THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to Medical Assistance Board Rule Concerning Provider Appeals, Section 8.050.1
Rule Number:	MSB 10-10-15-A
Division / Contact / Phone:	Claims Systems and Operations / Challon Winer / 303-866-3182

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 10-10-15-A, Revision to Medical Assistance Board Rule Concerning Provider Appeals, Section 8.050.1
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.050.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please replace current text at §8.050.1.2.a through c. with the new text provided. All other text included is for purposes of clarification only. This change is effective March 2, 2011.

*to be completed by MSB Board Coordinator

Title of Rule:	Revision to Medical Assistance Board Rule Concerning Provider Appeals, Section 8.050.1
Rule Number:	MSB 10-10-15-A
Division / Contact / Phone:	Claims Systems and Operations / Challon Winer / 303-866-3182

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 current rule requires the Department to send notices by USPS mail unless the provider specifically chooses to receive notices by electronic means only. By changing the rule to provide electronic notices to all providers by default, with the option for providers to choose to continue receiving USPS mail notices, the Department will reduce mailing expenses and allow for easier and more rapid dissemination of information.

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:

   No emergency rule is necessary

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

Initial Review	**12/10/2010**	Final Adoption	**01/14/2011**
Proposed Effective Date	**03/02/2011**	Emergency Adoption	

DOCUMENT #04

Title of Rule:	Revision to Medical Assistance Board Rule Concerning Provider Appeals, Section 8.050.1
Rule Number:	MSB 10-10-15-A
Division / Contact / Phone:	Claims Systems and Operations / Challon Winer / 303-866-3182

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.

   In addition to the Department, providers will be the class of persons affected by the change to this rule. Both Providers and the Department will benefit from the faster and less expensive dissemination of information through electronic means. Those providers wishing to continue to receive notices through USPS mail will bear the responsibility for notifying the Department of their desire to do so by updating their information of the Provider Update Form on the Department's Web site. This change would impact the transmission of all notices or other information the Department sends providers.

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

   This rule will reduce the cost to the Department of printing and mailing provider notices to providers that do not choose to receive notices through electronic means, and those that wish to continue to receive such notices through the USPS mail must notify the Department of their wish to do so. Electronic transmission of these notices will ensure a more timely delivery to the providers, make distribution amongst the provider's staff and other interested parties far easier and reduce paper waste. Without knowledge of the number of providers who will choose to continue receiving USPS mail notices, it is not practicable for the Department to calculate the exact amount of the savings generated from the implementation of this rule.

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 intent of this rule change is to reduce the cost of providing the notices required under the existing rule 8.050 by making the receipt of USPS mail notices a choice instead of the default option. The rule already allows for the electronic transmission of notices, so there will be no substantial system changes required or costs incurred to realize the savings that occur from the adoption of this rule.

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

If the rule is not changed, the Department will continue to incur the costs related to printing and mailing the notices to all providers who have not chosen to receive notices through electronic transmission. Enacting this change will allow the Department to reduce the number of providers who receive paper mail notices because they have not had the time to request receipt of the notices in electronic format.

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

   This proposed rule change will result in a cost savings to the Department and will have minimal impact on the effected providers.

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

   This change will modify what the default method is for the transmission of notices under the rule. The only other alternative was to rely completely on electronic transmission of notices, but this option was rejected because some providers are not comfortable with electronic transmission and others may not have the capability to receive such notices.

8.050 PROVIDER APPEALS

8.050.1 DEFINITIONS [Eff. 12/30/2008]

1. Adverse Action means:

   a. An adverse action means a finding of fact or interpretation of rules that results in a determination that goods or services were not medically necessary; results in identification of overpayments; or results in a reduction in, or denial of, other specific payments under the Medical Assistance program; or

   b. The denial, non-renewal or termination of a Provider agreement; or

   c. Denial of the application or request for additional information regarding an application pursuant to 10 C.C.R. 2505-10, Section 8.430.

2. Mailed means caused to be directed, transmitted, or made available and includes, but shall not be limited to:

   a. The use of the United States Postal Service, when requested by the provider;

   b. The use of electronic mail (e-mail) ~~when agreed to by the provider~~;

   c. Making a notice available for retrieval through the Internet or an internet application, **as long as notification of the availability is provided through e-mail** ~~when agreed to by the provider~~;

   d. The use of private courier or delivery services; and

   e. The use of facsimile (fax) machines.

3. Medical assistance shall have the meaning defined in 25.5-1-103(5), C.R.S.

4. Provider means any person, public or private institution, agency, or business concern that:

   a. Provides medical or remedial care, services or goods authorized under the Medical Assistance program;

   b. Holds, where applicable, a current valid license or certificate to provide such services or to dispense such goods; and

   c. Is enrolled in the Medical Assistance program.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Consumer Directed Attendant Support Services (CDASS) Rule Section 8.510.
Rule Number:	MSB 10-07-10-A
Division / Contact / Phone:	Long Term Care Benefits / 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 10-07-10-A, Revision to the Consumer Directed Attendant Support Services (CDASS) Rule Section 8.510.
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) 8.510, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). No

PUBLICATION INSTRUCTIONS*

This is a complete rule rewrite. Please delete existing text from §8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES through the end of §8.510.15.A. In its place, please insert new text provided from §8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES through the end of §8.510.16.E.

