THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.100.6.C.10
Rule Number:	MSB 11-08-24-A
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

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 11-08-24-A, Revision to the Medical Assistance Rule Concerning SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.100.6.C.10
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) 8.100.6.C.10, 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 provided beginning at §8.100.6.C.10 through §8.100.6.C.10.a.1.c). The new text will immediately follow §8.100.6.C.9. All other text is for clarification purposes only. This change is effective 11/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.100.6.C.10
Rule Number:	MSB 11-08-24-A
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

STATEMENT OF BASIS AND PURPOSE

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

   The proposed language was approved for publication effective September 1,2008. However, it was subsequently deleted through administrative error effective April 1, 2009. The proposed rule is being presented in order to reestablish the previously approved language. The purpose of this rule change is to revise the Supplemental Security Income (SSI) Medicaid eligibility requirements to incorporate changes in federal law governing the effective date of eligibility for individuals under 21 and to provide criteria for granting eligibility to infants who are found to be disabled shortly after birth.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR §435.120, 42 CFR §435.909(b)(1), 42 CFR §435.914, 42 USC §1396a(a)(10)(A)(i)(II)(cc)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-4-104(1), C.R.S. (2007)

Initial Review		Final Adoption	**10/14/2011**
Proposed Effective Date	**11/30/2011**	Emergency Adoption	

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning SSI Medicaid Eligibility Effective Date Rules for Children Under 21, Section 8.100.6.C.10
Rule Number:	MSB 11-08-24-A
Division / Contact / Phone:	Eligibility / Shawn Bodiker / 3584

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 language was approved for publication effective September 1, 2008. However, it was subsequently deleted through an administrative error effective April 1, 2009. The proposed rule is being presented in order to reestablish the previously approved language.

   The proposed rule changes will affect children under the age of 21 who are eligible for or who are receiving SSI benefits and infants found to be disabled at or shortly after birth who are eligible for or receiving SSI. Under the current rules, Medicaid eligibility for these infants does not begin until the date on which they are found eligible for SSI, and this sometimes does not occur until days or weeks after the child was born. As a result, some disabled children do not have insurance coverage to cover the cost of their birth and first few days or weeks of hospitalization. Current Department policy allows the effective date for Medicaid eligibility for individuals eligible for or receiving SSI benefits to be backdated up to 90 days, if the individual otherwise meets the SSI financial and disability criteria, and this policy has been employed to provide coverage for some infants in these situations. The proposed rule change would clarify that Medicaid coverage is available for SSI-eligible infants found to be disabled shortly after birth by providing for automatic coverage back to the date of birth if certain criteria are met.

   The proposed rule changes will also affect caseworkers at the county departments of social/human services and medical assistance sites who make determinations of Medicaid eligibility. These individuals will need to become familiar with the new rules and with procedures for implementing them.

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

   The proposed rule change will eliminate gaps in insurance coverage experienced by some disabled infants who are eligible for or who receive SSI. These gaps in coverage result in medical bills that become the responsibility of the infant's parents, counties, or other parties, and often end up unpaid, unless the infant's Medicaid eligibility is backdated 90 days. While the Department's policy has been to backdate Medicaid eligibility for up to 90 days for these

infants if they otherwise meet the SSI financial criteria, this has not been done consistently or expeditiously in all cases. The proposed regulations should help alleviate this problem.

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.

   Current Department policy already allows for backdating Medicaid eligibility for individuals who are eligible for or who are receiving SSI benefits up to 90 days, if they meet the SSI financial and disability criteria. This policy has not been consistently applied in all cases in which it could have been invoked and has resulted in some individuals who may have been eligible for Medicaid coverage of their medical bills not receiving that coverage. The proposed rule change is intended to help reduce the prevalence of this problem among infants, and , to the extent that it is successful, there may be a fiscal impact to the Department in providing that coverage. The Department does not have data at this time with which to quantify this potential fiscal impact.

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

   Inaction would result in the department being out of compliance with federal statue. It would also result in some SSI eligible disabled infants continuing to experience difficulties in obtaining Medicaid coverage for bills incurred from date of birth until the date on which SSI eligibility is established. The proposed rule would alleviate this problem.

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 proposed rule.

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

   There are no effective alternative methods for achieving the purpose of the proposed rule.

8.100.6.C. SSI Eligibles

1. Benefits of the Colorado Medical Assistance Program must be provided to the following:

    a. persons receiving financial assistance under SSI;

    b. persons who are eligible for financial assistance under SSI, but are not receiving SSI;

    c. persons receiving SSI payments based on presumptive eligibility for SSI pending final determination of disability or blindness; and persons receiving SSI payments based on conditional eligibility for SSI pending disposal of excess resources.

2. The Department has entered into an agreement with SSA in which SSA shall determine Medical Assistance for all SSI applicants. Medical Assistance shall be provided to all individuals receiving SSI benefits as determined by SSA to be eligible for Medical Assistance.

3. The eligibility sites shall have access to a weekly unmatched listing of all individuals newly approved and a weekly SSI-Cases Denied or Discontinued listing. These lists shall include the necessary information for the eligibility site to authorize Medical Assistance.

4. Medical Assistance shall not be delayed due to the necessity to contact the SSI recipient and obtain third party medical resources.

5. Notification shall be sent to the SSI recipient advising him/her of the approval of Medical Assistance.

6. The SISC Code for this type of assistance is B.

7. Denied or terminated Medical Assistance based on a denial or termination of SSI which is later overturned, must be approved from the original SSI eligibility date.

8. Individuals who remain eligible as SSI recipients but are not receiving SSI payments shall receive Medical Assistance benefits. This group includes persons whose SSI payments are being withheld as a means of recovering an overpayment, whose checks are undeliverable due to change of address or representative payee, and persons who lost SSI financial assistance due to earned income.

9. If the eligibility site obtains information affecting the eligibility of these SSI recipients, they shall forward such information to the local Social Security office.

10. For individuals under 21 years of age who are eligible for or who are receiving SSI, the effective date of Medicaid eligibility shall be the date on which the individual applied for SSI or the date on which the individual became eligible for SSI, whichever is later.

    a. Special Provisions for Infants

        1. For an infant who is eligible for or who is receiving SSI, the effective date of Medicaid eligibility shall be the infant's date of birth if:

            a) the infant was born in a hospital;

            b) the disability onset date, as reported by the Social Security Administration, occurred during the infant's hospital stay; and

c) the infant's date of birth is within three (3) months of the date on which the infant became eligible for SSI

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning the Nursing Facility Provider Fees and Reimbursement, Sections 8.443.11, 8.443.12 and 8.443.17.
Rule Number:	MSB 11-08-15-A
Division / Contact / Phone:	Financial & Administrative Services Office / Nancy Dolson / 303.866.3698

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 11-08-15-A, Revisions to the Medical Assistance Rule Concerning the Nursing Facility Provider Fees and Reimbursement, Sections 8.443.11, 8.443.12 and 8.443.17.
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) 8.443.11, 8.443.12 and 8.443.17, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? Yes
   If yes, state effective date: 9/9/11
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please delete old text as indicated and insert new text provided at §8.443.11.6. Please delete indicated text in the first unnumbered paragraph at §8.443.12 and at §8.443.12.6 please delete text indicated and add new text provided. Please add new text provided at §8.443.4.a. (vii) All other text is provided for clarity only. These changes are effective 11/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning the Nursing Facility Provider Fees and Reimbursement, Sections 8.443.11, 8.443.12 and 8.443.17.
Rule Number:	MSB 11-08-15-A
Division / Contact / Phone:	Financial & Administrative Services Office / Nancy Dolson / 303.866.3698

STATEMENT OF BASIS AND PURPOSE

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

   The rule is being updated to change the hierarchy of nursing provider fee-funded supplemental payments consistent with statute, to change the pay for performance component of nursing facility reimbursement to a $1 to $4 per day add-on scale consistent with the SB 06-131 committee's recommendations, and to add a supplemental payment for the acuity or case-mix of Medicaid residents to the list of components funded by nursing facility provider fees.

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. (2010);
   25.5-6-202, C.R.S. (2010)

Initial Review — Final Adoption **10/14/2011**

Proposed Effective Date **11/30/2011** — Emergency Adoption

DOCUMENT #08

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Rule Concerning the Nursing Facility Provider Fees and Reimbursement, Sections 8.443.11, 8.443.12 and 8.443.17.
Rule Number:	MSB 11-08-15-A
Division / Contact / Phone:	Financial & Administrative Services Office / Nancy Dolson / 303.866.3698

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.

   Class I nursing facility providers in the state are affected by the proposed rule. The proposed rule changes the pay-for-performance add-on from $1 to $3 per Medicaid day, depending on points earned, to $1 to $4 per Medicaid day. This proposed rule change means that more of the funding generated by nursing facility fees will be directed to nursing facilities that provide services that result in better care and higher quality of life for their residents. The pay-for-performance portion of nursing facility fee-funded payments increases approximately $1.6 million.

   In addition and as required by SB 11-125, the proposed rule re-orders the hierarchy of supplemental payments funded by nursing facility provider fees and adds a supplemental payment for the acuity or case-mix of Medicaid residents. The addition of an acuity or case-mix payment benefits class I nursing facilities that provide services to Medicaid residents by providing reimbursement for the resource utilization of their Medicaid residents.

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

   Under the fee limit per SB 11-125, total nursing facility fee-funded supplemental payments total $83.6 million. The proposed rule change directs $4.2 million toward pay-for-performance ($1.6 million more than under existing rule) and directs $3.9 million toward reimbursement for the acuity or case-mix of Medicaid residents.

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

   This proposed rule has no costs for the Department or other agencies.

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

   The benefit of the proposed rule is that it directs more reimbursement for nursing facilities toward higher quality care and toward the resource utilization of Medicaid residents based on

acuity or case-mix. There is no cost to implement the proposed rule as it makes changes within an existing reimbursement structure.

The amount of funds available for nursing facility reimbursement is fixed. If there is inaction, the rule would be inconsistent with statutory requirements. There is no benefit to inaction.

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

   There are no increased costs associated with the proposed rule.

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

   No alternatives exist. Without the proposed rule, the pay-for-performance will not be fully funded as intended by the SB 06-131 committee. Also, without the proposed rule, the funding hierarchy would be inconsistent with statute and the acuity or case-mix component would not be described rule.

8.443.11 FUNDING SPECIFICATIONS

The general fund share of the aggregate statewide average of the per diem rate net of patient payment pursuant to 8.443.7 (Health Care Services) and 8.443.8 (Administrative and General Costs) and 8.443.9 (Fair Rental Allowance for Capital-Related Assets) shall be limited by statute. . Any provider fee used as the state's share and all federal funds shall be excluded from the calculation of the general fund limitation. In the event that the reimbursement system described in this section would result in anticipated payments to nursing facility providers exceeding the statutory limitation on annual growth in the general fund share of the aggregate statewide average of the per diem rate net of patient payment, proportional decreases will be made to the rates so that anticipated payments will equal the statutory growth limitation in the general fund share of the per diem rate. The percentage will be determined in accordance with the following fraction: Legislative appropriations / The Sum of Each Facility's Calculated Rate Multiplied by Each Facility's Proportional Share of the Anticipated (Budgeted) Case Load for all class I Nursing Facilities.

1. Non-state and federal payment percent: Annually the Department will determine the percent of nursing facility per diem rates paid by non-state and non-federal fund sources. This determination will be based on an analysis of Medicaid nursing facility class I paid claims. A sample period of claims may be used to perform this analysis. The analysis will be prepared prior to the annual July 1st rate setting.

2. Legislative appropriation base year amount: The base year will be the state fiscal year (SFY) ending June 30, 2008. The legislative appropriation for the base year will be determined by multiplying each nursing facility's time weighted average Medicaid per diem rate during the base year by their expected Medicaid case load (Medicaid patient days) for the base year. This amount will be reduced by the non-state and non-federal payment percentage, and then the residual will be split between state and federal sources using the time weighted Federal Medical Assistance Percentage (FMAP) during the base year.

