approved by the Department or the Department's designee includes the specific remediation and timeline that will correct identified deficiencies.

Prior Authorization Request (PAR) means the department prescribed form to authorize the reimbursement for services.

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

State Plan Benefit means the benefits the state covers in the operation of its Medicaid program. The State Plan is submitted to and approved by the Centers for Medicare and Medicaid acting on behalf of the Secretary for Health and Human Services.

Uniform Long Term Care (ULTC) Instrument means the Department prescribed form used to determine Functional Eligibility and medical verification for LTC services ~~as defined at 25.5-6-104. C.R.S~~[JES4]~~.~~

Utilization Review (UR) means a system for prospective, concurrent, and retrospective review of the necessity and appropriateness ~~in~~of the allocation of supports and services to ensure the proper and efficient administration of Medicaid Long Term Care benefits. UR may ~~include the administration of~~use the ULTC Instrument and other assessment instruments as ~~designated~~indicated by the Department and/or its designee.

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

8.519.2
BENEFITS

8.519.2.A.
Home and Community Based Services for Children with Autism (HCBS-CWA) benefits shall be provided within Cost Containment.

8.519.2.B.
Behavioral therapies shall be provided in a group or individual setting.

8.519.2.C.
Behavioral therapies shall only be a benefit if they are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means. Behavioral therapies may include:

1. Intensive developmental behavioral therapies ~~developed~~ ~~created~~ ~~specific~~specifically created to meet the client's needs including conditioning, biofeedback or reinforcement techniques.

2. Treatment goals that are consistent with building elementary verbal skills, teaching imitation, establishing appropriate toy play or interactive play

~~3.~~ with other children, teaching appropriate expression of emotions and behaviors, and where necessary, reducing self stimulation and aggressive behaviors.

~~4~~3. One-on-one behavior therapy between a client and a therapist following a specific protocol established by the Lead Therapist. Therapy may be implemented by a ~~conducted with the client and Line Staff~~Lead Therapist, Senior Therapist, or Line Staff~~, following a specific protocol established by the Lead Therapist~~.

~~5~~4. Training or modeling for parents or a guardian so that the behavioral therapies can continue in the home. Training or modeling shall be:

a. Directed toward~~s~~ instruction on therapies and use of equipment specified in the Care Plan.

b~~.~~. Carried out in the presence of and for the direct benefit of the client.

~~c. Conducted by the Line Staff.~~
~~8.519.2.D.~~
~~Behavioral therapies shall only be a benefit if they are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.~~

8.519.2.~~E~~D.
Benefits shall be limited to three years, either contiguous or intermittent with a one~~-~~-year extension based on medical necessity as stated by the client's physician and upon approval by the Department.

8.519.2.E~~F~~.
The annual cost of benefits per client shall not exceed $25,000 or available funds whichever is less.

8.519.3
NON-BENEFIT

8.519.3.A.
Case Management shall not be a benefit of the HCBS-CWA waiver but shall be provided as an administrative activity through the ~~CCB~~CMA.

8.519.3.B.
Speech therapy shall not be a benefit under behavior therapies.

8.519.4
CLIENT ELIGIBILITY

8.519.4.A.
An eligible client shall:

1. ~~1.~~ Be determined financially eligible by the financial eligibility site in the county where the applicant resides.

2. ~~2.~~ Be determined to meet the ~~definition of disability~~ as defined by the Federal Social Security Administration ~~definition of disability~~.

3. ~~3.~~ Be ~~at risk of institutionalization into an ICF/MR as determined by the CCB case manager~~Case Manager using the ULTC ~~100.2~~Instrument.

4. Be safely served in the community within Cost Containment as determined by the Case Manager.

5. ~~4.~~ Meet the target population criteria as follows:

a. ~~a.~~ Has a diagnosis of Autism as certified by a physician.

~~a.~~b.~~b.~~ Has not yet reached six years of age.

~~5. Be determined by the CCB case manager to be able to be safely served in the community within Cost Containment.~~

8.519.4.B.
A client shall receive at least one HCBS-CWA waiver benefit per month to maintain enrollment in the waiver. Case Management itself is not a benefit for purposes of satisfying the requirement to receive at least one benefit per month on the HCBS-CWA waiver.

8.519.4.C.
A client who has not received at least one benefit on the HCBS-CWA waiver for a period of one month shall be discontinued from the waiver.

~~8.519.4.D.~~
~~Case Management shall not satisfy the requirement to receive at least one benefit per month on the HCBS-CWA waiver.~~

8.519.5
WAIT LIST

8.519.5.A.
The number of clients who may be served through the waiver at any one time during a year shall be limited ~~to 75~~by the Department.

8.519.5.B.
Applicants who are determined eligible for benefits under the HCBS-CWA waiver, who cannot be served within the ~~75 client~~Department established limit, shall be eligible for placement on a wait list maintained by the Department.

8.519.5.C.
The ~~CCB~~C ~~c~~ase M~~m~~anager shall ensure the applicant meets all criteria as set forth in Section 8.519.4 prior to notifying the Department to place the applicant on the wait list.

8.519.5.D.
The ~~CCB~~C ~~c~~ase M~~m~~anager shall notify the Department by entering the ~~ULTC 100.2~~Assessment ~~Form~~ and Professional Medical Information Page data in the ~~Benefits Utilization System (BUS~~BUS.~~).~~

8.519.5.E.

The date and time of ~~notification from~~the ULTC Instrument, as entered in the BUS, ~~the CCB case manager~~ shall be used to establish the order of an applicant's place on the wait list.

8.519.5.F.
Within five working days of notification from the Department that an opening for the HCBS-CWA waiver is available the ~~CCB~~CMA shall:

1. ~~1.~~ Reassess the applicant for functional level of care using the ULTC ~~100.2~~Instrument ~~Form~~ if ~~the date of the last Assessment is more than six months old.~~more than 6 months has elapsed since the previous assessment.

2. ~~2.~~ Update the existing ULTC Instrument~~100.2~~ in the BUS~~Form data~~ if ~~the date is less~~more than six months ~~old~~has elapsed since the date of the previous.

3. ~~3.~~ Reassess for the target population criteria.

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

8.519.6
PROVIDER ELIGIBILITY [Emer. Rule eff. 12/14/2007]

8.519.6.A.
Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CWA waiver, meet the responsibilities as set forth in Section 8.519.7 and enter into an agreement with the Department as set forth in 10 C.C.R. 2505-10, Section 8.130. [Emer. Rule eff. 12/14/2007]

8.519.6.B.
Providers shall enroll individually with the fiscal agent. [Emer. Rule eff. 12/14/2007]

8.519.6.C.
Providers shall be employed by a qualified Medicaid provider agency, clinic or hospital except for a Lead Therapist who may provide services independent from a Medicaid provider agency when the Lead Therapist employs the Senior Therapist and Line Staff. [Emer. Rule eff. 12/14/2007]

8.519.6.D.
Lead Therapists shall meet one of the following requirements: [Emer. Rule eff. 12/14/2007]

1. ~~1.~~ Have a doctoral degree with a specialty in psychiatry, medicine or clinical psychology and be actively licensed by the state board of examiners. Have completed 400 hours of training and/or have direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

2. ~~2.~~ Have a doctoral degree in one of the behavioral or health sciences and have completed 800 hours of specific training and/or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

3. ~~3.~~ Have a Master's degree, or higher, in behavioral sciences and be nationally certified as a "Board Certified Behavior Analyst" or certified Relationship Development Intervention

(RDI) consultant or certified by a similar nationally recognized organization. [Emer. Rule eff. 12/14/2007]

4. ~~4.~~ Have a Master's degree or higher in one of the behavior or health sciences and certification as a School Psychologist; or licensed teacher with an endorsement of special education or early childhood special education; or licensed psychotherapy provider; or credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist) and have completed 1,000 hours of direct supervised training or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