This change is effective 03/02/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Consumer Directed Attendant Support Services (CDASS) Rule Section 8.510.
Rule Number:	MSB 10-07-10-A
Division / Contact / Phone:	Long Term Care Benefits / Michelle Rogers / *3895

STATEMENT OF BASIS AND PURPOSE

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

This rule provides revised regulations for the Consumer Directed Attendant Support Services, a consumer directed service model authorized by 25.5-6-1100, C.R.S. The primary components of the rule revision include: more definite instruction to Case Managers regarding their duties and processes; clarification to clients regarding eligibility, services, and management of CDASS; more requirements for Attendants and Authorized Representatives who assist clients on CDASS; set limits on client allocations and wages paid to attendants to maintain cost neutrality; defined start of service procedures to eliminate discrepancies between client timesheets and Fiscal Management Service Provider (PPL) payments to Medicaid; and a defined termination processes to discontinue CDASS for clients unable to manage the program or committing fraud and abuse

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. Section 1315

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25.5-6-1101 et seq.: consumer directed services model, 25.5-6-307 (j) and 25.5-6-606.

Initial Review	**12/10/2010**	Final Adoption	**01/14/2011**
Proposed Effective Date	**03/02/2010**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Consumer Directed Attendant Support Services (CDASS) Rule Section 8.510.
Rule Number:	MSB 10-07-10-A
Division / Contact / Phone:	Long Term Care Benefits / 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.

   The rule will affect CDASS clients, CDASS attendants, the Fiscal Management Service, and Case Managers.

   The rule limits clients to spend within their established allocation. The rule allows case managers to find alternate care solutions for clients who cannot manage their care within their budget. The rule sets limits on the wages Attendants may be paid.

   The Case Managers have a more defined role and process to provide oversight for the CDASS option. Services will be more consistently applied on a statewide basis.

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

   Clients are assessed for a level of need and authorized an allocation amount that should cover the Long Term Care needs of the client. Services should not be limited because of this rule.

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

   The Department should see a cost savings with the enforcement of the proposed rule. By no longer allowing clients to overspend the allocations they are given, the Department will be within the prior authorized cost of CDASS for each client.

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

Information provided by the Department's fiscal intermediary has shown that wage rates set by clients are highly variable, and can change as often as weekly. In the three major categories of services, between 12% and 21% of wages are set at $20 per hour or higher. Further, some clients are setting wage rates far beyond what the Department would otherwise pay for these services – in some cases, as much as $100 per hour.

In calendar year 2009, the Department's cost for an average client enrolled in the traditional home and community based services waiver for elderly, blind, and disabled (HCBS-EBD) was 22.2% of a client enrolled in the HCBS-EBD CDASS option. In order to reduce costs in the

CDASS program, the Department will impose wage rate caps based on its current rates for similar services in the HCBS-EBD waiver, including homemaker, personal care, and health maintenance. However, the actual wage caps will be set after the Department solicits stakeholder input. Because the Department cannot yet predict the wage rate caps, it has set a target savings rate of 3.5% of total expenditure. The Department believes this savings amount is achievable based on currently available information on wage rates and expenditure.

The Department estimates that the policy would reduce fee-for-service expenditure by $1,420,692 total funds, $710,346 General Fund in FY 2011-12, and annualize to a reduction of $1,677,708 total funds, $838,854 General Fund in FY 2012-13.

Should the rule not be implemented, the CDASS option and the HCBS-EBD waiver may no longer show cost neutrality, which endangers the FMAP for these programs.

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

   The alternative to inaction is no longer offering a Consumer Directed option for clients. The option is potentially less costly but moves the State of Colorado away from the least restrictive option for care that Colorado is striving for. If CDASS were to be no longer offered, clients would be placed in agency based models of care.

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.

   Because the rule is a complete rewrite, there are many options for writing the rule. The Department has worked extensively with clients and Case Managers to best fit the needs of the stakeholders and the Department. The rule is intended to be a starting point for improving the CDASS service option.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

Adaptive Equipment means a device(s) that is used to assist with completing activities of daily living.

Allocation means the funds determined by the case manager and made available by the Department to clients receiving Consumer Directed Attendant Support Services (CDASS) and administered by the Fiscal Management Services (FMS) authorized for attendant support services and administrative fees paid to the FMS.

Attendant means the individual who meets qualifications in § 8.510.8 who provides CDASS as determined by § 8.510.3 and is hired through the contracted FMS organization.

Attendant Support Management Plan (ASMP) means the documented plan for clients to manage their care as determined by § 8.510.4 which is reviewed and approved by the Case Manager.

Authorized Representative (AR) means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to direct CDASS on a client's behalf and meets the qualifications as defined at § 8.510.6 and § 8.510.7.

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.

Case Management Agency (CMA) means a Department approved agency within a designated service area where an applicant or client can obtain Long Term Care case management services.

Case Manager means an individual who meets the qualifications to perform case management activities by contract with the Department.

Consumer Directed Attendant Support Services (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care, and homemaker activities.

CDASS Training means the required training, including a final, comprehensive assessment, provided by the Department or its designee to a client/AR who is interested in directing CDASS.

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

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.

Department means the Department of Health Care Policy and Financing

Eligibility means a client qualifies for Medicaid based on the applicable eligibility category and the client's individual financial circumstances, including, but not limited to, income and resources.

Fiscal Management Services organization (FMS) means the entity contracted with the Department as the employer of record for Attendants, to provide personnel management services, fiscal management services, and skills training to a client/AR receiving CDASS.

Functional Eligibility means an applicant or client meets the criteria for LTC services as determined by the Department's prescribed instrument as outlined defined in § 8.401.

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

Home and Community Based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to clients in community settings. These services are designed to help older persons and persons with disabilities remain living at home.

Inappropriate Behavior means offensive behavior which includes: documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language over a period of time.

Licensed Medical Professional means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses: physician, physician assistant and nurse governed by the Colorado Medical License Act.

Long Term Care (LTC) services means Nursing Facilities, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), Home and Community Based Services (HCBS), Long Term Home Health or the Program of All-inclusive Care for the Elderly (PACE), Swing Bed and Hospital Back Up Program (HBU).

Long Term Care Certification Period means the designated period of time in which a client is functionally eligible to receive LTC services not to exceed one year.