3. Medicaid case load for each facility will be determined using Medicaid paid claims data for the calendar year ending prior to the July 1st rate setting. Providers with less than a full year of paid claims data will have their case load annualized.

4. Preliminary state share: Effective July 1, 2009 and each succeeding year the Department shall calculate a preliminary state share commitment towards the class I Medicaid nursing facility reimbursement system. The preliminary state share shall be calculated using the same methodology used to calculate the legislative appropriation base year amount. The Medicaid per diem rates used in this calculation are the preliminary rates that would be effective July 1st prior to any rate reduction provided for within this section of the rule.

5. For SFY 2009 and each succeeding year the final state share of Medicaid per diem rates will be limited to the legislative appropriation amount from the base year increased by the statutory growth limitation over the prior SFY. These determinations will be made during the July 1st rate setting process each year. If the preliminary state share (less the amount applicable to provider fees) is greater than the indexed legislative base year amount, proportional reductions will be made to the preliminary nursing facility rates to reduce the state share to the indexed legislative appropriation base year amount.

6. Provider fee revenue will first be used to pay the provider fee offset payment, then the payment for acuity or case-mix of residents, ~~then the state's share of the per diem rate over the general fund cap,~~ then the Pay-for-Performance program, ~~and~~ then payments for residents who have moderately to severe mental health conditions, cognitive dementia ~~and~~ or acquired brain injury, and then the supplemental Medicaid payments for the amount by which the average statewide per diem rate exceeds the general fund share established under Section 25.5-6-202(9)(b)(II), C.R.S.~~.~~. Any difference between

the amount of provider fees expected to be available, and the amount needed to fund these programs will be used to adjust the preliminary state share above.

7. The following calculation illustrates the above and, for illustration purposes, assumes the statutory limit on general fund is 3%:

8.443.12 PAY-FOR-PERFORMANCE COMPONENT

Starting July 1, 2009, the Department shall make a ~~a~~ supplemental payment based upon performance to those nursing facility providers that provide services that result in better care and higher quality of life for their residents (pay-for-performance). The payment will be based on a nursing facility's performance in the domains of quality of life, quality of care and facility management.

1. The application for the additional quality performance payment includes specific performance measures in each of the domains, quality of life, quality of care and facility management. The application includes the following:

    a. The number of points associated with each performance measure;

    b. The criteria the facility must meet or exceed to qualify for the points associated with each performance measure.

2. The prerequisites for participating in the program are as follows:

    a. No facility with substandard deficiencies on a regular annual, complaint, or any other Colorado Department of Public Health and Environment survey will be considered for pay for performance.

    b. The facility must perform a resident/family satisfaction survey. The survey must (a) be developed, recognized, and standardized by an entity external to the facility; and, (b) be administered on an annual basis with results tabulated by an agency external to the facility. The facility must report their response rate, and a summary report must be made publically available along with the facility's State's survey results.

3. To apply the facility must have the requirements for each Domain/sub-category in place at the time of submitting an application for additional payment. The facility must maintain documentation supporting its representations for each performance measure the facility represents it meets or exceeds the specified criteria. The required documentation for each performance measure is identified on the application and must be submitted with the application. In addition, the facility must include a written narrative for each sub- category to be considered that describes the process used to achieve and sustain each measure.

4. The Department or the Department's designee will review and verify the accuracy of each facility's representations and documentation submissions. Facilities will be selected for onsite verification of performance measures representations based on risk.

5. A nursing facility will accumulate a maximum of 100 points by meeting or exceeding all performance measures indicated on the matrix.

6. The per diem rate add-on will be calculated according to the following table:

    0 –~~45~~20 points = No add-on

    21-45 points = $1.00 per day add-on

    46 – 60 points = $~~1~~2.00 per day add-on

    61 – 79 points = $~~2~~3.00 per day add-on

    80 – 100 points = $~~4~~3.00 per day add-on

If the expected average payment for those facilities receiving a supplemental payment is less than twenty-five hundredths of one percent of the statewide average per diem base rate, the above table rates will be proportionately increased or decreased in order to have an expected average Medicaid add-on payment equal to twenty-five hundredths of one percent of the average nursing facility base rate.

7. These calculations will be performed annually to coincide with the July 1st rate setting process.

8.443.17 PROVIDER FEES

8.443.17.A The state department shall charge and collect provider fees on health care items or services provided by nursing facility providers for the purpose of obtaining federal financial participation under the state's medical assistance program. The provider fees shall be used to sustain or increase reimbursement for providing medical care under the state's medical assistance program for nursing facility providers.

1. Each class I nursing facility that is licensed in this State shall pay a fee assessed by the state department.

2. The following nursing facility providers are excluded from the provider fee:

    a. A facility operated as a continuing care retirement community that provides a continuum of services by one operational entity providing independent living services, assisted living services and skilled nursing care on a single, contiguous campus. Assisted living services include assisted living residences as defined in Section 25-27-102 (1.3), C.R.S., or that provide assisted living services on-site, twenty-four hours per day, seven days per week;

    b. A skilled nursing facility owned and operated by the state;

    c. A nursing facility that is a distinct part of a facility that is licensed as a general acute care hospital; and

    d. A facility that has forty-five or fewer licensed beds.

3. To determine the amount of the fee to assess pursuant to this section, the state department shall establish a rate per non-Medicare patient day that is equivalent to a percentage of accrual basis gross revenue (net of contractual allowances) for services provided to patients of all class I nursing facilities licensed in this State. The percentage used to establish the rate must not exceed that allowed by federal law. For the purposes of this section, total annual accrual basis gross revenue does not include charitable contributions or revenues received by a nursing facility that are not related to services provided to nursing facility residents (for example, outpatient revenue).

4. The state department shall calculate the fee to collect from each nursing facility during the July 1 rate-setting process.

    a. Each July 1, the state department will determine the aggregate dollar amount of provider fee funds necessary to pay for the following:

        (i) State department's administrative cost pursuant to 8.443.17.B.1

        (ii) CPS pursuant to 8.443.10.A

        (iii) PASRR pursuant to 8.443.10.B

        (iv) Pay for Performance pursuant to 8.443.12

        (v) Provider Fee Offset Payment pursuant to 8.443.10.C

        (vi) Excess of the statutory limited growth in the general fund pursuant to 8.443.11

(vii) Acuity or case-mix of residents pursuant to 8.443.7.D

b. This calculation will be based on the most current information available at the time of the July 1 rate-setting process.

c. The aggregate dollar amount of provider fee funds necessary will be divided by non-Medicare patient days for all class I nursing facilities to obtain a per day provider fee assessment amount for each of the two following categories:

(i) nursing facilities with 55,000 total patient days or more;

(ii) nursing facilities with less than 55,000 total patient days.

The state department will lower the amount of the provider fee charged to nursing facility providers with 55,000 total patient days or more to meet the requirements of 42 CFR 433.68 (e). In addition, the 55,000 total patient day threshold can be modified to meet the requirements of 42 CFR 433.68 (e).

d. Each facility's annual provider fee amount will be determined by taking the per day provider fee calculated above times the facility's reported annual non-Medicare patient days.

e. Each nursing facility will report monthly its total number of days of care provided to non-Medicare residents to the Department of Health Care Policy & Financing. Non-Medicare patient days reported in the year prior to the July 1 rate-setting process will be used as the facility's annual non-Medicare patient days for the provider fee calculation.

f. If a facility's actual non-Medicare patient days differ by more than 5% from the prior year reported non-Medicare patient days used to determine the provider's fee payment, the facility can request the state department, in writing, to review the facility's provider fee calculation. If the state department determines that the facility's actual non-Medicare patient days differ by more than 5% from the facility's non-Medicare patient days used to determine the facility's provider fee, an adjustment to the facility's annual provider fee payment will be made. The facility's annual provider fee will be based on actual non-Medicare patient days rather than reported days in the prior year.

g. Each facility's annual provider fee amount will be divided by twelve to determine the facility's monthly amount owed the state department.

h. The state department shall assess the provider fee on a monthly basis.

i. The fee assessed pursuant to this section is due 30 days after the end of the month for which the fee was assessed.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies, Section 8.590.7.
Rule Number:	MSB 11-08-02-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / 5942

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: Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies, Section 8.590.7.
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) 8.590.7, Reimbursement, 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 delete current text at §8.590.7.D and renumber current §8.590.7.E and F to D and E; Please insert new text provide at §8.590.7.F through §8.590.7.F.5. This change is effective 11/30/2011. (*Eff* references are currently in the SOS publication and were not provided by the Department.)

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies, Section 8.590.7.
Rule Number:	MSB 11-08-02-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / 5942

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 amendment to the reimbursement section of the Durable Medical Equipment and Disposable Medical Supplies rule adds the reimbursement methodology for equipment modifications, service, and repairs. The Department is required to establish rules for the payment of providers under Title 25.5 Article 4 of the Colorado Revised Statutes. The methodology contained in this rule is consistent with the provider fee schedule established for the repair or service of durable medical equipment currently, to comply with the law. This methodology is currently used in practice, however, it was previously omitted from the rule. This amendment corrects the omission.

2. An emergency rule-making is imperatively necessary

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

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

Explain:

3. Federal authority for the Rule, if any:

42 CFR 440.70

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2010);
25.5-4-416 C.R.S.
25.5-4-401 C.R.S.

Initial Review	**09/09/2011**	Final Adoption	**10/14/2011**
Proposed Effective Date	**12/01/2011**	Emergency Adoption	

DOCUMENT # 09

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Durable Medical Equipment and Disposable Medical Supplies, Section 8.590.7.
Rule Number:	MSB 11-08-02-A
Division / Contact / Phone:	Medicaid Program Division / Jeanine Draut / 5942

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.

   Durable medical equipment providers, and those who make repairs and modifications to the equipment, are affected.

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

   Clarity in the rule and consistency with the DME Billing Manual will reduce any confusion among providers regarding reimbursement for equipment repair, service, and modifications.

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.

   No probable costs or anticipated effect on state revenues.

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

   There are no costs anticipated for implementing the proposed rule. If the Department does not amend the rule as proposed it may bear the costs of appeals and reimbursement for non-covered services, as a result of the lack of clarity in the rule regarding reimbursement for equipment repairs.

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

   None.

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

   The Department is required to amend the rule as a result of an audit conducted by the Office of the State Auditor. Therefore, no alternative methods for achieving the purpose of the proposed rule were considered.

8.590.7 REIMBURSEMENT

8.590.7.A. Invoices received from Related Owners or Related Parties shall not be accepted. Only invoices received from unrelated manufacturers or wholesale distributors shall be recognized as allowable invoices. *[Eff 12/31/2006]*

8.590.7.B. The provider shall not bill the Department for authorized accessory items included by the manufacturer as part of a standard package for an item. *[Eff 12/31/2006]*

8.590.7.C. The provider shall credit the cost of any accessory or part removed from a standard package to the Department. *[Eff 12/31/2006]*

~~8.590.7.D. Charges submitted for modifications that require the provider to provide them from their own inventory or stock shall be supported as to the necessity and actual cost of those modifications. *[Eff 12/31/2006]*~~

8.590.7.~~E~~D. Clients and providers may negotiate in good faith a trade-in amount for DME items no longer suitable for a client because of growth, development or a change in anatomical and or medical condition. Such trade-in allowances shall be used to reduce the cost incurred by the Department for a replacement item. *[Eff 12/31/2006]*

8.590.7.~~F~~E. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacture; wherever the item was returned, and the Department. *[Eff 12/31/2006]*

8.590.7.F. Reimbursement for allowable modifications, service, and repairs on durable medical equipment is as follows:

1. Labor for modifications, service, and repairs on durable medical equipment shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

2. Parts that are listed on the Department's fee schedule, with a HCPCS code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the rate specified on the Department fee schedule.