8.519.6.E.
The Lead Therapist shall assess the child and develop the treatment plan based on the child's individual needs. The Lead Therapist shall prescribe the amount, scope and duration of the therapy, make treatment adjustments and be responsible for treatment outcomes. The Lead Therapist shall be required to provide a written progress report for the case manager and the family every six months. [Emer. Rule eff. 12/14/2007]

8.519.6.F.
Senior Therapists shall meet one of the following requirements: [Emer. Rule eff. 12/14/2007]

1. ~~1.~~ Have a Master's degree or higher in one of the behavior or health related sciences and have completed 1,000 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

2. ~~2.~~ Have a bachelor's degree or higher in a human services field and have completed at least 2,000 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

8.519.6.G.
The senior therapist shall provide ongoing supervision and implementation of the treatment plan. This includes the supervision of line staff, training of the families and conducting team meetings with the family, line staff and other providers to review the child's progress. The senior therapist shall provide documentation of the location of the agency that is providing services, the time spent and the team members who participated in the delivery of services. [Emer. Rule eff. 12/14/2007]

8.519.6.H.
Line Staff shall meet all of the following requirements: [Emer. Rule eff. 12/14/2007]

1. ~~1.~~ Be at least 18 years of age [Emer. Rule eff. 12/14/2007]

2. ~~2.~~ Have graduated from high school or earned a high school equivalency degree. [Emer. Rule eff. 12/14/2007]

3. ~~3.~~ Have or acquire 20 hours or more of direct supervised experience billable under the direction of a Lead or a Senior Therapist, in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

4. ~~4.~~ Demonstrate understanding of the services and outcomes for children with Autism as attested to by the Lead Therapist or Senior Therapist. [Emer. Rule eff. 12/14/2007]

5. ~~5.~~ Have cleared the provider's background check at the time he/she is hired. [Emer. Rule eff. 12/14/2007]

8.519.6.I.
The line staff shall be trained directly by the lead and/or senior therapist. The senior therapist is responsible for the line staff supervision and shall work with the line staff to implement the treatment plan. All services provided by the line staff shall be under the direction of the senior therapist and shall be documented. [Emer. Rule eff. 12/14/2007]

8.519.7
PROVIDER RESPONSIBLITIES

8.519.7.A. HCBS-CWA[JES5]
~~Lead Therapists not employed by a Medicaid p~~Provider~~s agency, clinic or hospital~~ shall have written policies and procedures regarding :

1. ~~1.~~ Recruiting, selecting, retaining and terminating employees.

2. ~~2. Handling and reporting~~Responding to critical incidents, including accidents, suspicion of a~~abus~~buse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section 19-3-304 C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statues, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

   a. ~~a.~~ The Lead Therapist shall maintain a log of all complaints and critical incidents which shall include documentation of the resolution of the complaint or incident.

   b. ~~b.~~ The Lead Therapist shall communicate any critical incident via e-mail or fax to the Department within one ~~bus~~business~~iness~~ day.

8.519.7.B. CWA
~~Lead Therapists not employed by a Medicaid provider agency, clinic or hospital~~ Providers shall:

1. ~~1.~~ Ensure a client is not discontinued or refused services unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure client records and documentation of services are made available at the request of the Case Manager.

~~1.~~

~~2.~~3.~~2.~~ Ensure that adequate records are maintained.

   ~~c.~~a. ~~a.~~ Client records shall contain:

i. ~~i)~~ Name, address, phone number and other identifying information ~~on~~ for the client and the client's parent(s) and/or legal guardian.

ii. ~~ii)~~ Name, address and phone number of the ~~CCB~~CMA and the ~~CCB case manager~~Case Manager.

iii. ~~iii)~~ Name, address and phone number of the client's primary physician.

iv. ~~iv)~~ Special health needs or conditions of the client.

v. ~~v)~~ Documentation of the specific services provided which includes:

~~a.~~1.~~1)~~ Name of the individual provider.

~~b.~~2.~~2)~~ The location for the delivery of services.

~~c.~~3.~~3)~~ Units of service.

~~d.~~4.~~4)~~ The date, month and year of services and, if applicable, the beginning and ending time of day.

~~b.~~5.~~vi)~~ Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.

6. ~~vii)~~ Documentation regarding supervision of benefits.

7. Financial records for all claims, including documentation of services as set forth at 10 C.C. R. 2505-10, Section 8.040.02.

~~c.~~

~~b. Personnel records for each employee shall contain:~~

~~i. i) Documentation of qualifications to provide behavioral therapies.~~

~~ii. ii) Documentation of training.~~

~~iii. iii) Documentation of supervision and performance evaluation.~~

~~iv. iv) Documentation that an employee was informed of all policies and procedures as set forth in Section 8.519.7.B.~~

~~v. v) A copy of the employee's job description.~~

~~7. c. Financial records for all claims, including documentation of services as set forth at 10 C.C. R. 2505-10, Section 8.040.02.~~

b. Personnel[JES6] records for each employee shall contain:

i. Documentation of qualifications to provide behavioral therapies.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.519.7.B.

v. A copy of the employee's job description.

8.519.8
~~CCB~~CASE MANAGEMENT AGENCY ~~-~~ELIGIBILITY

8.519.8.A.
A ~~CCB~~CMA shall enter into a contract with the Department to provide client Assessment, Case Management and Utilization Review.

8.519.8.B.
The ~~CCB~~CMA shall have computer hardware and software, compatible with the Department's ~~BUS~~BUS, with capacity and capabilities as prescribed by the Department.

8.519.8.C.
The ~~CCB~~CMA shall be certified annually in accordance with quality assurance standards and requirements set forth in 10 C.C.R. 2505-10, Section 8.079.2.

1. ~~1.~~ Certification of a ~~CCB~~CMA shall be based on a survey of each ~~CCB~~CMA's performance in the following areas:

   ~~1.~~a. ~~a.~~ Quality of the Case Management services provided by the ~~CCB~~CMA to the clients based on the client satisfaction survey.

   ~~2.~~b. ~~b.~~ Compliance with waiver requirements.

   ~~3.~~c. ~~c.~~ Performance of administrative functions, including Cost Containment, timely reporting, on-site visits to clients, community outreach and client monitoring.

   ~~4.~~d. ~~d.~~ Whether targeted populations are identified and served.

   ~~5.~~e. ~~e.~~ Financial accountability .

   ~~6.~~f. ~~f.~~ Retention of qualified personnel to perform the contracted duties.

~~3.~~4. ~~2.~~ The ~~CCB~~CMA shall receive denial, provisional approval or approval of certification based on the outcome of the certification survey.

~~4.~~5. ~~3.~~ In the event that the ~~CCB~~CMA does not meet the quality assurance standards, the ~~CCB~~CMA may receive provisional approval for certification for a period not to exceed 60 days provided the deficiencies do not constitute a threat to the health and safety of the clients.

~~1.~~a.~~a.~~ The ~~CCB~~CMA shall submit a Corrective Action Plan to address any deficiencies. Upon receipt and review of the Corrective Action Plan, provisional certification may be approved at the Department's discretion for a single additional 60 day period.

~~2.~~b.~~b.~~ If the Corrective Action Plan is not implemented successfully within the 60 day period, the service area will be assigned to another Department Approved ~~CCB~~CMA.

c. ~~c.~~ The ~~CCB~~CMA may receive technical assistance from the Department to facilitate corrective action.

8.519.8.D.
The Department or its designee shall conduct reviews of the ~~CCB~~CMA agency.

8.519.9
~~CCB~~CMA RESPONSIBILITIES

8.519.9.A.
The ~~CCB~~CMA shall, in a format and manner specified by the Department, be responsible for the collection and reporting of summary and client specific data including, but not limited, to information and referral services provided by the agency, waiver eligibility determination, financial eligibility determination, care planning, service authorization, fiscal accountability and utilization review.

8.519.9.B.
The ~~CCB~~CMA shall maintain case records in accordance with Department requirements.

1. ~~1.~~ Case records shall be maintained for:

a. ~~a.~~ Individuals for whom the ~~CCB~~CMA completed an intake for HCBS-CWA.

b. ~~b.~~ Individuals who are HCBS-CWA clients.