Prior Authorization Request (PAR) means the Department prescribed form that assures the provider that the service is medically necessary and a Colorado Medical Assistance Program benefit.

Notification means the routine methods in which the Department or its designee conveys information about CDASS. Including but not limited to the CDASS web site, client statements, Case Manager contact, or FMS contact.

Reassessment means a review of the Assessment, to determine and document a change in the client's condition and/or client's service needs.

Stable Health means a medically predictable progression or variation of disability or illness.

8.510.2 Eligibility

8.510.2.A. To be eligible for CDASS, an individual shall meet all of the following:

1. Choose the CDASS service delivery option
2. Meet medical assistance Financial Eligibility requirements
3. Meet Long Term Care Functional Eligibility requirements
4. Be eligible for an HCBS Waiver with the CDASS option
5. Demonstrate a current need for Attendant support
6. Document a pattern of stable health that necessitates a predictable pattern of Attendant support and appropriateness of CDASS services

7. Provide a statement from the primary care physician attesting to the client's ability to direct his or her care with sound judgment or a required AR with the ability to direct the care on the client's behalf

8. Complete all aspects of the ASMP and training and demonstrate the ability to direct care or have care directed by an AR

8.510.3 CDASS SERVICES

8.510.3.A Covered services shall be for the benefit of only the client and not for the benefit of other persons living in the home.

8.510.3.B Services include:

1. Homemaker. General household activities provided by an Attendant in a client's home to maintain a healthy and safe environment for the client. Homemaker activities shall be applied only to the permanent living space of the client and multiple attendants may not be reimbursed for duplicating household tasks. Tasks may include the following activities or teaching the following activities:

    a. Routine light housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas

    b. Meal preparation

    c. Dishwashing

    d. Bed making

    e. Laundry

    f. Shopping for necessary items to meet basic household needs

2. Personal care. Services furnished to an eligible client in the client's home to meet the client's physical, maintenance, and supportive needs. Including:

    a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as forks, knives, and straws

    b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling the distilled water reservoir, and moving the cannula or mask from the client's face

    c. Skin care preventative in nature when skin is unbroken; including the application of non-medicated/non-prescription lotions and/or sprays and solutions, rubbing of reddened areas, and routine foot checks for people with diabetes

    d. Bladder/Bowel Care:

        i) Assisting client to and from the bathroom

        ii) Assistance with bed pans, urinals, and commodes

        iii) Changing of incontinence clothing or pads

iv) Emptying Foley or suprapubic catheter bags only if there is no disruption of the closed system

v) Emptying ostomy bags

e. Personal hygiene:

i) Bathing including washing, shampooing, and shaving

ii) Grooming

iii) Combing and styling of hair

iv) Trimming, cutting, and soaking of nails

v) Basic oral hygiene and denture care

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings and application of orthopedic devices such as splints and braces or artificial limbs

g. Transferring a client when the client has sufficient balance and strength to assist with and can direct the transfer

h. Assistance with mobility

i. Positioning when the client is able to verbally or non-verbally identify when the position needs to be changed including simple alignment in a bed, wheelchair or other furniture

j. Assistance with self administered medications when the medications have been preselected by the client, a family member, a nurse or a pharmacist and are stored in containers other than the prescription bottles, such as medication minders and medication reminding:

i) Medication minders must be clearly marked as to the day and time of dosage and must be kept in a way as to prevent tampering

ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable

k. Cleaning and basic maintenance of durable medical equipment

l. Protective oversight when the client requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property

m. Accompanying includes going with the client, as necessary on the care plan, to medical appointments, and errands such as banking and household shopping. Accompanying the client to provide one or more personal care services as needed during the trip. Companionship is not a benefit of CDASS

3. Health Maintenance Activities. Routine and repetitive health related tasks, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include:

   a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional

   b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation

   c. Mouth care performed when:

      i) there is injury or disease of the face, mouth, head or neck

      ii) in the presence of communicable disease

      iii) the client is unconscious

      iv) oral suctioning is required

   d. Dressing including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary

   e. Feeding:

      i) When oral suctioning is needed on a stand-by or other basis

      ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study

      iii) Syringe feeding

      iv) Feeding using apparatus

   f. Exercise prescribed by a licensed medical professional including passive range of motion

   g. Transferring a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed

   h. Bowel care provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist

   i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters

   j. Medical management required by a medical professional to monitor: blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections

k. Respiratory care:

i) Postural drainage

ii) Cupping

iii) Adjusting oxygen flow within established parameters

iv) Suctioning of mouth and nose

v) Nebulizers

vi) Ventilator and tracheostomy care

vii) Prescribed respiratory equipment

8.510.4 ATTENDANT SUPPORT MANAGEMENT PLAN

8.510.4.A The client/AR shall develop a written ASMP which shall be reviewed by the FMS and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date. The ASMP is required by the FMS upon initial training and shall be modified when there is a change in the client's needs. The plan shall describe the individual's:

1. Current health status

2. Needs and requirements for CDASS

3. Plans for securing CDASS

4. Plans for handling emergencies

5. Assurances and plans regarding direction of CDASS Services, as described at 10 CCR 2505 -10, § 8.510.3 and § 8.510.6 if applicable

6. Plans for management of the budget within the client's Individual Allocation

7. Designation of an Authorized Representative

8. Designation of regular and back-up employees approved for hire

8.510.4.B. If ASMP is disapproved by the Case Manager, the client has the right to review that disapproval. The client shall submit a written request to the CMA stating the reason for the review and justification of the proposed ASMP. The client's most recently approved ASMP shall remain in effect while the review is in process.

8.510.5 TRAINING ACTIVITIES

8.510.5.A. When necessary to obtain the goals of the ASMP, the client/AR shall verify that each attendant has been or will be trained in all necessary health maintenance activities prior to performance by the attendant.