3. Manually priced parts are reimbursed according to the same methodology used for purchased equipment, as described in 8.590.7.I.

4. The provider shall not be reimbursed for labor or parts in excess of unit limitations.

5. Reimbursement for a modification that requires the original equipment provider to supply a part from their own inventory or stock is contingent upon the provider submitting supporting documentation that demonstrates the need and actual cost of the parts to be used in the modification.

8.590.7.G. Reimbursement for used equipment shall include: *[Eff 12/31/2006]*

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Residential Treatment Center Reimbursement, Section 8.766
Rule Number:	MSB 11-06-08-B
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles or Sheeba Ibidunni / x2830 or x3510

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 11-06-08-B, Revision to the Medical Assistance Rule Concerning Residential Treatment Center Reimbursement, Section 8.766
3. This action is an adoption of: a repeal of existing rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

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

PUBLICATION INSTRUCTIONS*

Please remove all current text from §8.766 through the end of the section at §8.766.6 and replace with "8.766 This rule was repealed effective November 30, 2011. This rule change is effective 11/30/2011.

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

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Residential Treatment Center Reimbursement, Section 8.766
Rule Number:	MSB 11-06-08-B
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles or Sheeba Ibidunni / x2830 or x3510

STATEMENT OF BASIS AND PURPOSE

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

On July 2, 2006, The Center for Medicare and Medicaid Services (CMS) no longer reimbursed states for services provided by Residential Treatment Centers (RTCs). To replace RTCs in Colorado, three models of care were distinctly defined, and these models were the Psychiatric Residential Treatment Facilities (PRTFs), Therapeutic Residential Child Care Facilities (TRCCFs), and the Residential Child Care Facilities (RCCFs).

Although most of the rules in Volume 8 pertaining to RTCs were deleted, this entire section of 8.766 which focuses on RTCs was overlooked and needs to be removed to ensure compliance with CMS.

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:

   Section 8.766 is being removed from Rule, and there is no Federal Authority coinciding with doing so.

4. State Authority for the Rule:

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

Initial Review	**09/09/2011**	Final Adoption	**10/14/2011**
Proposed Effective Date	**12/01/2011**	Emergency Adoption	

DOCUMENT #10

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Residential Treatment Center Reimbursement, Section 8.766
Rule Number:	MSB 11-06-08-B
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles or Sheeba Ibidunni / x2830 or x3510

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.

   There are no costs and benefits for this proposed change, because it is simply removing the entire Section of 8.766 to ensure that we are in compliance with CMS. Although the Section is being removed, the services will still be rendered through RCCFs, PRTFs, and RCCFs that provide mental health services (changing from being called TRCCFs).

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

   Children who were previously in RTCs are now in RCCFs that provide mental health services.

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.

   N/A

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

   The rule is no longer in effect, so the Section that describes the rule, Section 8.766, needs to be removed to ensure that we are in compliance with CMS.

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

   N/A

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

   N/A

8.766 RESIDENTIAL TREATMENT CENTER REIMBURSEMENT

8.766.1 Effective July 1, 2005, Residential Treatment Centers (RTCs) shall be reimbursed based upon an interim rate that shall equal the rate effective as of July 1, 2004. This rate shall remain in effect until the date the Centers for Medicare and Medicaid Services (CMS) approves the State Plan Amendment and specifies the implementation date thereof.

8.766.2 On the 91st day following CMS approval, RTCs shall be reimbursed according to the methodology set forth in Section 8.766.4 and Section 8.766.5.

8.766.3 LEVEL OF CARE DETERMINATION

8.766.3.A. Clients placed in an RTC shall have their Level of Care determined through the Colorado Client Assessment Record (CCAR) as completed by the Referral Agency.

8.766.3.B. The CCAR Level shall be based upon the type and frequency of services needed by the client. CCAR Levels are predefined by the Department of Human Services consisting of Level A, Level B and Level C.

1. Level A services are provided to clients needing a lesser level of mental health services. Level A services may be provided off site or within the RTC facility and are provided to transition the client to a less restrictive setting. Clients rated as having moderate to slight level of care need on the CCAR are eligible for Level A services for a period not to exceed 180 consecutive calendar days.

2. Level B services are provided to clients with moderate mental health needs for a period not to exceed 365 consecutive calendar days.

3. Level C services are provided to clients with the most severe mental health needs and who need the most extensive services. Clients rated as having severe to extreme Level of Care need on the CCAR are eligible for Level C services upon request of the Referral Agency for a period not to exceed 45 consecutive calendar days, unless deemed medically necessary under Early Periodic Screening Diagnostic Treatment.

8.766.4 REIMBURSABLE SERVICES

8.766.4.A. Reimbursable services include:

1. Medical services provided by Medicaid qualified practitioners as set forth in 10 C.C.R. 2505-10, Section 8.200.

2. Psychiatric diagnostic or evaluative examination provided by qualified practitioners as outlined in provisions of Title 12, Article 43, C.R.S, or by a Medicaid qualified practitioner as set forth in 10 C.C.R. 2505-10, Section 8.200.

3. Individual psychotherapy provided by qualified practitioners as outlined in provisions of Title 12, Article 43, C.R.S. Individual psychotherapy means insight oriented, behavior modifying and/or supportive psychotherapy.

4. Individual interactive psychotherapy provided by qualified practitioners as outlined in provisions of Title 12, Article 43, C.R.S. Interactive psychotherapy uses play equipment, physical devices, language interpreter or other non-verbal communication.

5. Group psychotherapy provided by qualified practitioners as outlined in provisions of Title 12, Article 43, C.R.S.

6. Interactive group therapy provided by qualified practitioners as outlined in provisions of Title 12, Article 43, C.R.S.

7. Family therapy with patient present provided by qualified practitioners as outlined in provisions of Title 12, Article 43, C.R.S.

8. Milieu therapy which means symptom management that includes assisting a client to manage behavior and feelings, learn self-preservation skills in areas such as urban survival and alcohol/drug abuse, build confidence or self-esteem, learn, maintain or improve social, interpersonal, or living skills, develop independent living/functioning skills, develop coping skills strategies to manage stress, anger or anxiety, maintain personal health and hygiene, self-administer medication, behavior management, positive reward and limit setting, group meetings, crisis intervention and management. Staff members who provide milieu therapy need not meet the license or certification requirements as set forth in Title 12, Article 43, C.R.S. Staff members shall only work under the direct supervision of qualified practitioners licensed pursuant to Title 12, Article 43, C.R.S. The qualified practitioner shall only supervise staff members in the practitioner's area of licensure.

8.766.5 REIMBURSEMENT METHODOLOGY

8.766.5.A. RTC providers who do not participate as psychiatric residential treatment facilities (PRTFs) pursuant to §1905(h) of the Social Security Act and federal regulations at 42 CFR 440.160, 42 CFR 441 Subpart D and 42 CFR 483 Subpart G shall be reimbursed at the lower of:

1. Submitted charges; or

2. Fee schedule as determined by the Department.

8.766.5.B. Providers may choose to submit daily claims using one of two methods:

1. Submit individual codes corresponding to individual treatments; or

2. Submit claims using a single code that represents a blend of Medicaid allowable services to a corresponding Department specified block of time.

8.766.6 RTC providers who pa rticipate as PRTFs pursuant to §1905(h) of the Social Security Act and federal regulations at 42 CFR 440.160, 42 CFR 441 Subpart D and 42 CFR 483 Subpart G shall be reimbursed according to an actuarially sound daily rate as submitted annually by the Department of Human Services.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, Section 8.765
Rule Number:	MSB 11-06-08-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles or Sheeba Ibidunni / x2830 or x3510

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 11-06-08-A, Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, Section 8.765
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) Section 8.765, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Please replace all current text from §8.765 through §8.765.13.A with new text provided from §8.765 through §8.765.13.B. This change is effective 11/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, Section 8.765
Rule Number:	MSB 11-06-08-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles or Sheeba Ibidunni / x2830 or x3510

STATEMENT OF BASIS AND PURPOSE

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

On July 1, 2006, The Center for Medicare and Medicaid Services (CMS) no longer reimbursed states for services provided by Residential Treatment Centers (RTCs). Three Models of care were distinctly defined, and these models were the Psychiatric Residential Treatment Facilities (PRTFs), Therapeutic Residential Child Care Facilities (TRCCFs), and the Residential Child Care Facilities (RCCFs).

There are two main proposed changes:
1. Replacing TRCCFs with RCCFs that provide mental health services. This is to align with the Department of Human Services practices and rules, and to promote continuity of care for children who need therapeutic services intermittently.
2. Remove the requirement that an assessment called the Colorado Client Assessment Record (CCAR) be completed a child/youth prior to placement. Once a child/youth is placed, the authorized professional at the facility will complete a CCAR in the Trails system to determine what level of care is needed for the child/youth. This will improve access while maintaining medical necessity standards. Additionally, it will prevent RCCFs from being classified as Institutions for Mental Diseases (IMD) by CMS.

2. An emergency rule-making is imperatively necessary

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

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

Explain:

3. Federal authority for the Rule, if any:

42 CFR 44O.130(d)/42 CFR 440.160

4. State Authority for the Rule:

Initial Review	**09/09/2011**	Final Adoption	**10/14/2011**
Proposed Effective Date	**11/30/2011**	Emergency Adoption	

DOCUMENT #14

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

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Services for Clients in Psychiatric Residential Treatment Facilities or Residing in Therapeutic Residential Child Care Facilities, Section 8.765
Rule Number:	MSB 11-06-08-A
Division / Contact / Phone:	Medicaid Program Division / Amanda Belles or Sheeba Ibidunni / x2830 or x3510

REGULATORY ANALYSIS

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

   The classes of persons who will be affected by this proposed rule change include children, families, Court Appointed Special Advocate (CASA), the Department of Human Services case workers, and RCCF providers. One benefit of this rule change is that it removes the current requirement of having an assessment called the Colorado Client Assessment Record (CCAR) be completed PRIOR to placement of a child/youth. With this rule change, once the child/youth is placed the authorized profesional at the facility will complete the CCAR to determine what level of care is needed. By doing so, access will be improved and medical necessity standards will be maintained. Another benefit from this rule change will be that it will not jeopardize federal matching funds.

   There are no evident costs associated with this proposed rule change.

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

   The proposed rule will remove some of the administrative burden on case workers, because they will not need to complete a CCAR, as this will now be completed by the authorized professional at the facility once the child/youth is placed.

   Another qualitative impact that coincides with the above described qualitative impact of the proposed rule, is that by having the authorized professional at the facility complete a CCAR, the quality of the level of care that is determined for a child/youth will be improved.

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.

   We do not anticipate that this proposed rule change will increase the utilization or costs to the Department or to any agency associated with this rule change. Nor do we anticipate that this rule change will affect state revenues.

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

Without this rule change, a potential cost is that federal matching funds could be at risk. This proposed rule change will remove that risk.

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

   Not applicable to this proposed rule change.

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

   There are none.

8.765 SERVICES FOR CLIENTS IN PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES OR RESIDING IN ~~THERAPEUTIC~~ RESIDENTIAL CHILD CARE FACILITIES AS DEFINED BELOW

8.765.1 DEFINITIONS [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

Assessment means the process of continuously collecting and evaluating information to develop a client's profile on which to base a Plan of Care, service planning, and referral.

Clinical Staff means medical staff that are at a minimum licensed at the level of registered nurse, performing within the authority of the applicable practice acts.

Colorado Client Assessment Record (CCAR) means a clinical instrument designed to assess the behavior/mental health status of a medically eligible client. The CCAR is used to identify current diagnosis and clinical issues facing the client, to measure progress during treatment and to determine mental health medical necessity. This instrument is used for children in the custody of a county department of human/social services or Division of youth corrections and for those children receiving mental health services in an RCCF through the Child Mental Health Treatment Act.

Emergency Safety Intervention means the use of Restraint and Seclusion as an immediate response to an Emergency Safety Situation.