2. ~~2.~~ Case records shall contain:

~~1.~~a.~~a.~~ Identifying information, including the client's Medicaid identification number and social security number.

b. Identifying information referencing the client's parent(s) and/or legal guardian.

~~2.~~c.~~b.~~ A copy of the ULTC ~~100.2 Form~~Instrument -and the Professional Medical Information Page (PMIP).

~~3.~~d.~~c.~~ Documentation of the date on which the client referral was first received and dates of all actions taken thereafter by the ~~CCB~~CMA.

~~4.~~e.~~d.~~ Documentation of all Assessment and target population criteria outcomes.

~~5.~~f. ~~e.~~ Documentation of all Case Management activities, the monitoring of service delivery, and service effectiveness.

~~6. f. Identifying information referencing the client's parent(s) and/or legal guardian.~~
~~a.~~

~~7.~~g.~~g.~~ Documentation that all Department required forms have the required signatures .

3. ~~3.~~ The ~~CCB~~CMA shall protect the confidentiality of all applicants and recipient records in accordance with section 26-1-114, C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statues, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

4. ~~4.~~ The ~~CCB~~CMA shall protect the confidentiality of all applicants and recipient records in accordance with and the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 C.F.R., Parts 160 and 164. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the federal privacy law, copyright 1996, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

5. ~~5.~~ The ~~CCB~~CMA shall obtain release of information forms from the client's parent(s) and/or legal guardian which shall be signed, dated and renewed at least annually or when there is a change in benefit provider.

8.519.9.C.
The ~~CCB~~CMA shall assure that each client's parent(s) and/or legal guardian:

~~a.~~1.~~1.~~ Is fully informed of his/her rights and responsibilities.

2. ~~2.~~ Participates in the development and approval of the Care Plan and is provided a completed copy.

3. ~~3.~~ Is given a choice of service providers from qualified providers in the ~~CCB~~CMA district of his/her residence.

4. ~~4.~~ Is fully informed of and given access to a uniform complaint system as defined by the Department.

8.519.9.D.
At least annually, the ~~CCB~~CMA shall conduct a client satisfaction survey which consists of surveying a sample of clients selected by the Department to determine their level of satisfaction with services provided by the ~~CCB~~CMA.

~~a.~~1.~~1.~~ The random sample of clients shall include ten clients or ten percent of the ~~CCB~~CMA's average monthly HCBS-CWA caseload, whichever is higher.

~~b.~~2.~~2.~~ If the ~~CCB~~CMA's average monthly HCBS-CWA caseload is less than ten clients, all clients shall be included in the survey.

~~c.~~3.~~3.~~ The client satisfaction survey shall be on a Department approved form.

~~d.~~4.~~4.~~ The results of the client satisfaction survey shall be made available to the Department.

8.519.9.E.
The ~~CCB~~CMA shall not require clients to come to the agency's office to receive Assessments, Utilization Review services or Case Management services.

8.519.9.F.
The ~~CCB~~CMA shall provide adequate staff to meet all service and administrative functions including~~.~~:

~~a.~~1.~~1.~~ The ~~CCB~~CMA shall have a system for recruiting, hiring, evaluating, and terminating employees that complies with all federal and state affirmative action and civil rights requirements.

~~b.~~2.~~2.~~ The ~~CCB~~CMA shall employ at least one full time case manager.

3. ~~3.~~ The ~~CCB~~CMA shall have adequate support staff to maintain a computerized information system in accordance with the Department's requirements.

4. CMA staff shall attend training sessions as directed and/or provided by the Department at the Department's~~al~~ expense~~cost~~.
5. The CMA shall provide in-service and staff development training at the CMA's expense~~cost~~.
~~c.~~

~~d.~~6.~~4.~~ The supervisor and case manager shall meet minimum the following standards for education and/or experience:

~~i.~~a. ~~a.~~ The case manager shall have at least a bachelor's degree in one of the human behavioral science fields or nursing.

~~2.~~b.~~b.~~ The supervisor shall meet all qualifications for a case manager and have a minimum of two years of experience in long term care.

~~3.~~c.~~c.~~ The ~~CCB~~CMA may request a waiver of these requirements from the Department prior to employing an individual when the ~~CCB~~CMA has been unable to secure the services of a qualified individual. The waiver shall be granted approval at the discretion of the Department.

~~e. 5. CCB staff shall attend training sessions as directed and/or provided by the Department at Departmental cost.~~

~~f. 6. The CCB shall provide in-service and staff development training at the CCB cost.~~

8.519.~~9.G~~10.
~~CCB~~CMA SERVICE FUNCTIONS

8.519.10.A.

~~1.~~ The ~~CCB~~CMA shall complete the following activities as a part of its Intake/Screening/Referral function:

~~i.~~1. ~~a.~~ Evaluate inquiries and address accordingly.

~~ii.~~2. ~~b.~~ Determine the appropriateness of a referral for an Assessment.

3. ~~c.~~ Provide information and referral to other agencies as needed.

~~iii.~~4. Obtain the applicant's parent(s)' and/or legal guardian's signature on the ULTC Intake Form.

~~d. Initiate the ULTC 100.2 Form within two working days of receiving a referral.~~

~~e. Identify potential payment source(s), including the availability of private funding resources.~~

~~f. Verify the applicant's financial eligibility status for Medicaid, or refer the applicant to the financial eligibility site in the applicant's county of residence to determine financial eligibility for Medicaid.~~

~~g. Notify the applicant's parent(s) and/or legal guardian of his/her right to appeal adverse actions of the CCB, the Department, or contractors acting on behalf of the Department as set forth in 10 C.C.R. 2505-10, Section 8.057.~~

~~h. Obtain the applicant's parent(s) and/or legal guardian's signature on the ULTC 100.2 Intake Form.~~

8.519.10.B. ~~2.~~ If a referral for HCBS-CWA waiver services is determined to be appropriate, the ~~CCB~~CMA shall complete the following activities as a part of its Assessment:

1. Initiate the ULTC Instrument within two working days of receiving a referral.

2. Identify potential payment source(s), including the availability of private funding resources.

3. Verify the applicant's financial eligibility status for Medicaid, or refer the applicant to the financial eligibility site in the applicant's county of residence to determine financial eligibility for Medicaid.

4. Notify the applicant's parent(s) and/or legal guardian of his/her right to appeal adverse actions of the CMA, the Department, or contractors acting on behalf of the Department as set forth in 10 C.C.R. 2505-10, Section 8.057.

~~iv.~~5. ~~a.~~ Obtain diagnostic information supplied from the Professional Medical Information Page from the applicant's medical provider, physician or nurse.

~~v.~~6.~~b.~~ Determine the applicant's functional capacity during an Assessment~~,~~ through observation of the applicant and family in his/her residential setting.

~~vi.~~7. ~~c.~~ Determine the applicant's service needs, taking into consideration services available or already being received from all funding sources.

~~vii.~~8. ~~d.~~ Inform the applicant's parent(s) and/or legal guardian of the right to choose enrollment in other HCBS waivers for which the applicant is qualified. Document on the Care Plan, the parent(s)' and/or legal guardian's waiver selection preference.

~~viii.~~9. ~~e.~~ Maintain appropriate documentation for certification of waiver eligibility.

~~ix.~~10. ~~f.~~ Submit documentation, as determined by the Department, for authorization of services.

8.519.10.C. ~~3.~~ The ~~CCB~~CMA shall complete the following activities as a part of the Utilization Review function:

1. ~~a.~~ Log each ULTC ~~100 .2 F~~form received and reviewed.

2. ~~b.~~ Score the client ~~ULTC 100.2~~using the ULTC Instrument ~~Form~~ within one ~~bu~~business day from the date of the ~~CCB case manager~~Case Manager's Assessment.

3. ~~c.~~ Input an electronic copy of the ~~ULTC 100.2~~Assessment ~~Form~~ on the ~~BUS~~ BUS within 10 ~~bus~~business~~iness~~ days after completing the Assessment.