8.510.5. B The verification requirement of 8.510.5.A above will be on a form provided by the FMS and returned to the FMS with the client/AR completed employment packet.

8.510.6 CLIENT/AR RESPONSIBILITES

8.510.6.A. Client/AR responsibilities for CDASS Management:

1. Attend FMS Training; clients who cannot attend training shall designate an AR
2. Develop an ASMP
3. Determine wages for each Attendant not to exceed the rate established by the Department
4. Determine the required credentials for Attendants
5. Establish hiring agreements, as required by the FMS with each Attendant, outlining wages, services to be provided (limited to Personal Care, Homemaker or Health Maintenance Activities), schedules and working conditions
6. Ensure FMS receives hiring agreements prior to Attendants providing services
7. Completing previous employment reference checks on Attendants
8. Follow all relevant laws and regulations applicable to client's supervision of Attendants
9. Explain the role of the FMS to the Attendant
10. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation
11. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and client/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS services
12. Review and submit approved Attendant timesheets to FMS by the established timelines for Attendant reimbursement
13. Authorize the FMS to make any changes in the Attendant wages
14. Understand that misrepresentation or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. Client/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS
15. Completing and managing all paperwork and maintaining employment records

8.510.6.B. Client/AR responsibilities for CDASS Services:

1. Recruit, hire, fire and manage Attendants
2. Train Attendants to meet client needs
3. Terminate Attendants who are not meeting client needs

8.510.6.C. Client/AR responsibilities for Verification:

1. Sign and return a responsibilities acknowledgement form for activities listed in 8.510.6 and to the Case Manager.

8.510.6.D. Clients receiving CDASS services have the following Rights:

1. Right to receive instruction on managing CDASS

2. Right to receive program materials in accessible format

3. Right to receive notification of changes to CDASS

4. Right to participate in Department sponsored opportunities for input.

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

6. A client/AR may request a re-assessment, as described at § 8.390.1 (N), if his or her level of service needs have changed.

7. A client/AR may revise the ASMP at any time with CM approval. CM shall notify FMS of changes.

8.510.7 AUTHORIZED REPRESENTATIVES

8.510.7.A. CDASS clients who require an AR may not serve as an AR for another CDASS client.

8.510.7.B. Authorized Representatives shall not receive reimbursement for AR services and shall not be reimbursed for CDASS services as an Attendant for the client they represent.

8.510.8 ATTENDANTS

8.510.8.A. Attendants shall be at least 18 years of age and demonstrate competency in caring for the client to the satisfaction of the client/AR.

8.510.8.B. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more clients collectively.

8.510.8.C. Authorized Representatives shall not be employed as an Attendant for the client.

8.510.8.D. Attendants must be able to perform the tasks on the Service Plan they are being reimbursed for and the client must have adequate Attendants to assure compliance with all tasks on the service plan.

8.510.8.E. Attendants shall not represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse.

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

8.510.8.G. The FMS shall be the employer of record for all Attendants. The FMS shall comply with all laws including those regarding worker's compensation insurance, unemployment compensation insurance, withholding of all federal and state taxes, compliance with federal and state laws regarding overtime pay and minimum wage requirements. The FMS shall comply with Department regulations at 10 CCR 2505 and the contract with the Department.

8.510.8.H. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the client/AR not to exceed the amount established by the Department. The FMS shall make all payments from the client's Individual Allocation under the direction of the client/AR within the limits established by the Department.

8.510.8.I. Attendants may not attend FMS training during instruction.

8.510.9 START OF SERVICES

8.510.9.A. The start date shall not occur until all of the requirements defined at 10 C.C.R. 2505-10, § 8.510.2, 8.510.4, 8.510.5, 8.510.6 and 8.510.8 have been met.

8.510.9.B. The Case Manager shall approve the ASMP, establish a certification period, submit a PAR and receive a PAR approval before a client is given the start date and can begin CDASS.

8.510.9.C. The FMS shall process the Attendant's employment packet within the Department's prescribed timeframe and ensure the client has a minimum of two approved Attendants prior to starting CDASS.

8.510.9.D. The FMS will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS provides the client/AR with an employee number and confirms employment status.

8.510.9.E. If a client is transitioning from a Hospital, Nursing Facility, or HCBS agency services the CM shall coordinate with the Discharge Coordinator to ensure the discharge date and CDASS start date correspond.

8.510.10 SERVICE SUBSTITUTION

8.510.10.A. Once a start date has been established for CDASS, the Case Manager shall establish an end date and disenroll the individual from any other Medicaid-funded Attendant support including home health effective as of the start date of CDASS.

8.510.10.B. Case Managers shall not authorize, on the PAR, concurrent payments for CDASS and other waiver service delivery options for Personal Care services, Homemaker services, and Health Maintenance Activities for the same individual.

8.510.10.C. Clients may receive up to sixty days of Medicaid acute home health agency based services directly following acute episodes as defined by 8.523.11. Client allocations shall not be changed for sixty days in response to an acute episode unless acute home health services are unavailable. If acute home health is unavailable, a client's allocation may be temporarily adjusted to meet a client's need.

8.510.10.D. Clients may receive Hospice services in conjunction with CDASS services. CDASS service plans shall be modified to ensure no duplication of services.

8.510.11 ENDING CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.11.A. If an individual chooses to use an alternate care option, an institutional setting, or is terminated involuntarily, a client will be terminated from CDASS when the Case Manager has secured an adequate alternative to CDASS in the community.