Emergency Safety Situation means unanticipated behavior of the client that places the client or others at serious threat of violence or injury if no intervention occurs and that calls for Emergency Safety Intervention.

Emergency Services means emergency medical and crisis management services.

Independent Team means a team certifying the need for Psychiatric Residential Treatment Facility (PRTF) services that is independent of the Referral Agency and includes a physician who has competence in the diagnosis and treatment of mental illness and knowledge of the client's condition.

Interdisciplinary Team means staff in a PRTF comprised of a physician, and a Licensed Mental Health Professional, registered nurse or occupational therapist responsible for the treatment of the client.

Licensed Mental Health Professional means a psychologist licensed pursuant to part 3 of article 43 of title 12, C.R.S., a psychiatrist licensed pursuant to part 1 of article 36 of title 12, C.R.S., a clinical social worker licensed pursuant to part 4 of article 43 of title 12, C.R.S., a marriage and family therapist licensed pursuant to part 5 of article 43 of title 12, C.R.S., a professional counselor licensed pursuant to part 6 of article 43 of title 12, C.R.S., or a social worker licensed pursuant to part 4 of article 43 or title 12, C.R.S., that is supervised by a licensed clinical social worker. Sections 12-43-301, et seq, 12-36-101, et seq, 12-43-401, et seq, 12-43-501, et seq and 12-43-601, et seq, C.R.S. (2005) are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

Medication Management Services means review of medication by a physician at intervals consistent with generally accepted medical practice and documentation of informed consent for treatment.

Multidisciplinary Team means staff in a ~~Therapeutic~~ Residential Child Care Facility (~~T~~RCCF) providing mental health services comprised of at least one Licensed Mental Health Professional and other staff responsible for the treatment of the client and may include a staff member from the Referral Agency.

Plan of Care means a treatment plan designed for each client and family, developed by an Interdisciplinary or Multidisciplinary Team.

Prone Position means a client lying in a face down or front down position.

Psychiatric Residential Treatment Facility (PRTF) means a facility that is not a hospital and provides inpatient psychiatric services for individuals under age 21 under the direction of a physician, licensed pursuant to part 1 of article 36 of title 12, C.R.S.

Referral Agency means the Division of Youth Corrections, County Departments of Human/Social Services who have legal custody of a client, Behavioral Healthcare Organization or Community Mental Health Center that refers the client to a PRTF or ~~T~~RCCF for the purpose of placement through the Child Mental Health Treatment Act.

Restraint includes Drug Used as a Restraint, Mechanical Restraint and Personal Restraint.

Drug Used as a Restraint means any drug that is administered to manage a client's behavior in a way that reduces the safety risk to the client or to others; has the temporary affect of restricting the client's freedom of movement and is not a standard treatment for the client's medical or psychiatric condition.

Mechanical Restraint means any device attached or adjacent to the client's body that the client cannot easily remove that restricts freedom of movement or normal access to the client's body.

Personal Restraint means personal application of physical force without the use of any device, for the purpose of restraining the free movement of the client's body. This does not include briefly holding a client without undue force in order to calm or comfort, or holding a client's hand to safely escort the client from one area to another. This does not include the act of getting the client under control and into the required position for Restraint.

Residential Child Care Facility (RCCF) means any facility that provides out-of-home, 24-hour care, protection and supervision for children in accordance with 12 C.C.R. 2509-8, Section 7.705.91.A.

Seclusion means the involuntary confinement of a client alone in a room or an area from which the client is physically prohibited from leaving.

~~Therapeutic Residential Child Care Facility (TRCCF) means a facility as defined at 12 C.C.R. 2509-8, Section 7.705.91.A.~~

8.765.2 PRTF BENEFIT [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.2.A. PRTF benefit shall include services as identified in the Plan of Care as well as other services necessary for the care of the client in the facility. These services include, but are not limited to:

1. Individual therapy.

2. Group therapy.

3. Family, or conjoint, therapy conducted with the client present, unless client contact with family members is contraindicated.

4. Emergency services.

5. Medication Management Services.

6. Room and Board.

8.765.3 PRTF NON-BENEFIT [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.3.A. The following are not a benefit in a PRTF:

1. The day of discharge.

2. Leave days.

3. Days when the client is in detention.

8.765.4 PRTF CLIENT ELIGIBILITY [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.4.A. To receive benefits in a PRTF, the client shall:

1. Be between the ages of three and twenty-one.

2. Be certified to need PRTF level of care by an Independent Team. The Team shall certify that:

   a. Ambulatory care resources available in the community do not meet the treatment needs of the client.

   b. Proper treatment of the client's mental illness condition requires services on an inpatient basis under the direction of a physician.

   c. The services can reasonably be expected to improve the client's mental health or prevent further regression so that the services shall no longer be needed.

3. Be certified to have a diagnosis of a psychiatric disorder classified as a Diagnostic Statistical Manual (DSM) IV Text Revision, Fourth Edition, diagnosis that is the primary reason for placement from one of the following diagnostic categories:

   295 Schizophrenic disorders

   296 Affective psychoses

   297 Paranoid states

   298 Other nonorganic psychoses

   300 Neurotic disorders

   301 Personality disorders

   307 Eating Disorders, Tic Disorders and Sleep Disorders

   308 Acute reaction to stress

   309 Adjustment reaction

   311 Depressive disorder, not elsewhere classified

   312 Disturbance of conduct, not elsewhere classified

   313 Disturbance of emotions specific to childhood and adolescence

314 Hyperkinetic syndrome of childhood

4. Be certified to have a DSM Axis 5 GAF score of 40 or less.

5. Be assessed using a current valid Colorado Client Assessment Record (CCAR) that supports medical necessity and scores at a level C.

8.765.4.B. The client shall be not be eligible to receive services when:

1. The client is no longer able to benefit from the service or is no longer progressing towards goals.

2. The client is absent without leave in excess of 24 consecutive hours or has been removed from the facility and placed in non-PRTF services.

3. The Interdisciplinary Team determines that the client has attained treatment goals.

4. Admission of minors not in the custody of a County Department of Human/Social Services or DHS as a result of commitment to the Division of Youth Corrections shall be subject to the requirements set forth at Section 27-10-103, C.R.S (2005), which is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

8.765.5 PRTF PROVIDER ELIGIBILITY [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.5.A. All PRTF Providers shall have an Interdisciplinary Team.

1. The Interdisciplinary Team shall include either a board-certified psychiatrist, or a clinical psychologist who has a doctoral degree and a physician licensed to practice medicine or osteopathy, and one of the following:

   a. A licensed clinical social worker, licensed marriage and family therapist or licensed professional counselor.

   b. A registered nurse with specialized training or one year's experience in treating mentally ill individuals.

   c. A certified occupational therapist with specialized training or one year’s experience in treating mentally ill individuals; or

   d. A licensed psychologist.

2. The Interdisciplinary team shall:

   a. Assess the client's immediate and long-range therapeutic needs, developmental priorities, and personal strengths and liabilities.

   b. Assess the potential resources of the client and client’s family.

   c. Develop and implement a comprehensive, individualized written Plan of Care.

   d. Set treatment objectives.

e. Prescribe therapeutic modalities to achieve the objectives of the Plan of Care.

8.765.5.B . All PRTF providers shall implement a Plan of Care.

8.765.5 .C. An initial Plan of Care shall be developed within 72 hours of the client's admission and shall address the immediate and emergency needs of the client.

8.765.5 .D. A comprehensive Plan of Care shall:

1. Be completed within 14 days of admission.

2. Be signed and dated by the client, the Referral Agency and the Licensed Mental Health Professional.

3. Address clinical and other needs including the client's presenting problems, physical health, emotional status, behavior, support system in the community, available resources and discharge plan.

4. Include specific goals and measurable objectives, expected dates of achievement and specific discharge criteria to be met for termination of treatment. Criteria for discharge shall include provisions for follow-up services.

5. Specify the type, frequency and duration of all PRTF services necessary to meet the needs of the client and to treat the client's current diagnosis.

6. Identify the provision of or the referral for services other than PRTF Services.

7. Be readily identifiable and be maintained in the client's record.

8. Document any court-ordered treatment including identifying the agency responsible for providing the court-ordered treatment.

9. Include revisions to the Plan of Care at least monthly, or sooner if appropriate.

8.765.5.E. The PRTF shall designate a Licensed Mental Health Professional to act as a case manager for each client to oversee the formulation, implementation, review and revision to the Plan of Care.

8.765.5.F. The Licensed Mental Health Professional shall sign and date the Plan of Care.

8.765.5.G. The PRTF shall ensure the client and/or legal guardian participate in the formulation, review and revision of the Plan of Care. If the client or legal guardian is unable to participate or when his or her participation is clinically contraindicated, the PRTF shall document the reasons in the client's record. Any decision to not involve the family or guardian shall be approved by the Referral Agency. In addition, other persons selected by the client, the family or guardian, the Referral Agency or the Licensed Mental Health Professional may be included in the formulation, review and revision of the Plan of Care.

8.765.5.H Except in cases of emergency, all PRTF services in the Plan of Care shall be provided.

8.765.5.I. The PRTF shall ensure that physician prescribed information is used for the component of the Plan of Care requiring Medication Management Services.

8.765.5.J. The PRTF shall ensure all clients and/or guardians are aware of the complaint and grievance procedures.

8.765.5.K. The PRTF shall ensure all clients and/or guardians are aware of the PRTFs policies regarding Restraint and Seclusion as required in 42 C.F.R. 483.350-376, which is incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.

8.765.5.L. The PRTF shall facilitate access to necessary medical care and shall be responsible for coordinating mental health treatment with medical treatment.

8.765.5.M. Client Transfers:

1. A client shall be transferred only to the care of another PRTF or placement facility when adequate arrangements for care have been made by the Referral Agency.

2. The client and the legal guardian shall be given a minimum of 24 hours notice before the client is transferred unless this notice is waived by the Referral Agency or legal guardian in writing or if an emergency condition exists.

3. Transfers shall be documented in the clinical record.

8.765.5.N. PRTF Licensure and Certification Requirements.

1. The PRTF shall:

   a. Be certified by the Department of Human Services (DHS), to provide mental health services as a PRTF.

   b. Be licensed by DHS, Division of Child Care Licensing, as a Residential Child Care Facility and a PRTF.

   c. Be certified as a qualified residential provider by the Department of Public Health and Environment.

   d. Be accredited by the Joint Commission ~~on Accreditation of Healthcare Organizations~~, the Commission on Accreditation of Rehabilitation Facilities, or the Council on Accreditation of Services for Families and Children.

   e. Provide an attestation to the Department that the PRTF is in compliance with the condition of participation for Restraint and Seclusion as described in Section 8.765.6.F and in federal law.

2. A PRTF located in another state shall meet the requirements as set forth in Section 8.765.5.N.1.d. and e. and shall meet all other license and certification requirements for a PRTF in the state in which it is located.

3. A PRTF that has more than one physical address shall have a separate Medicaid provider number for each facility.

8.765.6 PRTF PROVIDER RESPONSIBILITIES [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.6.A. A PRTF shall complete a CCAR and maintain an organized, legible, chronological, current treatment record for each client. Treatment records shall include:

1. Admission information such as the client's personal information and demographic data, source of referral, most current Diagnostic Statistical Manual diagnosis and substance abuse history.

2. Documentation of the client's legal status, including but not limited to guardianship, conservatorship, court orders, custody, certifications, advisement and consent.

3. Copies of all CCARs.

4. All Plans of Care and revisions.

5. Documentation of client's attendance at, participation in and outcomes of PRTF Services.

6. Documentation that the client and/or the legal guardian was provided with a copy of the Plan of Care.

7. Correspondence to and from agencies and individuals involved in the client's treatment.

8. An explanation whenever any member of the Interdisciplinary Team, client, parent or guardian, when appropriate, does not sign a Plan of Care.

9. The name of the Licensed Mental Health Professional responsible for the formulation, implementation, review and revision of the client's Plan of Care.