4. ~~d.~~ Notify the applicant's parent(s) and/or legal guardian of the outcome of the ~~ULTC 100.2~~ Assessment ~~and~~with the Notice of Services Status (LTC 803) Form including~~.~~:

   a. The Assessment outcome shall be based upon waiver requirements and the ULTC Instrument score and shall determine if a client is approved or denied for enrollment or continued stay in the waiver.

   b. When the Assessment outcome is a denial for enrollment in the waiver, the CMA shall notify the applicant's parent(s) and/or legal guarding in accordance with 10 C.C. R. 2505-10, Section 8.057.

5. The CMA shall develop the Care Plan upon completion of the Assessment and prior to authorizing services. The CMA shall complete the Care Plan and all required paperwork within 15 business days upon eligibility determination. Care planning shall include, but not be limited to:

   ~~i) The Assessment outcome shall be based upon waiver requirements and the ULTC 100.2 functional needs assessment score and shall determine if a client is approved or denied for enrollment or continued stay in the waiver.~~

   ~~ii) When the Assessment outcome is a denial for enrollment in the waiver, the CCB shall notify the applicant's parent(s) and/or legal guarding in accordance with 10 C.C. R. 2505-10, Section 8.057.~~

~~a.~~

~~4. The CCB shall develop the Care Plan upon completion of the ULTC 100.2 functional needs assessment and prior to authorizing services. The CCB shall complete the Care Plan and all required paperwork within 15 business days upon eligibility determination. Care planning shall include, but not be limited to:~~

   a. ~~a.~~ Identifying and documenting Care Plan goals made with the participation of the client's parent(s) and/or legal guardian~~'s participation~~.

   b. ~~b.~~ Identifying and documenting services needed including the type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but not available.

c. ~~c.~~ Documenting a client's parent(s)' and/or legal guardian's selection of qualified providers.

8.519.10.D. The CMA shall complete a CSR of a client within 12 months of the initial Assessment or the previous CSR. The CSR shall be completed not more than three months before the end of the current certification period. A CSR shall be completed sooner if the client's condition changes.

1. A CSR shall include but not be limited to the following activities:

a. Obtain an update of the Professional Medical Information Page from the client's physician.

b. Assess a client's functional status face-to-face at the client's place of residence using the ULTC Instrument.

c. Update the Care Plan and provider contacts.

d. Evaluate service effectiveness, quality of care and appropriateness of services.

e. Verify continuing Medicaid financial and waiver eligibility.

f. Inform the client's Lead Therapist of any changes in the client's needs.

g. Refer the client to community resources as needed and develop resources for the client to the extent that the resource can be made available in the community.

8.519.10.E.
The CMA shall authorize services

1. The CMA shall Submit the PAR to the Department or the Department's designeess ~~to~~ to approved the authorization of services and provider reimbursement.

~~4.~~2.~~5.~~ The ~~CCB~~CMA shall be financially responsible for any services authorized which do not meet the requirements as set forth in Section 8.519 et. seq., or which are rendered by a provider due to the ~~CCB~~CMA's failure to timely notify the provider that the client is no longer eligible for services.

8.519.10.F ~~6.~~ The ~~CCB~~CMA shall provide on-going Case Management for a client as defined below:

1. ~~a.~~ On-going Case Management shall include, but not be limited to:

a. Review the Care Plan.

b. Contact the client's parent(s) and/or legal guardian concerning the satisfaction with services provided.

c. Contact the service providers concerning their effectiveness and appropriateness regarding their service coordination.

d. Investigate complaints raised by the client's parent(s) and/or legal guardian concerning the service providers.

e. Contact the appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client's parent(s) and/or legal guardian.

f. Resolve conflict or crisis related to the waiver benefit or Medicaid state plan service delivery, as needed.

g. Assess changes in the client's functioning, service effectiveness, service appropriateness and service cost-effectiveness.

h. Refer to community resources as needed.

2. The CMA shall contact the client's parent(s) and/or legal guardian at least monthly or more frequently as determined by the client's needs.

3. The[JES7] CMA[A8] shall review and update the ULTC Instrument and Care Plan, with the client's parent(s) and/or legal guardian as required by a significant change in the client's condition. The review shall be conducted by telephone or at the client's place of residence, place of service or other appropriate setting as determined by the client's needs.

4. The CMA shall contact the service providers to monitor service delivery at least every three months, as required by the client's needs or the specific service requirements.

5. If the CMA suspects a client to be a victim of abuse, neglect or exploitation, the CMA shall immediately refer the client to the protective services section of the county department of social services in the client's county or residence and/or the local law enforcement agency.

6. The CMA shall immediately report any information that indicates an overpayment, incorrect payment or misuse of any public assistance benefit to the Department. The CMA and case manager shall cooperate with the appropriate agency in any subsequent recovery process in accordance with the 10 C.C.R. 2505-10, Section 8.076.

~~i) Review the Care Plan.~~

~~ii) Contact the client's parent(s) and/or legal guardian concerning the satisfaction with services provided.~~

~~iii) Contact the service providers concerning their effectiveness and appropriateness regarding their service coordination.~~

~~iv) Investigate complaints raised by the client's parent(s) and/or legal guardian concerning the service providers.~~

~~v) Contact the appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client's parent(s) and/or legal guardian.~~

vi) Resolve conflict or crisis related to the waiver benefit or Medicaid state plan service delivery, as needed.

vii) Assess changes in the client's functioning, service effectiveness, service appropriateness and service cost-effectiveness.

viii) Refer to community resources as needed.

b. The CCB shall contact the client's parent(s) and/or legal guardian at least monthly or more frequently as determined by the client's needs.

c. The CCB shall review and update the ULTC 100.2 Form and Care Plan, with the client's parent(s) and/or legal guardian annually or as required by a significant change in the client's condition. The review shall be conducted by telephone or at the client's place of residence, place of service or other appropriate setting as determined by the client's needs.

d. The CCB shall contact the service providers to monitor service delivery at least every three months, as required by the client's needs or the specific service requirements.

e. If the CCB suspects a client to be a victim of abuse, neglect or exploitation, the CCB shall immediately refer the client to the protective services section of the county department of social services in the client's county or residence and/or the local law enforcement agency.

f. The CCB shall immediately report any information that indicates an overpayment, incorrect payment or misuse of any public assistance benefit to the Department. The CCB and case manager shall cooperate with the appropriate agency in any subsequent recovery process in accordance with the 10 C.C.R. 2505-10, Section 8.076.

a.

7. The CCB shall complete a CSR of a client within 12 months of the initial ULTC 100.2 Assessment or the previous CSR. The CSR shall be completed at least one, but not more than three months before the end of the current certification period. A CSR shall be completed sooner if the client's condition changes.

a. A CSR shall include but not be limited to the following activities:

i) Obtain an update of the Professional Medical Information Page from the client's physician.

ii) Assess a client's functional status face-to-face at the client's place of residence using the ULTC 100.2 Form.

iii) Update the Care Plan and provider contacts.

iv) Evaluate service effectiveness, quality of care and appropriateness of services.

v) Verify continuing Medicaid financial and waiver eligibility.

vi) Inform the client's Lead Therapist of any changes in the client's needs.

~~vii) Refer the client to community resources as needed and develop resources for the client to the extent that the resource can be made available in the community.~~

~~viii) Submit the appropriate Department approved form for authorization of services.~~

8.519.10.G. The CMA shall complete Denials and discontinuations.

1. ~~8.~~ The ~~CCB~~CMA shall notify the client's parent(s) and/or legal guardian within one working day of determining the client no longer meets waiver requirements.