8.510.11.B. Prior to a client being terminated for reasons other than those listed in section 8.510.13, the following steps may be taken:

1. Mandatory re-training conducted by the FMS

2. Required designation of an AR if one is not in place, or mandatory re-designation of an AR if one has already been assigned

3. Discontinuation according to the following:

   i) The notice shall provide the client/AR with the reasons for termination and with information about the client's rights to fair hearing and appeal procedures, in accordance with 10 C.C.R. 2505-10, § 8.057. Once notice has been given for termination, the client/AR shall contact the Case Manager for assistance in obtaining other home care services. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS services and begin alternate care services. Exceptions may be made to the thirty (30) day advance notice requirement when the Department has documented that there is danger to the client or to the Attendant(s). The Case Manager shall notify the FMS of the date on which the client is being terminated from CDASS.

8.510.12 TERMINATION

8.510.12.A. Clients may be terminated for the following reasons:

1. The client/AR fails to comply with CDASS program requirements

2. The client/AR demonstrates an inability to manage Attendant support

3. A client/AR no longer meets program criteria due to deterioration in physical or cognitive health

4. The client/AR spends the monthly Allocation in a manner indicating premature depletion of funds

5. The client's medical condition causes an unsafe situation for the client, as determined by the treating physician

6. The client provides false information or false records as determined by the Department

8.510.12.B Clients who are terminated according to § 8.510.12 may be re-enrolled for future CDASS service delivery

8.510.13 INVOLUNTARY TERMINATION

8.510.13.A. Clients may be involuntarily terminated for the following reasons:

1. A client/AR no longer meets program criteria due to deterioration in physical or cognitive health AND refuses to designate an AR to direct services

2. The client/AR demonstrates a consistent pattern of overspending their monthly Allocation leading to the premature depletion of funds AND the Department has determined that adequate attempts to assist the client/AR to resolve the overspending have failed

3. The client/AR exhibits Inappropriate Behavior toward Attendants, Case Managers, or the FMS, and the Department has determined that the FMS has made adequate attempts to assist the client/AR to resolve the Inappropriate Behavior, and those attempts have failed

4. Documented misuse of the monthly Allocation by client/AR has occurred

5. Intentional submission of fraudulent CDASS documents to Case Managers, the Department or the FMS

6. Instances of convicted fraud and/or abuse

8.510.13.B. Termination may be initiated immediately for clients being involuntarily terminated

8.510.13.C. Clients who are involuntarily terminated according to § 8.510.13 may not be re-enrolled in CDASS as a service delivery option.

8.510.14 CASE MANAGEMENT FUNCTIONS

8.510.14.A. The Case Manager shall review and approve the ASMP completed by the client/AR. The Case Manager shall notify the client/AR of the approval and establish a certification period and Allocation.

8.510.14.B. If the Case Manager determines that the ASMP is inadequate to meet the client's CDASS needs, the Case Manager shall assist the client/AR with further development of the ASMP.

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

1. Calculate the number of Personal Care, Homemaker, and Health Maintenance Activities hours needed on a monthly basis using the Department prescribed method. The needs determined for the Allocation should reflect the needs in the ULTC assessment tool and the service plan. The Case Manager shall use the Departments established rate for Personal Care, Homemaker, and Health Maintenance Activities to determine the client's Allocation.

2. The Allocation should be determined using the Department prescribed method at the initial enrollment and at CSR, and should always match the client's need for services.

8.510.14.D. Prior to FMS training or when an allocation changes, the Case Manager shall provide written notification of the Individual Allocation to each client.

8.510.14.E. A client/AR who believes he or she needs a change in Attendant support, may request the Case Manager to perform a reassessment. If the reassessment indicates that a change in Attendant support is justified, the client/AR shall amend ASMP and the Case Manager shall complete a PAR revision indicating the increase and submit it to the Department's fiscal agent. The Case Manager shall provide notice of the change to client/AR and make changes in the BUS.

8.510.14.F. In approving an increase in the individual Allocation, the Case Manager shall consider all of the following:

1. Any deterioration in the client's functioning or change in the natural support condition

2. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services

3. The appropriate use and application of funds to CDASS services

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

1. Improvement of functional condition or changes in the available natural supports

2. Inaccuracies or misrepresentation in previously reported condition or need for service

3. The appropriate use and application of funds to CDASS services

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

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

1. Contact the CDASS client/AR once a month during the first three months to assess their CDASS management, their satisfaction with care providers and the quality of services received. Case Managers may refer clients to the FMS for assistance with payroll and budgeting

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

3. Contact the client/AR when a change in AR occurs and contact the client/AR once a month for three months after the change takes place

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

5. Utilize Department overspending protocol when needed to assist clients

8.510.14.J. Reassessment: For clients receiving CDASS, the Case Manager shall conduct an interview with each client/AR every six months and at least every 12 months, the Interview shall be conducted face to face. The interview shall include review of the ASMP and documentation from the physician stating the client/AR's ability to direct care.

8.510.15 ATTENDANT REIMBURSEMENT

8.510.15.A. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the client/AR hiring the Attendant. The FMS shall make all payments from the client's Individual Allocation under the direction of the client/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified on the ASMP.

8.510.15.B. Once the client's yearly Allocation is used, further payment will not be made by the FMS, even if timesheets are submitted. Reimbursement to Attendants for services provided when a client is no longer eligible for CDASS or when the client's Allocation has been depleted are the responsibility of the client.

8.510.15.C. Allocations shall not exceed the monthly cost containment cap. The Department may approve an over cost containment Allocation if it meets prescribed Department criteria.

8.510.16 REIMBURSEMENT TO FAMILY MEMBERS

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

8.510.16.B. The family member and/or legal guardian shall be employed by the FMS and be supervised by the client/AR if providing CDASS.

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

1. A family member and/or legal guardian shall not be reimbursed for more than forty (40) hours of CDASS in a seven day period from 12:00am on Sunday to 11:59pm on Saturday.

2. Family member wages shall be commensurate with the level of skill required for the task and should not deviate greatly from that of a non-family member Attendant unless there is evidence of a higher level of skill.