10. A discharge report, within 30 consecutive days of the discharge from the PRTF, summarizing treatment received and outcomes.

11. For transfers between facilities, documentation of appropriate clinical information and coordination of services between the two facilities.

12. Documentation of any unplanned discharges without advance notice and any discharges against the Licensed Mental Health Professional's advice.

13. Information regarding any serious injury sustained while in the PRTF to the client or by the client and details describing the circumstances by which the injury occurred.

14. Information regarding a client's death and details of the circumstances by which the death occurred.

15. Dates, times and circumstances of unauthorized leave.

16. Documentation of detention dates.

17. Treatment entries that are signed and dated by the person providing treatment, including title or position of the person providing treatment.

8.765.6.B. All members of the Clinical Staff shall be trained annually in the development and review of Plans of Care and the details of this training shall be documented.

8.765.6.C. Records shall be kept in a secure location at the PRTF.

8.765.6.D. Data, including claims data, shall be retained for six years unless there is a written statutory requirement or regulation available from a county, state or federal agency requiring a longer retention period.

8.765.6.E. Clinical records shall be retained for six years after the client's 21st birthday.

8.765.6.F. The PRTF shall comply with the following requirements for the use of Restraint and Seclusion:

1. Personal, Mechanical and Drugs Used as Restraint shall be ordered only by a physician, physician's assistant or nurse practitioner.

2. An order for Restraint or Seclusion shall not be written as a standing order or on an as-needed basis.

3. Restraint and Seclusion shall not result in harm or injury to the client and shall be used only to ensure the safety of the client or others during an Emergency Safety Situation and only until the Emergency Safety Situation has ceased.

4. Restraint and Seclusion shall not be used simultaneously.

5. A Personal Restraint when a client is in a Prone Position is prohibited.

6. If the order for Restraint or Seclusion is verbal, it shall be received by a registered nurse, licensed practical nurse or physician's assistant.

7. The Restraint or Seclusion shall be carried out by Clinical Staff who are trained in the use of emergency safety intervention.

8. Only a physician, registered nurse, licensed practical nurse or physician's assistant shall administer a Drug Used as a Restraint.

9. Clinical Staff trained in the use of emergency safety interventions that are physically present during the Restraint or Seclusion shall monitor the client during the Restraint or Seclusion period.

10. Each order for Restraint or Seclusion shall never:

    a. Exceed the duration of the emergency safety situation; and

    b. Exceed four hours in length for youth ages 18 to 21; two hours in length for clients ages nine to 17; or one hour in length for clients under age of nine.

11. Within one hour of the initiation of the Emergency Safety Intervention a physician, registered nurse or physician's assistant shall conduct a face-to-face assessment of the physical and psychological well being of the client. A psychologist may conduct the face-to-face assessment if done in conjunction with a physician, registered nurse or physician's assistant.

12. The PRTF shall report each serious occurrence to both the Department and the federally-designated Protection and Advocacy agency no later than close of business the next business day. Serious occurrences to be reported include a client's death, a serious injury to a client, or a client's suicide attempt.

13. The PRTF shall notify the parent(s) or legal guardian(s) of a client who has been restrained or secluded as soon as possible, but not to exceed 24 hours, after the initiation of each emergency safety intervention and shall document the date and time of this notification in the client's record.

14. Within 24 hours of the use of Restraint or Seclusion, staff involved in an Emergency Safety Intervention and the client shall have a face-to-face discussion. This discussion shall include all staff involved in the intervention except when the presence of a particular staff person may jeopardize the well-being of the client. Other staff and the client's parent or guardian may participate in the discussion, if appropriate.

15. Within 24 hours after the use of Restraint or Seclusion, all staff involved in the Emergency Safety Intervention, and appropriate supervisory and administrative staff, shall conduct a debriefing session that includes, at a minimum, a review and discussion of:

    a. The situation that required the intervention, including a discussion of the precipitating factors that led up to the intervention.

    b. Alternative techniques that may have prevented the use of the Restraint or Seclusion.

    c. New procedures implemented to mitigate any recurrence of the use of Restraint or Seclusion.

    d. The outcome of the intervention, including any injuries that may have resulted from the use of Restraint or Seclusion.

8.765.7 REIMBURSEMENT FOR PRTFs [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.7.A. A PRTF shall be reimbursed a per diem rate as determined by DHS and approved by the Department.

8.765.7.B. The Department shall recover the per diem reimbursement when:

1. Each service is not documented in the treatment record at the frequency specified in the Plan of Care.

2. There is no Plan of Care in the record, for the period of time claims were paid.

3. Records are requested but not provided with 21 calendar days.

8.765.C. A PRTF may appeal the Department's recovery actions within 30 calendar days from the date of notice. The appeal shall be submitted in accordance with 10 C.C.R. 2505-10, Section 8.050.

~~**8.765.8 TRCCF GENERAL PROVISONS [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]**~~

~~8.765.8.A. Results from the Multidisciplinary Team's Assessment, the client's Medicaid eligibility, diagnoses, characteristics and presenting problem shall be contained in the client's record and transmitted to the Referral Agency for verification of the Assessment results and authorization of the level of care. If the Referral Agency disagrees with the Multidisciplinary Team's Assessment and the client is denied admission, the client has the right to appeal pursuant to 10 C.C.R. 2505-10, Section 8.057.~~

[akb1]**8.765.~~9~~ 8 ~~TRCCF~~ MENTAL HEALTH BENEFITS FOR CLIENTS IN AN RCCF [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]**

8.765.~~9~~8.A. Family therapy shall not exceed maximum of one service unit per day.

1. Family therapy without the client present may be provided at a maximum of one service unit per week if treatment is documented in the Plan of Care that client contact with family

members is contraindicated. Family Therapy without the client present shall be for the specific benefit of the client.

8.765.~~9~~8.B. Individual therapy shall not exceed two service units per day.

8.765.~~9~~8.C. Group therapy shall not exceed eight service units per day.

8.765.~~9~~8.D. A Licensed Mental Health Professional may authorize family, individual and group therapy in excess of maximum service units per day if the following is documented in the Plan of Care:

1. The reason for the additional therapy.

2. How many additional units are necessary.

3. How long the additional therapy is necessary.

8.765.~~9~~8.E. The Licensed Mental Health Professional shall re-authorize therapy in excess of the maximum service units per day in the Plan of Care at least every 30 days.

~~8.765.9.F. The Licensed Mental Health Professional shall maintain an organized, legible, chronological, current record on each client.~~[akb2]

8.765.9 NON-COVERED BENEFITS FOR CLIENTS IN AN RCCF

8.765.9.A. The following ~~are non-covered~~ benefits are not covered for clients in an RCCF:

~~———~~1. Court-ordered treatment that is not otherwise medically indicated;

~~———~~2. Room and board services;

~~———~~3. Educational, vocation and job training services;

~~———~~4. Recreational or social activities;

~~———~~5. Habilitative care for children who are developmentally disabled or mentally retarded; and

~~———~~6. Services provided ~~to inmates of~~ by public institutions or ~~residents of~~ institutions for mental

~~———————~~diseases.

[akb3]**8.765.10 CLIENT ELIGIBILITY FOR MENTAL HEALTH SERVICES IN AN ~~T~~RCCF [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]**

8.765.10.A. To be eligible for mental health services ~~admission into~~ delivered in an ~~T~~RCCF the client shall ~~be~~:

1. Be ~~B~~between the ages of three and 21 years of age.

2. Have a ~~D~~diagnosis ~~ed with~~of a psychiatric disorder classified by a *Diagnostic and Statistical Manual of Mental Disorders (DSM)* ~~diagnosis~~.

3. Have a ~~completed~~ current, and valid CCAR ~~A~~assessment completed by a Licensed Mental Health Professional ~~ed using a current valid CCAR~~ that supports medical necessity for

placement.mental health services, and demonstrates which services the client would benefit from.

4. Determined in an initial Assessment to be capable of benefiting from the mental health services provided in a TRCCF services as determined by a Licensed Mental Health Professional.

8.765.11 TRCCF PROVIDER ELIGIBILITY FOR PROVIDERS DELIVERING SERVICES IN AN RCCF [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.11.A Individual, group and family therapy provided in an RCCF shall be provided by a Licensed Mental Health Professionial or a provisionally-licensed Mental Health Professional supervised by a Licensed Mental Health Professional, employed by or contracted with A TRCCF shall be an RCCF that is licensed by the Colorado Department of Human Services. DHS as a Residential Child Care Facility and as a TRCCF.

8.765.11.B. Licensed Mental Health Professionals providing mental health services to clients in the an TRCCF shall be are exempt from the direct physician supervision requirement in 10 C.C.R. 2505-10, Section 8.200.3.E.

8.765.11.C. Licensed Mental Health Professionals providing mental health services to clients in the RCCF enroll as Medicaid rendering providers.

8.765.12 TRCCF PROVIDER RESPONSIBLITIES [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.12.A. The RCCF shall include the following in the client's record:

1. Results from the Multidisciplinary Team's Assessment;

2. Client's Medicaid Eligibility Determination Form; Medicaid eligibility; and

3. Client's diagnoses, characteristics and presenting problem.

8.765.12.B. The RCCF shall transmit the items listed in 8.765.12.A. to the Referral Agency. If the Referral Agency disagrees with the Multidisciplinary Team's Assessment and the client is denied admission, the client has the right appeal pursuant to 10 C.C.R. 2505-10, Section 8.057.[akb4]

8.765.12.AC. The TRCCF shall designate a Licensed Mental Health Professional to act as a case manager for therapeutic mental health services for each client.

8.765.12.B. Individual, group and family therapy shall be provided by a Licensed Mental Health Professional or a provisionally-licensed Mental Health Professional supervised by a Licensed Mental Health Professional, employed by or contracted with the TRCCF.[akb5]

8.765.12.C. A TRCCF shall enroll as a Medicaid provider for the purposes of acting as a billing entity for Licensed Mental Health Professionals providing mental health services in the TRCCF.[akb6]

8.765.12.D. Licensed Mental Health Professionals providing mental health services to clients in the TRCFCF shall enroll as Medicaid rendering providers.[akb7]

8.765.12.D.9.F. The Licensed Mental Health Professional shall maintain an organized, legible, chronological, current record on each client.

8.765.12.E. The ~~patient's~~ client's Plan of ~~Care~~ Treatment for ~~TRCCF~~ mental health services shall be integrated into the agency's comprehensive Plan of Care reviewed ~~developed~~ by the Multidisciplinary Team. The Plan of Care shall:

1. Be signed and dated by the client, the Referral Agency and the Licensed Mental Health Professional and the parent/guardian.

2. Include an initial plan ~~of care~~ developed prior to the onset of mental health services that ~~within 72 hours of the client's admission and shall address the immediate and emergency~~ needs of the client.

~~3. Include a comprehensive plan of care completed within 14 days of the client's admission.~~

~~4.~~ 3. Address mental health ~~clinical~~ and other needs including the client's presenting problems, physical health, emotional status, behavior, support system in the community, available resources and discharge plan.

~~5.~~ 4. Include specific goals and measurable objectives, expected dates of achievement and specific discharge criteria to be met for termination of treatment. Criteria for discharge shall include provisions for follow-up services.

~~6.~~ 5. Specify all ~~TRCCF~~ mental health services necessary to meet the needs of the client and to treat the client's current diagnosis while the client is in the RCCF.

~~7.~~ 6. Identify the provision of or the referral for services other than ~~TRCCF~~ mental health ~~S~~services.

~~8.~~ 7. Be readily identifiable and be maintained in the client's record.

~~9.~~ 8. Document any court-ordered mental health services ~~treatment~~ including identifying the agency responsible for providing the court-ordered treatment.

~~10.~~ 9. Be reviewed by the Multidisciplinary Team monthly and revised as needed. ~~Include revisions to the Plan of Care on an as needed, or at least a monthly basis.~~

8.765.12.F. Except in cases of emergency, all mental health services indicated in the Plan of Care shall be provided.