~~1.~~
~~2.~~
2. ~~a.~~ A client shall be notified of the denial/discontinuation by the ~~CCB~~CMA on the Department prescribed LTC 803 form if he/she is determined ineligible due to any of the following reasons:

    a. The client no longer meets all of the criteria set forth at Sections 8.519.4.

    b. The client exceeds the limitations set forth at Sections 8.519.2.E and 8.519.2.F.

    c. The client's parent(s) and/or legal guardian has twice in a 30 day consecutive period, refused to schedule an appointment for an Assessment or Case Management visit.

    d. The client's parent(s) and/or legal guardian has failed to keep three scheduled provider appointments in a 30 day period.

    e. The client's parent(s) and/or legal guardian fails to sign the Intake, Care Plan, Release of Information, or other forms as required.

3. The CMA shall notify a client's parent(s) and/or legal guardian of the denial or discontinuation of services using the Department prescribed advisement letter for reasons not related to enrollment criteria:

    a. A client who moves out of Colorado shall be discontinued effective upon the day after the date of the move.

    b. A client whose parent(s) and/or legal guardian voluntarily withdraws the client from the waiver shall be discontinued effective upon the day after the date on which the request is documented, or the date on which the client enters a long term care institution or another HCBS waiver.

4. The CMA shall not send notification when the denial or discontinuation is due to the death of the client. A client who dies shall be discontinued from the waiver, effective upon the day after the date of death.

5. The case manager shall provide the client with appropriate referrals to other community resources, as needed, within one working day of discontinuation.

~~i) The client no longer meets all of the criteria set forth at Sections 8.519.4.A and 8.519.4.B.~~

~~ii) The client exceeds the limitations set forth at Sections 8.519.2.E and 8.519.2.F.~~

~~iii) The client's parent(s) and/or legal guardian has twice in a 30 day consecutive period, refused to schedule an appointment for an Assessment or Case Management visit.~~

~~iv) The client's parent(s) and/or legal guardian has failed to keep three scheduled provider appointments in a 30 day period.~~

~~v) The client's parent(s) and/or legal guardian fails to sign the Intake, Care Plan, Release of Information, or other forms as required.~~

~~b. The CCB shall notify a client's parent(s) and/or legal guardian of the denial or discontinuation of services using the Department prescribed advisement letter for reasons not related to enrollment criteria:~~

~~i) A client who moves out of Colorado shall be discontinued effective upon the day after the date of the move.~~

~~ii) A client whose parent(s) and/or legal guardian voluntarily withdraws the client from the waiver shall be discontinued effective upon the day after the date on which the request is documented, or the date on which the client enters a long term care institution or another HCBS waiver.~~

~~c. The CCB shall not send notification when the denial or discontinuation is due to the death of the client. A client who dies shall be discontinued from the waiver, effective upon the day after the date of death.~~

~~d. The case manager shall provide the client with appropriate referrals to other community resources, as needed, within one working day of discontinuation.~~

~~3.~~6.~~e.~~ The ~~CCB~~CMA shall notify all providers on the Care Plan within one working day of discontinuation.

~~4.~~7.~~f.~~ The ~~CCB~~CMA shall notify the financial eligibility site within one working day after the denial or discontinuation.

~~5.~~8.~~g.~~ If a case is discontinued before an approved HCBS prior authorization request (PAR) has expired, the case manager shall submit to the Department, within five working days of discontinuation, a copy of the current PAR form on which the end date is adjusted and highlighted. The reason for discontinuation shall be noted on the form.

8.519.10.H. ~~9.~~ The ~~CCB~~CMA shall participate in the appeals process per 10 C.C.R. 2505-10, Section 8.057 et seq.

1. ~~a.~~ The ~~CCB~~CMA shall provide information to an applicant's parent(s) and/or legal guardian regarding appeal rights when he/she applies for the waiver or whenever such information is requested, whether or not an adverse action has been taken by the ~~CCB~~CMA.

2. ~~b.~~ The ~~CCB~~CMA shall attend an appeals hearing to defend a determination of enrollment, denial or discontinuation .

3. ~~c.~~ The ~~CCB~~CMA shall not attend an appeal hearing for a denial or discontinuation based on financial eligibility unless subpoenaed or requested by the Department.

8.519.1~~0~~1
PRIOR AUTHORIZATION REQUESTS

8.519.~~10~~11.A
~~.~~ The ~~CCB~~CMA shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CWA waiver.

1. ~~1.~~ All units of service requested shall be listed on the Care Plan form.

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

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

b. The assigned start date on the certification page of the ULTC Instrument.

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

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

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

3. ~~3.~~ The PAR shall not cover a period of time longer than that indicated on the ULTC ~~certification period assigned on the certification page of the ULTC 100~~Instrument~~.2 Form~~.

4. ~~4.~~ The ~~CCB~~CMA shall submit a revised PAR if a change in the Care Plan results in a change in type or amount of services.

a.~~a.~~ The revised Care Plan shall list the services being changed and state the reason for the change. Services on the revised Care Plan form, plus all services on the original Care Plan, shall be entered on the revised PAR.

b.~~b.~~ Revisions to the Care Plan requested by providers after the end date on a PAR shall be disapproved.

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

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

8.519.11

REIMBURSEMENT

8.519.11.A.
Reimbursement for ~~CCB~~CMA functions shall be determined by the number of clients served and the type of services provided and is subject to the availability of funds.

8.519.11.B.
~~P~~Providers shall be reimbursed at the lower of:

~~2.~~1.~~1.~~ Submitted charges; or

~~3.~~2.~~2.~~ A fee schedule as determined by the Department.

*****Redline Version Submitted to the MSB for Permanent Adoption in November *****

8.519 HOME AND COMMUNITY BASED SERVICES FOR CHILDREN WITH AUTISM WAIVER

8.519.1 DEFINITIONS

Assessment means a comprehensive and uniform process using the ULTC Instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, including ADLs and Instrumental Activities of Daily Living, health status and other factors relevant to determine the client's level of functioning. Assessment process includes collecting information from the client and appropriate collaterals pertaining to service needs, available resources, potential funding sources and includes supporting diagnostic information from a licensed medical professional.

Autism means the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests as set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000. No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000 is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

Benefits Utilization System (BUS) means the web based data system maintained by the Department for recording case management activities associated with Long Term Care (LTC) services.

Care 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 service and the expected outcome or purpose of such services.

Case Management means the evaluation of functional eligibility and other activities which may include assessment, service plan development, service plan implementation and service monitoring, the evaluation of service effectiveness, and the periodic reassessment of such client's needs. Case Management activities may also include assistance in accessing waiver, State Plan, and other non-Medicaid services and resources and ensuring the right to a Fair Hearing.

Case Management Agency (CMA) means an agency contracted by the Department to furnish case management services to applicants and clients within a designated service area. CMAs may include Single Entry Point (SEP) agencies, Community Centered Boards (CCB), and private case management agencies.

Continued Stay Review (CSR) means a periodic face to face review of a client's condition and service needs performed in the client's residence, by a case manager to determine a client's continued eligibility for LTC services.

Cost Containment means the cost of providing care in the community is less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services, Long Term Home Health services and Home Care Allowance.

Department means the Department of Health Care Policy and Finacing.

Functional Eligibility means an applicant or client meets the criteria for LTC services as determined by the Department's ULTC instrument.

Functional Needs Assessment means a component of the Assessment process which includes a comprehensive face-to-face evaluation using the ULTC Instrument to determine if the client meets the appropriate Level of Care (LOC).

Intake/Screening/Referral means the initial contact with an individual by the CMA and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services, referral to other programs or services and the need for the Assessment.

Lead Therapist means a qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.

Line Staff means a qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.

Senior Therapist means the qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.

Plan of Correction (POC) means a written plan submitted to and approved by the Department or the Department's designee includes the specific remediation and timeline that will correct identified deficiencies.

Prior Authorization Request (PAR) means the department prescribed form to authorize the reimbursement for services.

State Plan Benefit means the benefits the state covers in the operation of its Medicaid program. The State Plan is submitted to and approved by the Centers for Medicare and Medicaid acting on behalf of the Secretary for Health and Human Services.