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

8.510.16.D. A client/AR must provide a planned work schedule to the FMS a minimum of two weeks in advance of beginning CDASS, and variations to the schedule shall be supplied to the FMS when billing as submitted on the FMS timesheets.

8.510.16.E. A client/AR who choose a family member as a care provider, shall document the choice on the Attendant Support Services management plan.

~~8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES [Eff. 12/30/2007]~~

~~**8.510.1 DEFINITIONS**~~

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

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

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

~~Case Manager is defined at 10 C.C.R. 2505-10, § 8.390.1 C.~~

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

~~Financial Management Services organization (FMS) is the entity or entities under contract with the~~

~~Department, which entity is the employer of attendants, and which provides personnel management services, fiscal management and skills training to a client receiving CDASS and/or Authorized Representative.~~

~~Health Maintenance Activities is defined at 10 C.C.R. 2505-10, § 8.552.1.~~

~~Homemaker services is defined at 10 C.C.R. 2505-10, § 8.490.~~

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

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

~~Personal Care services is defined at 10 C.C.R. 2505-10, § 8.489.~~

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

~~**8.510.2 ELIGIBILITY**~~

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

~~1. Meet medical assistance eligibility requirements.~~

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

~~3. Demonstrate a current need for Attendant support.~~

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

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

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

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

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

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

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

   a. To recruit and hire Attendants;

   b. To communicate expectations;

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

   d. To manage necessary paperwork; and

   e. To dismiss Attendants when necessary.

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

8.510.3 BENEFITS

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

8.510.3.A. Benefits include:

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

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

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

8.510.4 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES MANAGEMENT PLAN

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

1. Current status;

2. Needs and requirements for CDASS;

3. Plans for securing CDASS;

4. Plans for handling emergencies;

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

6. Plans for using the Individual Allocation.

8.510.5 DIRECTION OF HEALTH MAINTENANCE ACTIVIITES

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

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

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

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

8.510.6 CLIENT AND/OR AUTHORIZED REPRESENTATIVES RESPONSIBILITES

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

1. Determine wages for each Attendant;

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

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

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

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

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

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

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

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

10. Review all Attendant timesheets for accuracy and completeness;

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

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

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

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

1. Completing training.

2. Developing a CDASS management plan.

3. Budgeting for CDASS within the established monthly allocation.

4. Recruiting, hiring, firing and managing Attendants.

5. Completing reference checks on Attendants.

6. Reviewing background checks on Attendants, if applicable.

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

8. Determining work schedules.

9. Training and supervising Attendants.

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

11. Completing and managing all paperwork.

8.510.7 START DATE FOR SERVICES

8.510.7.A. The start date shall not occur until all of the requirements defined at 10 C.C.R. 2505-10, § 8.510.2 and 8.510.6 have been met.

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

8.510.8 SERVICE SUBSTITUTION

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

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

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

8.510.9 CLIENT AND AUTHORIZED REPRESENTATIVE RIGHTS

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

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

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

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

8.510.10 INVOLUNTARY TERMINATION

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

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

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

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

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

5. The client and/or Authorized Representative exhibits Inappropriate Behavior toward Attendants, and the Department has determined that the FMS has made adequate

attempts to assist the client and/ or Authorized Representative to resolve the Inappropriate Behavior, and resolution has failed.

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

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

8.510.11 DISCONTINUATION OF CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

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

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

8.510.12 CASE MANAGEMENT FUNCTIONS

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

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

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

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

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

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

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

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

~~1. Any change in the client's condition.~~

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

~~3. The appropriateness of Attendant wages.~~

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

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

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

~~1. Improvement or changes in the condition.~~

~~2. Reasons for unspent allocated funds.~~

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

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

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

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

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

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

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

~~8.510.12.J. Reassessment:~~

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

~~**8.510.13 ATTENDANTS**~~

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

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

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

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

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

~~8.510.14 LIMITATIONS ON PAYMENT TO FAMILY AND/ OR LEGAL GUARDIANS~~

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

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

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

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

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

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

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

~~8.510.15 ATTENDANT REIMBURSEMENT~~

~~8.510.15.A. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the client and/or Authorized Representative hiring the Attendant. The Fiscal Management~~

~~Services organization shall make all payments from the client's Individual Allocation under the direction of the client and/or Authorized Representative.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Eligibility Citizenship Documentation Requirements, Section 8.100.3.H.
Rule Number:	MSB 10-07-15-B
Division / Contact / Phone:	CCR / Ann Clemens / 6115

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 10-07-15-B, Revisions to the Medicaid Eligibility Citizenship Documentation Requirements, Section 8.100.3.H.
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.100.3.H., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please add new text from §8.100.3.H.2.f. through §8.100.3.H.2.f.ii)2) to text that currently ends at §8.100.3.H.2.e.iii)4). This is the only change all other text is included for clarification purposes only.

This change is effective 03/02/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medicaid Eligibility Citizenship Documentation Requirements, Section 8.100.3.H.
Rule Number:	MSB 10-07-15-B
Division / Contact / Phone:	CCR / Ann Clemens / 6115

STATEMENT OF BASIS AND PURPOSE

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

The purpose of this rule change is to provide Medicaid applicants and clients who do not possess a Colorado birth certificate with the opportunity to have the fee for issuing the record waived. 25-2-117(2)(a)(I)(C), C.R.S. requires the fee to be waived by the Department of Public Health and Environment for Medicaid applicants and clients who have been referred by the county department of human/social services. The Department currently does not have any rules implementing this provision. A Colorado birth certificate is one of the documents that a Medicaid applicant or client can use to meet the citizenship documentation requirement for Medicaid eligibility.

Currently, only county departments of human/social services have the authority to issue referral letters to clients in need. The Department is currently working with the Colorado Department of Public Health and Environment, Vital Statistics in order to allow additional medical assistance and application sites the authority to issue referral letters. Once the expanded process is completed and implemented, revisions to this rule will be required to allow additional entities to issue referral letters.