8.765.13 REIMBURSEMENT FOR MENTAL HEALTH SERVICES IN A ~~T~~RCCF [Emer. Rule eff. 9/8/06; Perm. Rule eff. 10/1/06]

8.765.13A. Reimbursement for Mental Health Services in a ~~T~~RCCF shall be the lower of billed charges or the maximum unit rate of reimbursement.

8.765.13.B. The RCCF shall enroll as a Medicaid provider for the purposes of acting as a billing entity for Licensed Mental Health Professionals providing mental health services in the RCCF.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for the Supported Living Services Program, Section 8.500.9
Rule Number:	MSB 11-07-07-A
Division / Contact / Phone:	Long Term Benefits / John R. Barry / 3173

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Revision to the Medical Assistance Rule Concerning Home and Community Based Services for the Supported Living Services Program, Section 8.500.9
2. Title of Rule: MSB 11-07-07-A
3. This action is an adoption of: <Select One>
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) , 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)? <Select One>

   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Please replace current text from §8.500.90 through §8.500.102 with the new text provided. This change is effective 11/30/2011.

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

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Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for the Supported Living Services Program, Section 8.500.9
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STATEMENT OF BASIS AND PURPOSE

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

   This rule is changed to incorporate the requirements of the existing HCBS Waiver implemented in July 2009. The existing rule is outdated and incorporates the terminated waiver and no longer represents the plan for services delivered under the provisions of the current federally approved waiver. Additionally, rules including language specific to proposed waiver amendments have been included for consideration by MSB pending the approval of Centers for Medicare and Medicaid Services.

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:

   Title 1915 (c) federal "Social Security Act"

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-6-404
   25.5-6-409

Initial Review	**09/09/2011**	Final Adoption	**10/14/2011**
Proposed Effective Date	**12/01/2011**	Emergency Adoption	

DOCUMENT #11

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Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for the Supported Living Services Program, Section 8.500.9
Rule Number:	MSB 11-07-07-A
Division / Contact / Phone:	Long Term Benefits / John R. Barry / 3173

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.

   Eligible clients receiving HCBS-SLS may be minimally effected by proposed rule. Each client's Service Plan has already included changes as a result of the federally approved waiver effective July 1, 2009. It is not expected that the rules changed as a result of the incorporation of the existing waiver will have a negative effect on clients. The implementation of the HCBS-SLS waiver on July 1, 2009 resulted in a reduction of services for some clients. This was due to the redefinition of some services and the introduction of Service Plan Authorization Limits that set a spending limit for each client based on need.

   The inclusion of rules for proposed amendments to the HCBS-SLS waiver may have an effect on some clients. These amendments are under consideration by CMS for approval. The amendments include measures to increase efficiencies and to keep the cost of service delivery within the budget. This may result in a decrease of services in Behavioral Services, and/or Dental Services to some clients.

   Clarification of provider qualifications and specific procedures within Behavioral Services may have an impact on providers. Qualifications are now aligned with the level of service needed which may result in reduced revenue for the provider.

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 implementation of the HCBS-SLS waiver on July 1, 2009 did result in a service reduction for some clients. This was a result of the implementation of Service Plan Authorization Limits for each client that applied a spending limit that is determined by client needs. These adjustments have been made to each client's Service Plan. The implementation of these rules will not create additional adjustments.

   Approximately 178 clients receive Behavioral Services and the proposed rule may effect clients differently but will result in more effective use of funds by clear definition of the service and provider qualifications.

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

There are no costs to the Department associated with implementation and enforcement and no impact to state revenue.

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

   The rules to implement the proposed HCBS waiver amendments will not increase cost. These rules address, in part, a projected total cost that exceeds the annual appropriation from the General Assembly. A portion of the budget shortfall for FY 12 is attributed to increased utilization of specific services in the HCBS waivers for this current year. The Department's inaction may result in implementation of other measures to reduce costs to ensure expenses do not exceed the spending authority. These actions may include rate reductions, reduction of alternative or additional services, or termination of some services.

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

   There is no additional cost expected with these proposed rules.

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

   The proposed rules are to align the existing HCBS waiver document into rule. This is both necessary and required. The proposed changes to implement HCBS waiver amendments for Day Habilitation Services and Supports, Behavioral Services and Dental Services are contingent on the CMS approval of the proposed HCBS waiver amendments. Once the amendments are approved, these rules will be necessary and required. Alternatives considered to these waiver amendments include rate reductions, alternative or additional service reductions, and the termination of some services. The proposed HCBS waiver amendments are determined to be the method that has the least amount of negative impact on clients and providers..

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293, ~~as it may be amended periodically.~~ To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

HCBS-SLS services and supports which are available to assist persons with developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an HCBS-SLS setting. HCBS-SLS services are not intended to provide twenty four (24) hours of paid support or meet all identified client needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

~~Supported Living Services (SLS) are services and supports which are available to assist persons with developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an SLS setting. Supported Living Services are subject to the availability of appropriate services and supports within existing resources.~~

ACTIVITIES OF DAILY LIVING (ADL) **MEANS BASIC SELF CARE ACTIVITIES INCLUDING BATHING, BOWEL AND BLADDER CONTROL, DRESSING, EATING, INDEPENDENT AMBULATION, ~~TRANSFERRING FROM BED TO CHAIR~~, AND NEEDING SUPERVISION TO SUPPORT BEHAVIOR, MEDICAL NEEDS AND MEMORY/COGNITION.**

ADVERSE ACTION **MEANS A DENIAL, REDUCTION, TERMINATION OR SUSPENSION FROM THE HCBS-SLS WAIVER OR A SPECIFIC HCBS-SLS WAIVER SERVICE (S).**

APPLICANT means an individual who is seeking a Long Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in a~~n~~ a~~A~~ssessment.

AUTHORIZED REPRESENTATIVE (AR) MEANS AN INDIVIDUAL DESIGNATED BY THE CLIENT OR THE LEGAL GUARDIAN, IF APPROPRIATE, WHO HAS THE JUDGMENT AND ABILITY TO DIRECT ~~CD~~CONSUMER DIRECTED ATTENDANT SUPPORT ~~S ON~~SERVICES ON THE CLIENT'S BEHALF AND MEETS THE QUALIFICATIONS AS DEFINED AT 10 CCR 2505-10, SECTIONS 8.510.6 AND 8.510.7.

~~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.~~

CLIENT MEANS AN INDIVIDUAL WHO HAS MET LONG TERM CARE (LTC) ELIGIBILITY REQUIREMENTS, IS ENROLLED IN AND CHOOSES TO RECEIVE LTC SERVICES, AND SUBSEQUENTLY RECEIVES LTC SERVICES.

CLIENT REPRESENTATIVE **MEANS A PERSON WHO IS DESIGNATED BY THE CLIENT TO ACT ON THE CLIENT'S BEHALF. A CLIENT REPRESENTATIVE MAY BE: (A) A LEGAL REPRESENTATIVE INCLUDING, BUT NOT LIMITED TO A COURT-APPOINTED GUARDIAN, A PARENT OF A MINOR CHILD, OR A SPOUSE; OR, (B) AN INDIVIDUAL, FAMILY MEMBER OR FRIEND SELECTED BY THE CLIENT TO SPEAK FOR AND/OR ACT ON THE CLIENT'S BEHALF.**

COMMUNITY CENTERED BOARD (CCB) **MEANS A PRIVATE CORPORATION, FOR PROFIT OR NOT FOR PROFIT, WHICH WHEN DESIGNATED PURSUANT TO SECTION 27-10.5-105, C.R.S., PROVIDES CASE MANAGEMENT SERVICES TO CLIENTS WITH DEVELOPMENTAL DISABILITIES, IS AUTHORIZED TO DETERMINE ELIGIBILITY OF SUCH CLIENTS WITHIN A SPECIFIED GEOGRAPHICAL AREA, SERVES AS THE SINGLE POINT OF ENTRY FOR CLIENTS TO RECEIVE SERVICES AND SUPPORTS UNDER SSECTION 27-10.5-105, C.R.S. *ET SEQ* ~~ET SEQ~~, AND PROVIDES AUTHORIZED SERVICES AND SUPPORTS TO SUCH PERSONS EITHER DIRECTLY OR BY PURCHASING SUCH SERVICES AND SUPPORTS FROM SERVICE AGENCIES.**

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, HOMEMAKER ACTIVITIES.

COST CONTAINMENT **MEANS LIMITING THE COST OF PROVIDING CARE IN THE COMMUNITY TO 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, AND MEDICAID STATE PLAN BENEFITS INCLUDING LONG TERM HOME HEALTH SERVICES, AND TARGETED CASE MANAGEMENT. ~~MANAGEMENT.~~**

COST EFFECTIVENESS **MEANS THE MOST ECONOMICAL AND RELIABLE MEANS TO MEET AN IDENTIFIED NEED OF THE CLIENT.**

~~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, HOMEMAKER ACTIVITIES.~~**

DEPARTMENT MEANS THE COLORADO DEPARTMENT OF HEALTH CARE POLICY AND FINANCING, THE SINGLE STATE MEDICAID AGENCY.

DEVELOPMENTAL DISABILITY MEANS A DISABILITY THAT IS MANIFESTED BEFORE THE PERSON REACHES TWENTY-TWO (22) YEARS OF AGE, WHICH CONSTITUTES A SUBSTANTIAL DISABILITY TO THE AFFECTED INDIVIDUAL, AND IS ATTRIBUTABLE TO MENTAL RETARDATION OR RELATED CONDITIONS WHICH INCLUDE CEREBRAL PALSY, EPILEPSY, AUTISM OR OTHER NEUROLOGICAL CONDITIONS WHEN SUCH CONDITIONS RESULT IN IMPAIRMENT OF GENERAL INTELLECTUAL FUNCTIONING OR ADAPTIVE BEHAVIOR SIMILAR TO THAT OF A PERSON WITH MENTAL RETARDATION. UNLESS OTHERWISE SPECIFICALLY STATED, THE FEDERAL DEFINITION OF "DEVELOPMENTAL DISABILITY" FOUND IN 42 U.S.C., SECTION 6000, *ET SEQ.*, SHALL NOT APPLY.

Impairment of general intellectual functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (Seventy (70) or less assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (15)), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. When an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

Adaptive behavior similar to that of a person with mental retardation" means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

Substantial intellectual deficits means an intellectual quotient that is between seventy one (71) and seventy five (75) assuming a scale with a mean of one hundred100 and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified

professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the operating agencyOperating Agency for HhHome and CcCommunity bBased SsServices-SsSupported LLiving SsServices (HCBS-SLS) to persons with developmental disabilities within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING AND DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of the Medicaid State Plan for Medicaid eligible children up to age 21.

FAMILY MEANS A RELATIONSHIP AS IT PERTAINS TO THE CLIENT AND INCLUDES THE FOLLOWING:

A mother, father, brother, sister or,
Extended blood relatives such as grandparent, aunt or uncle
Cousins or,
An adoptive parent; or,
One or more individuals to whom legal custody of a client with a developmental disability has been given by a court; or,
A spouse; orOR
The client's children.

FISCAL MANAGEMENT SERVICES ORGANIZATION (FMS) MEANS THE ENTITY CONTRACTED WITH THE DEPARTMENTDEPARTMENT AS THE EMPLOYER OF RECORD FOR ATTENDANTS TO PROVIDE PERSONNEL MANAGEMENT SERVICES, FISCAL MANAGEMENT SERVICES, AND SKILLS TRAINING TO AN AUTHORIZED REPRESENTATIVE OR A CLIENT RECEIVING CDASS.

FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for Long Term Care services as determined by the departmentDepartment' s prescribed instrument. epartment td instrument.