Uniform Long Term Care (ULTC) Instrument means the Department prescribed form used to determine Functional Eligibility and medical verification for LTC services

Utilization Review (UR) means a system for prospective, concurrent, and retrospective review of the necessity and appropriateness of the allocation of supports and services to ensure the proper and efficient administration of Medicaid Long Term Care benefits. UR may use the ULTC Instrument and other assessment instruments as indicated by the Department and/or its designee.

8.519.2 BENEFITS

8.519.2.A. Home and Community Based Services for Children with Autism (HCBS-CWA) benefits shall be provided within Cost Containment.

8.519.2.B. Behavioral therapies shall be provided in a group or individual setting.

8.519.2.C. Behavioral therapies shall only be a benefit if they are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means. Behavioral therapies may include:

1. Intensive developmental behavioral therapies specifically created to meet the client's needs including conditioning, biofeedback or reinforcement techniques.

2. Treatment goals that are consistent with building elementary verbal skills, teaching imitation, establishing appropriate toy play or interactive play with other children, teaching appropriate expression of emotions and behaviors, and where necessary, reducing self stimulation and aggressive behaviors.

3. One-on-one behavior therapy between a client and a therapist following a specific protocol established by the Lead Therapist. Therapy may be implemented by a Lead Therapist, Senior Therapist, or Line Staff.

4. Training or modeling for parents or a guardian so that the behavioral therapies can continue in the home. Training or modeling shall be:

    a. Directed toward instruction on therapies and use of equipment specified in the Care Plan.

    b. Carried out in the presence of and for the direct benefit of the client.

8.519.2.D. Benefits shall be limited to three years, either contiguous or intermittent with a one-year extension based on medical necessity as stated by the client's physician and upon approval by the Department.

8.519.2.E. The annual cost of benefits per client shall not exceed $25,000 or available funds whichever is less.

8.519.3 NON-BENEFIT

8.519.3.A. Case Management shall not be a benefit of the HCBS-CWA waiver but shall be provided as an administrative activity through the CMA.

8.519.3.B. Speech therapy shall not be a benefit under behavior therapies.

8.519.4 CLIENT ELIGIBILITY

8.519.4.A. An eligible client shall:

1. Be determined financially eligible by the financial eligibility site in the county where the applicant resides.

2. Be determined to meet the definition of disability as defined by the Federal Social Security Administration.

3. Be at risk of institutionalization into an ICF/MR as determined by the Case Manager using the ULTC Instrument.

4. Be safely served in the community within Cost Containment as determined by the Case Manager.

5. Meet the target population criteria as follows:

    a. Has a diagnosis of Autism as certified by a physician.

    b. Has not yet reached six years of age.

8.519.4.B. A client shall receive at least one HCBS-CWA waiver benefit per month to maintain enrollment in the waiver. Case Management itself is not a benefit for purposes of satisfying the requirement to receive at least one benefit per month on the HCBS-CWA waiver.

8.519.4.C. A client who has not received at least one benefit on the HCBS-CWA waiver for a period of one month shall be discontinued from the waiver.

8.519.5 WAIT LIST

8.519.5.A. The number of clients who may be served through the waiver at any one time during a year shall be limited by the Department.

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

8.519.5.C. The Case Manager shall ensure the applicant meets all criteria as set forth in Section 8.519.4 prior to notifying the Department to place the applicant on the wait list.

8.519.5.D. The Case Manager shall notify the Department by entering the Assessment and Professional Medical Information Page data in the BUS.

8.519.5.E. The date and time of the ULTC Instrument, as entered in the BUS, shall be used to establish the order of an applicant's place on the wait list.

8.519.5.F. Within five working days of notification from the Department that an opening for the HCBS-CWA waiver is available the CMA shall:

1. Reassess the applicant for functional level of care using the ULTC Instrument if more than 6 months has elapsed since the previous assessment.

2. Update the existing ULTC Instrument in the BUS if more than six months has elapsed since the date of the previous.

3. Reassess for the target population criteria.

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

8.519.6 PROVIDER ELIGIBILITY [Emer. Rule eff. 12/14/2007]

8.519.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CWA waiver, meet the responsibilities as set forth in Section 8.519.7 and enter into an agreement with the Department as set forth in 10 C.C.R. 2505-10, Section 8.130. [Emer. Rule eff. 12/14/2007]

8.519.6.B. Providers shall enroll individually with the fiscal agent. [Emer. Rule eff. 12/14/2007]

8.519.6.C. Providers shall be employed by a qualified Medicaid provider agency, clinic or hospital except for a Lead Therapist who may provide services independent from a Medicaid provider agency when the Lead Therapist employs the Senior Therapist and Line Staff. [Emer. Rule eff. 12/14/2007]

8.519.6.D. Lead Therapists shall meet one of the following requirements: [Emer. Rule eff. 12/14/2007]

1. Have a doctoral degree with a specialty in psychiatry, medicine or clinical psychology and be actively licensed by the state board of examiners. Have completed 400 hours of training and/or have direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

2. Have a doctoral degree in one of the behavioral or health sciences and have completed 800 hours of specific training and/or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

3. Have a Master's degree, or higher, in behavioral sciences and be nationally certified as a "Board Certified Behavior Analyst" or certified Relationship Development Intervention (RDI) consultant or certified by a similar nationally recognized organization. [Emer. Rule eff. 12/14/2007]

4. Have a Master's degree or higher in one of the behavior or health sciences and certification as a School Psychologist; or licensed teacher with an endorsement of special education or early childhood special education; or licensed psychotherapy provider; or credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist) and have completed 1,000 hours of direct supervised training or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

8.519.6.E. The Lead Therapist shall assess the child and develop the treatment plan based on the child's individual needs. The Lead Therapist shall prescribe the amount, scope and duration of the therapy, make treatment adjustments and be responsible for treatment outcomes. The Lead Therapist shall be required to provide a written progress report for the case manager and the family every six months. [Emer. Rule eff. 12/14/2007]

8.519.6.F. Senior Therapists shall meet one of the following requirements: [Emer. Rule eff. 12/14/2007]

1. Have a Master's degree or higher in one of the behavior or health related sciences and have completed 1,000 hours of direct supervised training in the use of behavioral therapies that are

consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

2. Have a bachelor's degree or higher in a human services field and have completed at least 2,000 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

8.519.6.G. The senior therapist shall provide ongoing supervision and implementation of the treatment plan. This includes the supervision of line staff, training of the families and conducting team meetings with the family, line staff and other providers to review the child's progress. The senior therapist shall provide documentation of the location of the agency that is providing services, the time spent and the team members who participated in the delivery of services. [Emer. Rule eff. 12/14/2007]

8.519.6.H. Line Staff shall meet all of the following requirements: [Emer. Rule eff. 12/14/2007]

1. Be at least 18 years of age [Emer. Rule eff. 12/14/2007]

2. Have graduated from high school or earned a high school equivalency degree. [Emer. Rule eff. 12/14/2007]

3. Have or acquire 20 hours or more of direct supervised experience billable under the direction of a Lead or a Senior Therapist, in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities. [Emer. Rule eff. 12/14/2007]

4. Demonstrate understanding of the services and outcomes for children with Autism as attested to by the Lead Therapist or Senior Therapist. [Emer. Rule eff. 12/14/2007]

5. Have cleared the provider's background check at the time he/she is hired. [Emer. Rule eff. 12/14/2007]

8.519.6.I. The line staff shall be trained directly by the lead and/or senior therapist. The senior therapist is responsible for the line staff supervision and shall work with the line staff to implement the treatment plan. All services provided by the line staff shall be under the direction of the senior therapist and shall be documented. [Emer. Rule eff. 12/14/2007]

8.519.7 PROVIDER RESPONSIBLITIES

8.519.7.A. HCBS-CWA Providers shall have written policies and procedures regarding :

1. Recruiting, selecting, retaining and terminating employees.

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section 19-3-304 C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statues, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

    a. The Lead Therapist shall maintain a log of all complaints and critical incidents which shall include documentation of the resolution of the complaint or incident.

    b. The Lead Therapist shall communicate any critical incident via e-mail or fax to the Department within one business day.