2. An emergency rule-making is imperatively necessary

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

   for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2009);
   25-2-117(2)(a)(I)(C), C.R.S. (2010)
   Senate Bill 10-006

Initial Review		Final Adoption	**01/14/2011**
Proposed Effective Date	**03/02/2011**	Emergency Adoption	

DOCUMENT #04

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Rule Number:	MSB 10-07-15-B
Division / Contact / Phone:	CCR / Ann Clemens / 6115

REGULATORY ANALYSIS

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

The proposed rule change will affect county caseworkers who will need to become familiar with the new provision and who will be responsible for providing Medicaid applicants and clients with the referrals. The proposed rule change will benefit any Medicaid applicant or client who is subject to the citizenship documentation requirements who does not possess a Colorado birth certificate, as he or she will have the opportunity to have a birth certificate issued at no cost.

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

The Department does not have any data on the number of Medicaid applicants or clients subject to the citizenship documentation requirements who do not possess a Colorado birth certificate.

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.

Implementation and enforcement of the proposed rule change is not expected to result in any cost to the Department or have any effect on Medicaid enrollment. The proposed rule change may result in decreased fee revenues for the Department of Public Health and Environment, depending on the number of Medicaid applicants and clients provided with referrals.

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

N/A The rules are necessary to be in conformity with current state law.

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

There are no less costly or less intrusive methods for achieving the purpose of the rule.

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

N/A

8.100.3.H. Citizenship and Identity Documentation Requirements

2. Satisfactory documentary evidence of citizenship or nationality includes the following:

a. Primary Evidence of Citizenship and Identity. The following evidence shall be accepted as satisfactory documentary evidence of both identity and citizenship:

i) A U.S. passport issued by the U.S. Department of State that:

1) includes the applicant or recipient, and

2) was issued without limitation. A passport issued with a limitation may be used as proof of identity, as outlined in 8.100.3.H.3.

ii) A Certificate of Naturalization (DHS Forms N-550 or N-570) issued by the Department of Homeland Security (DHS) for naturalized citizens.

iii) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561) issued by the Department of Homeland Security for individuals who derive citizenship through a parent.

iv) A document issued by a federally recognized Indian tribe, evidencing membership or enrollment in, or an affiliation with, such tribe (such as a tribal enrollment card or certificate of degree of Indian blood).

1) Special Provisions for Retroactive Reversal of a Previous Denial

a) For a member of a federally recognized Indian tribe who was determined ineligible for Medical Assistance solely for failure to meet citizenship and identity documentation requirements, the denial of eligibility shall be reversed and eligibility shall be effective as of the date on which the individual was determined to be ineligible provided all of the following criteria are met:

(1) The individual was determined to be ineligible for Medical Assistance on or after July 1, 2006 solely on the basis of not meeting the citizenship and identity documentation requirements as they existed during that period;

(2) The individual would have been determined to be eligible for Medical Assistance had 8.100.3.H.2.a.iv) been in effect on or after July 1, 2006; and

(3) The individual or legally appointed guardian, or conservator of the individual requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) A member of a federally recognized Indian tribe for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at

8.100.3.Q.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed as provided in this subsection 2.

b. Secondary Evidence of Citizenship. If primary evidence from the list in 8.100.3.H.2.a. is unavailable, an applicant or recipient shall provide satisfactory documentary evidence of citizenship from the list specified in this section to establish citizenship AND satisfactory documentary evidence from the documents listed in section 8.100.3.H.3. to establish identity. Secondary evidence of citizenship includes:

i) A U.S. public birth certificate.

1) The birth certificate shall show birth in any one of the following:

a) One of the 50 States,

b) The District of Columbia,

c) Puerto Rico (if born on or after January 13, 1941),

d) Guam (if born on or after April 10, 1899),

e) The Virgin Islands of the U.S. (if born on or after January 17, 1917),

f) American Samoa,

g) Swain's Island, or

h) The Northern Mariana Islands (NMI) (if born after November 4, 1986 (NMI local time)).

2) The birth record document shall have been issued by the State, Commonwealth, Territory or local jurisdiction.

3) The birth record document shall have been recorded before the person was 5 years of age. A delayed birth record document that is recorded at or after 5 years of age is considered fourth level evidence of citizenship, as described in 8.100.3.H.2.d.

ii) A Certification of Report of Birth (DS-1350) issued by the U.S. Department of State to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth.

iii) A Report of Birth Abroad of a U.S. Citizen (Form FS-240) issued by the U.S. Department of State consular office overseas for children under age 18 at the time of issuance. Children born outside the U.S. to U.S. military personnel usually have one of these.

iv) A Certification of birth issued by the U.S. Department of State (Form FS-545 or DS-1350) before November 1,1990.

v) A U.S. Citizen I.D. card issued by the U.S. Immigration and Naturalization Services (INS):

1) Form I-179 issued from 1960 until 1973, or

2) Form I-197 issued from 1973 until April 7, 1983.

vi) A Northern Mariana Identification Card (I-873) issued by INS to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986.

vii) An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC."

viii) A final adoption decree that:

1) shows the child's name and U.S. place of birth, or

2) a statement from a State approved adoption agency that shows the child's name and U.S. place of birth. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

ix) Evidence of U.S. Civil Service employment before June 1, 1976. The document shall show employment by the U.S. government before June 1, 1976.

x) U.S. Military Record that shows a U.S. place of birth such as a DD-214 or similar official document showing a U.S. place of birth.

xi) Data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens.

xii) Child Citizenship Act. Adopted or biological children born outside the United States may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000). section 320 of the Immigration and Nationality Act (8 USC § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted on October 30, 2000) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Documentary evidence must be provided at any time on or after February 27, 2001, if the following conditions have been met:

1) At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the requirements of this part);

2) The child is under the age of 18;

3) The child is residing in the United States in the legal and physical custody of the U.S. citizen parent;

4) The child was admitted to the United States for lawful permanent residence (as verified through the Systematic Alien Verification for Entitlements (SAVE) Program); and

5) If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 USC § 1101(b)(1)) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred. 8 USC § 1101(b)(1) is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

c. Third Level Evidence of U.S. Citizenship. Third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence is available. Third level evidence shall be used only when primary evidence cannot be obtained within 10 business days, secondary evidence does not exist or cannot be obtained, and the applicant or recipient alleges being born in the U.S. A second document from the list in 8.100.3.H.3. to establish identity shall also be presented.

i) Extract of a hospital record on hospital letterhead.