FUNCTIONAL NEEDS ASSESSMENT MEANS A COMPREHENSIVE FACE-TO-FACE EVALUATION USING THE UNIFORM LONG TERM CARE INSTRUMENT AND MEDICAL VERIFICATION ON THE PROFESSIONAL MEDICAL INFORMATION PAGE TO DETERMINE IF THE APPLICANT OR CLIENT MEETS THE INSTITUTIONAL LEVEL OF CARE (LOCLOC).

GUARDIAN means an individual at least twenty-one (21) years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Gguardianship may include a limited, emergency, and temporary substitute guardian but not a guardian ad litem.

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915-(c) waiver of the social security act and provided in

community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR).

INSTITUTION means a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR) for which the Department makes Medicaid payment under the State plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR) MEANS A PUBLIC OR PRIVATE FACILITY THAT PROVIDES HEALTH AND HABILITATION SERVICES TO A CLIENT WITH DEVELOPMENTAL DISABILITIES OR RELATED CONDITIONS.

LEGALLY RESPONSIBLE PERSON MEANS THE PARENT OF A MINOR CHILD, OR THE CLIENT'S SPOUSE.

LEVEL OF CARE (LOC) MEANS THE SPECIFIED MINIMUM AMOUNT OF ASSISTANCE THAT A CLIENT MUST REQUIRE IN ORDER TO RECEIVE SERVICES IN AN INSTITUTIONAL SETTING UNDER THE STATE PLAN.

LONG TERM CARE (LTC) SERVICES MEANS SERVICES PROVIDED IN NURSING FACILITIES OR INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED (ICF-MR), OR HOME AND COMMUNITY BASED SERVICES (HCBS), LONG TERM HOME HEALTH SERVICES, ~~THE PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE),~~ SWING BED AND HOSPITAL BACK UP PROGRAM (HBU) .

MEDICAID ELIGIBLE MEANS AN APPLICANT OR CLIENT MEETS THE CRITERIA FOR MEDICAID BENEFITS BASED ON THE APPLICANT'S FINANCIAL DETERMINATION AND DISABILITY DETERMINATION.

MEDICAID STATE PLAN MEANS THE FEDERALLY APPROVED DOCUMENT THAT SPECIFIES THE ELIGIBILITY GROUPS THAT A STATE SERVES THROUGH ITS MEDICAID PROGRAM, THE BENEFITS THAT THE STATE COVERS, AND HOW THE STATE ADDRESSES ADDITIONAL FEDERAL MEDICAID STATUTORY REQUIREMENTS CONCERNING THE OPERATION OF ITS MEDICAID PROGRAM.

~~**MEDICAID STATE PLAN MEANS THE FEDERALLY APPROVED DOCUMENT THAT SPECIFIES THE ELIGIBILITY GROUPS THAT A STATE WILL SERVE THROUGH ITS MEDICAID PROGRAM, THE BENEFITS THAT THE STATE COVERS, AND HOW THE STATE ADDRESSES ADDITIONAL FEDERAL MEDICAID STATUTORY REQUIREMENTS CONCERNING THE OPERATION OF ITS MEDICAID PROGRAM.**~~

MEDICATION ADMINISTRATION MEANS ASSISTING A CLIENT IN THE INGESTION, APPLICATION OR INHALATION OF MEDICATION INCLUDING PRESCRIPTION AND NON-PRESCRIPTION DRUGS ACCORDING TO THE DIRECTIONS OF THE ATTENDING PHYSICIAN OR OTHER LICENSED HEALTH PRACTITIONER AND MAKING A WRITTEN RECORD THEREOF.

NATURAL SUPPORTS MEANS INFORMAL RELATIONSHIPS THAT PROVIDE ASSISTANCE AND OCCUR IN A CLIENT'S EVERYDAY LIFE INCLUDING, BUT NOT LIMITED TO, COMMUNITY SUPPORTS AND RELATIONSHIPS WITH FAMILY MEMBERS, FRIENDS, CO-WORKERS, NEIGHBORS AND ACQUAINTANCES.

OPERATING AGENCY MEANS THE DEPARTMENT OF HUMAN SERVICES, DIVISION FOR DEVELOPMENTAL DISABILITIES, WHICH MANAGES THE OPERATIONS OF THE HOME AND COMMUNITY

BASED SERVICES-FOR PERSONS WITH DEVELOPMENTAL DISABILITIES (HCBS-DD), HCBS-SUPPORTED LIVING SERVICES (HCBS-SLS) AND HCBS-CHILDREN'S EXTENSIVE SUPPORTS (HCBS-CES) WAIVERS UNDER THE OVERSIGHT OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) MEANS A PUBLIC OR PRIVATELY MANAGED SERVICE ORGANIZATION THAT PROVIDES, AT MINIMUM, TARGETED CASE MANAGEMENT AND CONTRACTS WITH OTHER QUALIFIED PROVIDERS TO FURNISH SERVICES AUTHORIZED IN THE HOME AND COMMUNITY BASED SERVICES FOR THE -DEVELOPMENTALLY DISABLED (HCBS-DD), HOME AND COMMUNITY BASED SERVICES -SUPPORTED LIVING SERVICES (HCBS-SLS) AND HOME AND COMMUNITY BASED SERVICES -CHILDREN'S EXTENSIVE SUPPORT (HCBS-CES) WAIVERS.

POST ELIGIBILITY TREATMENT OF INCOME (PETI) MEANS THE DETERMINATION OF THE FINANCIAL LIABILITY OF AN HCBS WAIVER CLIENT AS DEFINED IN 42 C.F.R 435.217.

PRIOR AUTHORIZATION MEANS APPROVAL FOR AN ITEM OR SERVICE THAT IS OBTAINED IN ADVANCE EITHER FROM THE ~~DEPARTMENT~~DEPARTMENT, THE ~~OPERATING AGENCY~~OPERATING AGENCY, A STATE FISCAL AGENT OR THE CASE MANAGEMENT AGENCY.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) MEANS THE MEDICAL INFORMATION FORM SIGNED BY A LICENSED MEDICAL PROFESSIONAL USED TO VERIFY THE CLIENT NEEDS INSTITUTIONAL LEVEL OF CARE.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1, Section 16.200 *et seq.*, ~~2 503-1 CCR 16.200 ET SEQ.~~, that has received program approval to provide HCBS-SLS services.

PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use including vehicles for hire.

Reimbursement rates means the maximum allowable Medicaid reimbursement to a provider for each unit of service.

RELATIVE means a person related to the client by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department ~~and/~~or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service

SERVICE PLAN means the written document that specifies identified and needed services to include Medicaid eligible and non-Medicaid eligible services, regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the ~~department~~Department and the ~~operating agency~~Operating Agency'peratin set forth in 10 CCR 2505-10, Section 8.400. ~~10 CCR 2505-10 Section 8.400.~~

SERVICE PLAN AUTHORIZATION LIMIT~~S~~ (SPAL~~S~~) MEANS AN ANNUAL ~~SPENDING LIMITATION~~ UPPER PAYMENT LIMIT OF TOTAL ~~DOLLARS~~FUNDS AVAILABLE TO ~~ADDRESS~~ PURCHASE SERVICES TO MEET THE CLIENT'S ONGOING NEEDS., ~~BASED ON A UNIFORM METHOD USING THE SUPPORTS INTENSITY SCALE (SIS) AND ADDITIONAL STATISTICALLY SIGNIFICANT FACTORS.~~EACH SPAL IS DETERMINED BY THE DEPARTMENT AND OPERATING AGENCY BASED ON THE ANNUAL APPROPRIATION FOR THE HCBS-SLS WAIVER, THE NUMBER OF CLIENTS IN EACH LEVEL, AND PROJECTED UTILIZATION.

SUPPORT is any task performed for the client where learning is secondary or incidental to the task itself or an adaptation is provided.

SUPPORTS INTENSITY SCALE (SIS) MEANS THE STANDARDIZED ASSESSMENT TOOL THAT GATHERS INFORMATION FROM A SEMI- STRUCTURED INTERVIEW OF RESPONDENTS WHO KNOW THE CLIENT WELL. IT IS DESIGNED TO IDENTIFY AND MEASURE THE PRACTICAL SUPPORT REQUIREMENTS OF ADULTS WITH DEVELOPMENTAL DISABILITIES.

"SUPPORT LEVEL" MEANS A NUMERIC VALUE DETERMINED USING AN ALGORITHM THAT PLACES CLIENTS INTO GROUPS WITH OTHER CLIENTS WHO HAVE SIMILAR OVERALL SUPPORT NEEDS.

TARGETED CASE MANAGEMENT (TCM) MEANS A MEDICAID STATE PLAN BENEFIT FOR A TARGET POPULATION WHICH INCLUDES FACILITATING ENROLLMENT, LOCATING, COORDINATING AND MONITORING NEEDED HCBS WAIVER SERVICES AND COORDINATING WITH OTHER NON-WAIVER RESOURCES SUCH AS MEDICAL, SOCIAL, EDUCATIONAL AND OTHER RESOURCES TO ENSURE NON-DUPLICATION OF WW~~W~~AIVER SS~~S~~ERVICES AND THE MONITORING OF EFFECTIVE AND EFFICIENT PROVISION OF WW~~W~~AIVER SS~~S~~ERVICES ACROSS MULTIPLE FUNDING SOURCES.

THIRD PARTY RESOURCES **MEANS SERVICES AND SUPPORTS THAT A CLIENT MAY RECEIVE FROM A VARIETY OF PROGRAMS AND FUNDING SOURCES BEYOND NATURAL SUPPORTS OR MEDICAID THAT MAY INCLUDE, BUT ARE NOT LIMITED TO COMMUNITY RESOURCES, SERVICES PROVIDED THROUGH PRIVATE INSURANCE, NON-PROFIT SERVICES AND OTHER GOVERNMENT PROGRAMS.**

WAIVER SERVICE MEANS OPTIONAL SERVICES DEFINED IN THE CURRENT FEDERALLY APPROVED WAIVER DOCUMENTS AND DO NOT INCLUDE MEDICAID STATE PLAN BENEFITS.

8.500.~~91~~ 91 ~~PROGRAM~~ HCBS-SLS WAIVER ADMINISTRATION

~~The Supported Living Services program for persons with developmental disabilities is administered by the Department of Human Services, Developmental Disabilities Services under the oversight of the Department of Health Care Policy and Financing.~~

8.500.91.A ~~Supported Living Services~~HCBS-SLS ~~for persons with developmental disabilities~~ shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities ~~Developmental Disabilities Services (DDS)~~, 2 CCR 503-1 and promulgated in accordance with the provision of Section- 25.5-6-404(4), C.R.S. ~~26-4-624 C.R.S.~~

8.500.91.B In the event a direct conflict arises between the rules and regulations of the Department ~~of Health Care Policy and Financing~~ and the ~~Department of Human Services~~Operating Agency, ~~the rules and regulations of the Department of Health Care Policy and Financing shall control~~ the provisions of Section ~~26-4-624 (5) C.R.S.~~25.5-6-404(4), C.R.S. shall apply and the regulations of the Department shall control.~~.~~

8.500.10.C The HCBS-SLS Waiver is operated by the Department of Human Services, Division for Developmental Disabilities under the oversight of the Department of Health Care Policy and Financing.

~~8.500.91.D HCBS-SLS provides the necessary support to meet the daily living needs of a client who is responsible for the client's own living arrangements in the community.~~

8.500.910.E HCBS-SLS services are available only to address those needs identified in the functional needs assessment and authorized in the service plan when the service or support is not available through the Medicaid State plan, EPSDT, natural supports, or third party payment resources.

8.500.91.F The HCBS-SLS Waiver:

1. Shall not constitute an entitlement to services from either the Department or the O~~o~~perating A~~a~~gency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments into the HCBS-SLS Waiver do not exceed the ~~Federally~~federally approved waiver c~~C~~apacity, and

4. May limit the enrollment when utilization of the HCBS-SLS Waiver program is projected to exceed the spending authority.