8.519.7.B. CWA Providers shall:

1. Ensure a client is not discontinued or refused services unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure client records and documentation of services are made available at the request of the Case Manager.

3. Ensure that adequate records are maintained.

   a. Client records shall contain:

      i. Name, address, phone number and other identifying information for the client and the client's parent(s) and/or legal guardian(s).

      ii. Name, address and phone number of the CMA and the Case Manager.

      iii. Name, address and phone number of the client's primary physician.

      iv. Special health needs or conditions of the client.

      v. Documentation of the specific services provided which includes:

         1. Name of the individual provider.

         2. The location for the delivery of services.

         3. Units of service.

         4. The date, month and year of services and, if applicable, the beginning and ending time of day.

         5. Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.

         6. Documentation regarding supervision of benefits.

         7. Financial records for all claims, including documentation of services as set forth at 10 C.C. R. 2505-10, Section 8.040.02.

   b. Personnel records for each employee shall contain:

      i. Documentation of qualifications to provide behavioral therapies.

      ii. Documentation of training.

      iii. Documentation of supervision and performance evaluation.

      iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.519.7.B.

      v. A copy of the employee's job description.

8.519.8 CASE MANAGEMENT AGENCY ELIGIBILITY

8.519.8.A. In accordance with C.R.S. 25.5-6-804(5), A CMA shall enter into a contract with the Department to provide client Assessment, Case Management and Utilization Review.

8.519.8.B. The CMA shall have computer hardware and software, compatible with the Department's BUS, with capacity and capabilities as prescribed by the Department.

8.519.8.C. The CMA shall be certified annually in accordance with quality assurance standards and requirements set forth in 10 C.C.R. 2505-10, Section 8.079.2.

1. Certification of a CMA shall be based on a survey of each CMA's performance in the following areas:

   a. Quality of the Case Management services provided by the CMA to the clients based on the client satisfaction survey.

   b. Compliance with waiver requirements.

   c. Performance of administrative functions, including Cost Containment, timely reporting, on-site visits to clients, community outreach and client monitoring.

   d. Whether targeted populations are identified and served.

   e. Financial accountability .

   f. Retention of qualified personnel to perform the contracted duties.

2. The CMA shall receive denial, provisional approval or approval of certification based on the outcome of the certification survey.

3. In the event that the CMA does not meet the quality assurance standards, the CMA may receive provisional approval for certification for a period not to exceed 60 days provided the deficiencies do not constitute a threat to the health and safety of the clients.

   a. The CMA shall submit a Corrective Action Plan to address any deficiencies. Upon receipt and review of the Corrective Action Plan, provisional certification may be approved at the Department's discretion for a single additional 60 day period.

   b. If the Corrective Action Plan is not implemented successfully within the 60 day period, the service area will be assigned to another Department Approved CMA.

   c. The CMA may receive technical assistance from the Department to facilitate corrective action.

8.519.8.D. The Department or its designee shall conduct reviews of the CMA agency.

8.519.9 CMA RESPONSIBILITIES

8.519.9.A. The CMA shall, in a format and manner specified by the Department, be responsible for the collection and reporting of summary and client specific data including, but not limited, to information and referral services provided by the agency, waiver eligibility determination, financial eligibility determination, care planning, service authorization, fiscal accountability and utilization review.

8.519.9.B. The CMA shall maintain case records in accordance with Department requirements.

1. Case records shall be maintained for:

   a. Individuals for whom the CMA completed an intake for HCBS-CWA.

   b. Individuals who are HCBS-CWA clients.

2. Case records shall contain:

   a. Identifying information, including the client's Medicaid identification number and social security number.

   b. Identifying information referencing the client's parent(s) and/or legal guardian(s).

c. A copy of the ULTC Instrument and the Professional Medical Information Page (PMIP).

d. Documentation of the date on which the client referral was first received and dates of all actions taken thereafter by the CMA.

e. Documentation of all Assessment and target population criteria outcomes.

f. Documentation of all Case Management activities, the monitoring of service delivery, and service effectiveness.

g. Documentation that all Department required forms have the required signatures .

3. The CMA shall protect the confidentiality of all applicants and recipient records in accordance with section 26-1-114, C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statues, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

4. The CMA shall protect the confidentiality of all applicants and recipient records in accordance with and the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 C.F.R., Parts 160 and 164. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the federal privacy law, copyright 1996, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

5. The CMA shall obtain release of information forms from the client's parent(s) and/or legal guardian(s) which shall be signed, dated and renewed at least annually or when there is a change in benefit provider.

8.519.9.C. The CMA shall assure that each client's parent(s) and/or legal guardian(s):

1. Is fully informed of his/her rights and responsibilities.

2. Participates in the development and approval of the Care Plan and is provided a completed copy.

3. Is given a choice of service providers from qualified providers in the CMA district of his/her residence.

4. Is fully informed of and given access to a uniform complaint system as defined by the Department.

8.519.9.D. At least annually, the CMA shall conduct a client satisfaction survey which consists of surveying a sample of clients selected by the Department to determine their level of satisfaction with services provided by the CMA.

1. The random sample of clients shall include ten clients or ten percent of the CMA's average monthly HCBS-CWA caseload, whichever is higher.

2. If the CMA's average monthly HCBS-CWA caseload is less than ten clients, all clients shall be included in the survey.

3. The client satisfaction survey shall be on a Department approved form.

4. The results of the client satisfaction survey shall be made available to the Department.

8.519.9.E. The CMA shall not require clients to come to the agency's office to receive Assessments, Utilization Review services or Case Management services.

8.519.9.F. The CMA shall provide adequate staff to meet all service and administrative functions including:

1. The CMA shall have a system for recruiting, hiring, evaluating, and terminating employees that complies with all federal and state affirmative action and civil rights requirements.

2. The CMA shall employ at least one full time case manager.

3. The CMA shall have adequate support staff to maintain a computerized information system in accordance with the Department's requirements.

4. CMA staff shall attend training sessions as directed and/or provided by the Department at the Department's expense.

5. The CMA shall provide in-service and staff development training at the CMA's expense.

6. The supervisor and case manager shall meet minimum the following standards for education and/or experience:

   a. The case manager shall have at least a bachelor's degree in one of the human behavioral science fields or nursing.

   b. The supervisor shall meet all qualifications for a case manager and have a minimum of two years of experience in long term care.

   c. The CMA may request a waiver of these requirements from the Department prior to employing an individual when the CMA has been unable to secure the services of a qualified individual. The waiver shall be granted approval at the discretion of the Department.

8.519.10. CMA SERVICE FUNCTIONS

8.519.10.A. The CMA shall complete the following activities as a part of its Intake/Screening/Referral function:

1. Evaluate inquiries and address accordingly.

2. Determine the appropriateness of a referral for an Assessment.

3. Provide information and referral to other agencies as needed.

4. Obtain the applicant's parent(s)' and/or legal guardian(s)' signature on the ULTC Intake Form.

8.519.10.B. If a referral for HCBS-CWA waiver services is determined to be appropriate, the CMA shall complete the following activities as a part of its Assessment:

1. Initiate the ULTC Instrument within two working days of receiving a referral.

2. Identify potential payment source(s), including the availability of private funding resources.

3. Verify the applicant's financial eligibility status for Medicaid, or refer the applicant to the financial eligibility site in the applicant's county of residence to determine financial eligibility for Medicaid.

4. Notify the applicant's parent(s) and/or legal guardian(s) of his/her right to appeal adverse actions of the CMA, the Department, or contractors acting on behalf of the Department as set forth in 10 C.C.R. 2505-10, Section 8.057.

5. Obtain diagnostic information supplied from the Professional Medical Information Page from the applicant's medical provider, physician or nurse.

6. Determine the applicant's functional capacity during an Assessment through observation of the applicant and family in his/her residential setting.

7. Determine the applicant's service needs, taking into consideration services available or already being received from all funding sources.