1) The record shall have been established at the time of the person's birth;

2) The record shall have been created at least 5 years before the initial application date; and

3) The record shall indicate a U.S. place of birth;

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

5) Souvenir "birth certificates" issued by a hospital are not acceptable.

ii) Life, health, or other insurance record.

1) The record shall show a U.S. place of birth; and

2) The record shall have been created at least 5 years before the initial application date.

3) For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

iii) Religious record.

1) The record shall have been recorded in the U.S. within 3 months of the date of the individual's birth;

2) The record shall show that the birth occurred in the U.S.;

3) The record shall show either the date of birth or the individual's age at the time the record was made; and

4) The record shall be an official record recorded with the religious organization.

iv) Early school record that meets the following criteria:

1) The school record shows the name of the child;

2) The school record shows the child's date of admission to the school;

3) The school record shows the child's date of birth;

4) The school record shows a U.S. place of birth for the child; and

5) The school record shows the name(s) and place(s) of birth of the applicant's parents.

d. Fourth Level Evidence of Citizenship. Fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence shall only be used in the rarest of circumstances. This level of evidence is used only when primary evidence is unavailable, both secondary and third level evidence do not exist or cannot be obtained within 10 business days, and the applicant alleges U.S. citizenship. The affidavit process described in 8.100.3.H.2.d.5. may be used by U.S. citizens or nationals born inside or outside the U.S. In addition, a second document establishing identity shall be presented as described in 8.100.3.H.3.

i) Federal or State census record showing U.S. citizenship or a U.S. place of birth and the applicant's age.

ii) One of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for The Medical Assistance Program. For children under 16 the document must have been created near the time of birth or at least 5 years before the date of application.

1) Seneca Indian tribal census record;

2) Bureau of Indian Affairs tribal census records of the Navajo Indians;

3) U.S. State Vital Statistics official notification of birth registration;

4) A delayed U.S. public birth record that is recorded more than 5 years after the person's birth;

5) Statement signed by the physician or midwife who was in attendance at the time of birth; or

6) The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.

iii) Institutional admission papers from a nursing facility, skilled care facility or other institution created at least 5 years before the initial application date that indicate a U.S. place of birth.

iv) Medical (clinic, doctor, or hospital) record.

1) The record shall have been created at least 5 years before the initial application date; and

2) The record shall indicate a U.S. place of birth.

3) An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.

4) For children under 16 the document shall have been created near the time of birth or at least 5 years before the date of application.

v) Written affidavit. Affidavits shall only be used in rare circumstances. They may be used by U.S. citizens or nationals born inside or outside the U.S. If documentation is by affidavit, the following rules apply:

1) There shall be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship (the two affidavits could be combined in a joint affidavit);

2) At least one of the individuals making the affidavit cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient;

3) In order for the affidavit to be acceptable the persons making them shall provide proof of their own U.S. citizenship and identity.

4) If the individual(s) making the affidavit has (have) information which explains why documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit shall contain this information as well;

5) The applicant/recipient or other knowledgeable individual (guardian or representative) shall provide a separate affidavit explaining why the evidence does not exist or cannot be obtained; and

6) The affidavits shall be signed under penalty of perjury pursuant to 18 U.S.C. §1641 and Title 18 of the Criminal Code article 8 part 5 and need not be notarized.

e. Evidence of Citizenship for Collectively Naturalized Individuals. If a document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. A second document from 8.100.3.H.3.. to establish identity shall also be presented.

i) Puerto Rico:

1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the U.S., a U.S. possession or Puerto Rico on January 13, 1941; OR

2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain.

ii) US Virgin Islands:

1) Evidence of birth in the U.S. Virgin Islands, and the applicant's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927; OR

2) The applicant's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on January 17, 1917 and residence in the U.S., a U.S. possession or the U.S. Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; OR

3) Evidence of birth in the U.S. Virgin Islands and the applicant's statement indicating residence in the U.S., a U.S. possession or Territory or the Canal Zone on June 28, 1932.

iii) Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); OR

3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe

allegiance to a foreign state on November 4, 1986 (NMI local time).

4) If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile, and the individual is not a U.S. citizen.

f) Referrals for Colorado Birth Certificates

i) An applicant or client who was born in the State of Colorado who does not possess a Colorado birth certificate shall receive a referral to the Department of Public Health and Environment by the county department to obtain a birth certificate at no charge, pursuant to 25-2-117(2)(a)(I)(C), C.R.S.

ii) The referral shall be provided on county department letterhead and shall include the following:

1) The name and address of the applicant or client;

2) A statement that the county department requests that the Department of Public Health and Environment waive the birth certificate fee, pursuant to 25-2-117(2)(a)(I)(C), C.R.S.; and

3) The name and contact telephone number for the county caseworker responsible for the referral.

iii) An applicant or client who has been referred to the Department of Public Health and Environment to obtain a birth certificate shall not be required to present a birth certificate to satisfy the citizenship documentation requirement at 8.100.3.H.2. The applicant or client shall have the right to use any of the documents listed under 8.100.3.H.2. to satisfy the citizenship documentation requirement.