8. Inform the applicant's parent(s) and/or legal guardian(s) of the right to choose enrollment in other HCBS waivers for which the applicant is qualified. Document on the Care Plan, the parent(s)' and/or legal guardian(s)' waiver selection preference.

9. Maintain appropriate documentation for certification of waiver eligibility.

10. Submit documentation, as determined by the Department, for authorization of services.

8.519.10.C. The CMA shall complete the following activities as a part of the Utilization Review function:

1. Log each ULTC form received and reviewed.

2. Score the client using the ULTC Instrument within one business day from the date of the Case Manager's Assessment.

3. Input an electronic copy of the Assessment on the BUS within 10 business days after completing the Assessment.

4. Notify the applicant's parent(s) and/or legal guardian(s) of the outcome of the Assessment with the Notice of Services Status (LTC 803) Form including:

   a. The Assessment outcome shall be based upon waiver requirements and the ULTC Instrument score and shall determine if a client is approved or denied for enrollment or continued stay in the waiver.

   b. When the Assessment outcome is a denial for enrollment in the waiver, the CMA shall notify the applicant's parent(s) and/or legal guarding in accordance with 10 C.C. R. 2505-10, Section 8.057.

5. The CMA shall develop the Care Plan upon completion of the Assessment and prior to authorizing services. The CMA shall complete the Care Plan and all required paperwork within 15 business days upon eligibility determination. Care planning shall include, but not be limited to:

   a. Identifying and documenting Care Plan goals made with the participation of the client's parent(s) and/or legal guardian(s).

   b. Identifying and documenting services needed including the type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but not available.

   c. Documenting a client's parent(s)' and/or legal guardian(s)' selection of qualified providers.

8.519.10.D. The CMA shall complete a CSR of a client within 12 months of the initial Assessment or the previous CSR. The CSR shall be completed not more than three months before the end of the current certification period. A CSR shall be completed sooner if the client's condition changes.

1. A CSR shall include but not be limited to the following activities:

a. Obtain an update of the Professional Medical Information Page from the client's physician.

b. Assess a client's functional status face-to-face at the client's place of residence using the ULTC Instrument.

c. Update the Care Plan and provider contacts.

d. Evaluate service effectiveness, quality of care and appropriateness of services.

e. Verify continuing Medicaid financial and waiver eligibility.

f. Inform the client's Lead Therapist of any changes in the client's needs.

g. Refer the client to community resources as needed and develop resources for the client to the extent that the resource can be made available in the community.

8.519.10.E. The CMA shall authorize services

1. The CMA shall Submit the PAR to the Department or the Department's designees to approve the authorization of services and provider reimbursement.

2. The CMA shall be financially responsible for any services authorized which do not meet the requirements as set forth in Section 8.519 et. seq., or which are rendered by a provider due to the CMA's failure to timely notify the provider that the client is no longer eligible for services.

8.519.10.F The CMA shall provide on-going Case Management for a client as defined below:

1. On-going Case Management shall include, but not be limited to:

a. Review the Care Plan.

b. Contact the client's parent(s) and/or legal guardian(s) concerning the satisfaction with services provided.

c. Contact the service providers concerning their effectiveness and appropriateness regarding their service coordination.

d. Investigate complaints raised by the client's parent(s) and/or legal guardian(s) concerning the service providers.

e. Contact the appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client's parent(s) and/or legal guardian(s).

f. Resolve conflict or crisis related to the waiver benefit or Medicaid state plan service delivery, as needed.

g. Assess changes in the client's functioning, service effectiveness, service appropriateness and service cost-effectiveness.

h. Refer to community resources as needed.

2. The CMA shall contact the client's parent(s) and/or legal guardian(s) at least monthly or more frequently as determined by the client's needs.

3. The CMA shall review and update the ULTC Instrument and Care Plan, with the client's parent(s) and/or legal guardian(s) as required by a significant change in the client's condition. The review shall be conducted by telephone or at the client's place of residence, place of service or other appropriate setting as determined by the client's needs.

4. The CMA shall contact the service providers to monitor service delivery at least every three months, as required by the client's needs or the specific service requirements.

5. If the CMA suspects a client to be a victim of abuse, neglect or exploitation, the CMA shall immediately refer the client to the protective services section of the county department of social services in the client's county or residence and/or the local law enforcement agency.

6. The CMA shall immediately report any information that indicates an overpayment, incorrect payment or misuse of any public assistance benefit to the Department. The CMA and case manager shall cooperate with the appropriate agency in any subsequent recovery process in accordance with the 10 C.C.R. 2505-10, Section 8.076.

8.519.10.G. The CMA shall complete Denials and discontinuations.

1. The CMA shall notify the client's parent(s) and/or legal guardian(s) within one working day of determining the client no longer meets waiver requirements.

2. A client shall be notified of the denial/discontinuation by the CMA on the Department prescribed LTC 803 form if he/she is determined ineligible due to any of the following reasons:

   a. The client no longer meets all of the criteria set forth at Sections 8.519.4.

   b. The client exceeds the limitations set forth at Sections 8.519.2.E and 8.519.2.F.

   c. The client's parent(s) and/or legal guardian(s) has twice in a 30 day consecutive period, refused to schedule an appointment for an Assessment or Case Management visit.

   d. The client's parent(s) and/or legal guardian(s) has failed to keep three scheduled provider appointments in a 30 day period.

   e. The client's parent(s) and/or legal guardian(s) fails to sign the Intake, Care Plan, Release of Information, or other forms as required.

3. The CMA shall notify a client's parent(s) and/or legal guardian(s) of the denial or discontinuation of services using the Department prescribed advisement letter for reasons not related to enrollment criteria:

   a. A client who moves out of Colorado shall be discontinued effective upon the day after the date of the move.

   b. A client whose parent(s) and/or legal guardian(s) voluntarily withdraws the client from the waiver shall be discontinued effective upon the day after the date on which the request is documented, or the date on which the client enters a long term care institution or another HCBS waiver.

4. The CMA shall not send notification when the denial or discontinuation is due to the death of the client. A client who dies shall be discontinued from the waiver, effective upon the day after the date of death.

5. The case manager shall provide the client with appropriate referrals to other community resources, as needed, within one working day of discontinuation.

6. The CMA shall notify all providers on the Care Plan within one working day of discontinuation.

7. The CMA shall notify the financial eligibility site within one working day after the denial or discontinuation.

8. If a case is discontinued before an approved HCBS prior authorization request (PAR) has expired, the case manager shall submit to the Department, within five working days of

discontinuation, a copy of the current PAR form on which the end date is adjusted and highlighted. The reason for discontinuation shall be noted on the form.

8.519.10.H. The CMA shall participate in the appeals process per 10 C.C.R. 2505-10, Section 8.057 et seq.

1. The CMA shall provide information to an applicant's parent(s) and/or legal guardian(s) regarding appeal rights when he/she applies for the waiver or whenever such information is requested, whether or not an adverse action has been taken by the CMA.

2. The CMA shall attend an appeals hearing to defend a determination of enrollment, denial or discontinuation .

3. The CMA shall not attend an appeal hearing for a denial or discontinuation based on financial eligibility unless subpoenaed or requested by the Department.

8.519.11 PRIOR AUTHORIZATION REQUESTS

8.519.11.A The CMA shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CWA waiver.

1. All units of service requested shall be listed on the Care Plan form.

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

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

   b. The assigned start date on the certification page of the ULTC Instrument.

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

3. The PAR shall not cover a period of time longer than that indicated on the ULTC Instrument.

4. The CMA shall submit a revised PAR if a change in the Care Plan results in a change in type or amount of services.

   a. The revised Care Plan shall list the services being changed and state the reason for the change. Services on the revised Care Plan form, plus all services on the original Care Plan, shall be entered on the revised PAR.

   b. Revisions to the Care Plan requested by providers after the end date on a PAR shall be disapproved.

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

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

8.519.11 REIMBURSEMENT

8.519.11.A. Reimbursement for CMA functions shall be determined by the number of clients served and the type of services provided and is subject to the availability of funds.

8.519.11.B. Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.