~~Supported Living Services shall not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services. Supported Living Services shall be subject to annual appropriations by the Colorado General Assembly. The Department of Human Services, Developmental Disabilities Services shall limit the utilization of the Supported Living Services waiver based on the federally approved capacity and cost effectiveness of the waiver and the total appropriations, and shall limit the enrollment when utilization of the Supported Living Services waiver program is projected to exceed the spending authority.~~

~~Designated Community Centered Boards shall be responsible for performing all functions related to the provision of Supported Living Services, pursuant to 27-10.5-105, C.R.S., et seq. (1995 Supp.).~~

8.500.~~92~~ 92 ~~PROGRAM~~ GENERAL PROVISIONS

8.500.92.A ~~The State of Colorado requested and was granted authority to provide the following services under the Supported Living Services waiver.~~The following provisions

shall apply to the Home and Community Based Services-Supported Living Services (HCBS-SLS) Waiver:

~~A.~~1. ~~Supported Living Services are provided as an alternative to institutional placement for individuals with developmental disabilities and include personal assistant services, habilitation services, environmental engineering, professional services, and dental services. Home And Community Based Services-Supported Living Services (HCBS-SLS)~~ HCBS-SLS shall be provided as an alternative to ICF-MR services for an eligible client with developmental disabilities.

~~B.~~2. ~~The Supported Living Services program is waived from the requirements of Section 1902(a)(10)(B) (comparability of services) and Section 1902(a)(l) (statewideness) of the Social Security Act Therefore, the availability and comparability of services may not be consistent throughout the State of Colorado.~~ HCBS-SLS is waived from the requirements of Section 1902(a)(10)(b) of the Social Security Act concerning comparability of services. T~~t~~he availability and comparability of services may not be consistent throughout the State of Colorado.

~~C~~3. ~~Individuals eligible for services under the SLS program are eligible for all other Medicaid services for which they qualify and must first access all benefits available under the regular Medicaid State Plan prior to accessing funding for those same services under the SLS program.~~ A client enrolled in the HCBS-SLS Waiver shall be eligible for all other Medicaid services for which the client qualifies and shall first access all benefits available under the Medicaid State plan or Medicaid EPSDT prior to accessing services under the HCBS-SLS Waiver. Services received through the HCBS-SLS Waiver may not duplicate services available through the State Plan

~~D. Case management agencies shall provide case management services under administrative activity including: assessment of the individual's needs to determine if SLS waiver services are appropriate; completion of the Individualized Plan (IP); and submission of the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for SLS waiver services. These Individualized Plans are also subject to review by the Department of Health Care Policy and Financing.~~

~~E. The provision of Supported Living Services may be subcontracted by the SLS agency to other qualified agencies, professionals, individuals, or family members living in the same household as the person with a developmental disability, or vendors in order to provide additional opportunities for individual choice and the use of general services,~~

F. The individual receiving services and/or his/her family or guardian are responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources; cooperating with the case management agency and service providers as agreed to in the Individualized Plan; and choosing between SLS waiver services and institutional care.

8.500.93 93 CLIENT ELIGIBILITYLE INDIVIDUALS

8.500.93.A Supported Living Services may be offered to an individual who meets the following criteria:To be eligible for the HCBS-SLS Waiver an individual shall meet the target population criteria as follows:

A.1. Has beenBe determined to have a developmental disability as defined in Section 27-10.5-102, C.R.S., (1995 Supp.), by a designated Community Centered Board; and

B.2. Is an adult, Be eighteen (18) years of age or older.; and

C.3. Does not require twenty-four (24) hour supervision on a continuous basis which is reimbursed as a HCBS-SLS service.

D.4. Is served safely in the community with the type or amount of HCBS-SLS waiver services available and within the federally approved capacity and cost containment limits of the waiver,

E.5. Meet ICF-MRICF-MR level of care as determined by the Functional Needs Assessment

F. 6.Meet the Medicaid financial determination for LTC eligibility as specified at 10 CCR 2505-10, Section 8.100 *et seq.* 10 C.C.R. 2505-10, § 8.100 ET SEQ; and,

G.7. Resides in an eligible HCBS-SLS setting. SLS settings are the client's residence, which is defined as the following:

1.a. A living arrangement (e.g., home, apartment, or condominium), which the client owns, rents or leases in own name,

2.b. The home where the client lives with the client's family or legal guardian, or and

3.c. A lLiving arrangement of nNo more than three (3) persons receiving HCBS-SLS residing in one household, unless they are all members of the same family.

H.8. The client shall maintain eligibility by continuing to meet the HCBS-SLS eEligibility requirements and the following:

1.a. Receives at least one (1) HCB-SLS waiver service each calendar month,

2.b. Is not be simultaneously enrolled in any other HCBS waiver, and.

3.c. Is not residing in a hospital, nursing facility, ICF-MR, correctional facility or other institution.

~~I.~~9. When the HCBS-SLS waiver reaches capacity for enrollment, a client determined eligible for a waiver shall be placed on a wait list in accordance with these rules. 10 CCR 2505-10, ~~at~~ Section 8.500.96 *et seq*.

~~C. Has been certified by the Department of Human Services/Developmental Disabilities Services through the ULTC-100 and LTC-102 assessment forms that he/she meets the established minimum criteria used in the designated screening instrument for the Level of Care for placement into an Intermediate Care Facility for the Mentally Retarded (ICF/MR); and~~

~~D. For whom an Individualized Plan (IP) has been developed which conforms to the purchase of service limitations as provided herein; and~~

~~E. Meets the medical assistance eligibility criteria as specified in the section on PERSONS RECEIVING HOME AND COMMUNITY-BASED SERVICES at §8.110.8; and~~

~~F. Does not require twenty-four (24) hour supervision on an ongoing basis which is paid for with SLS funding; and~~

~~G. Resides in an eligible SLS setting. SLS settings are the individual's "own home" which is defined as the following:~~

~~1. A living arrangement (e.g., home, apartment, or condominium) which the individual owns or rents or leases in his/her own name; or~~

~~2. The home where the individual lives with his/her family or legal guardian; and~~

~~3. No more than three (3) persons receiving Supported Living Services may reside in one household, unless they are all members of the same family; and~~

~~H. The individual receiving Supported Living Services is not simultaneously enrolled in the Home and Community-Based Services for the Developmentally Disabled (HCB-DD) program, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program or any other waiver program; and~~

~~I. The individual is not residing in a hospital, nursing facility or ICF/MR; and~~

~~J. Provided the individual can be served within the federally approved capacity and cost effectiveness limits of the waiver; and,~~

~~K. The individual receives at least one waiver service each month.~~

8.500.94 HCBS-SLS WAIVER SERVICES

8.500.94.A The following services are available through the HCBS-SLS Waiver within the specific limitations as set forth in the federally approved HCBS-SLS Waiver.

1. Assistive technology includes services, supports ~~and/~~or devices that assist a client to increase, maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:

a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,

b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

c. Training or technical assistance for the client, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives of the client,

d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-SLS Waiver, and

e. ~~Skill acquisition devices which are proven to be a cost effective and efficient means to meet the need and which make learning easier, such as a~~Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized ~~by the State .~~in accordance with the Ooperating Aagency's procedures~~.~~

f. Assistive technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan or third party resource.

g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

h. When the expected cost is to exceed $2,500 per device three estimates shall be obtained and maintained in the case record.

i. Training and technical assistance shall be time limited, goal specific and outcome focused.

j. The following items and services are specifically excluded under HCBS-SLS waiver and not eligible for reimbursement:

i) Purchase, training or maintenance of service animals,
ii) Computers,
iii) Items or devices that are generally considered to be entertainment in nature including but not limited to CDs~~S~~, DVDs~~S~~, iTunes®, any type of game, ~~or.~~
iv) Training or adaptation directly related to a school or home educational goal or curriculum.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five year life of the waiver unless an exception is applied for and approved. ~~without an exception.~~ Costs that exceed this limitation may be approved by the Ooperating Aagency for devices to ensure the health, and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Ooperating Aagency's procedures within thirty (30) days of the request.

2. Behavioral services are services related to the client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral Services:

i) Behavioral consultation services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.

ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall ~~must~~ be established.

ii). Behavioral consultation services are limited to eighty (80) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and

assessment, evaluations and completion of a written assessment document.

v) Behavioral plan assessment services are limited to forty (40) units and one (1) assessment per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

vi) Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:

1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

3) Counseling services are limited to two hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and ~~is~~are:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a client at risk of institutional placement, and that places the client's health and safety or the safety of others at risk

4) ~~To address an identified challenging behavior that places the client's health and safety and/or the safety of others at risk~~.

5) Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. ~~Requests for an~~

~~exception shall be prior authorized in accordance with the operating agency's procedures.~~ All behavioral line services shall be prior authorized in accordance with Operating Agency procedure

3.Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical ~~and/~~or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.

b. Day habilitation services and supports encompass three (3) types of habilitative environments ; , specialized habilitation services, supported community connections, and prevocational services.

c. Specialized habilitation (SH) services are provided to enable the client to attain the maximum functional level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services:

i) Are provided in a non-integrated setting where a majority of the clients have a disability,

ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported community connections services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan,

ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings,

iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan.

v) ~~Movies and a~~Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational services are provided to prepare a client for paid community employment. Services include teaching concepts including ~~compliance,~~ attendance, task completion, problem solving and safety and are associated with performing compensated work.

i) Prevocational services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for prevocational services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than 50 percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the ~~department~~Department of ~~labor~~Labor regulations.

iv) Prevocational services are provided to support the client to obtain paid ~~or unpaid~~ community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving prevocational services shall occur at least once every five years to determine whether or not the person has developed the skills necessary for paid ~~or unpaid~~ community employment.

vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under section 110 of the rehabilitation act of 1973

or the Individuals with Educational Disabilities Act ~~idea ((~~20 U.S.C. Section 1401-~~*et seq*~~) ~~ET SEQ~~.

f. Day habilitation services are limited to seven thousand one hundrend and twelve (7,112) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. The number of units available for day habilitation services in combination with prevocational services and supported employment shall not exceed seven thousand one hundred and twelve (7,112) units.

4. Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and~~&~~ co-paymentss~~/co-insurance,~~

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

~~viii) Fillings,~~

~~ix) Treatment of injuries,~~

~~x) Restoration of decayed or fractured teeth,~~

xi) Retention or recovery of space between teeth when indicated, and

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges~~, and~~

v) Non-emergency extractions including simple, surgical, full and partial,

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of ~~dentures~~, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with ~~operating agency~~Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures

d. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, 8011.11 or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client

.

e. Implants shall not be a benefit for clients who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users.

f. Subsequent implants are not a covered service when prior implants fail.

g. Full mouth implants or crowns are not covered.

h. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodotic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

i. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

j. Preventative and basic services are limited to two thousand ($2,000) per service plan year. Major services are limited to ten thousand ($10,000) for the five (5) year renewal period of the waiver.

5.Home Aaccessibility Aadaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health, and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include:

a. The installation of ramps,

b. Widening or modification of doorways,

c. Modification of bathroom facilities to allow accessibility and assist with needs in activities of daily living,

d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment supplies that are necessary for the welfare of the client, and

e. Safety enhancing supports such as basic fences, door and window alarms.

f. The following items are specifically excluded from home accessibility adaptations and shall not be reimbursed:

i) Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,
ii) Carpeting,
iii) Roof repair,
iv). Central air conditioning,
v) Air duct cleaning,
vi) Whole house humidifiers,
vii) Whole house air purifiers,
viii)Installation or repair of driveways and sidewalks,
ix) Monthly or ongoing home security monitoring fees,
x) Home furnishings of any type, and
~~xi) Adaptations to rental units when the adaptation is not portable and can not move with the renter, and~~
xii) Luxury upgrades.

g. When ~~a~~ the HCBS-SLS waiver has provided modifications to the client's home and the client moves to another home, those modifications shall not be duplicated

in the new residence unless prior authorized in accordance with Operating Agency procedures.

Adaptation to rental units, when the adaptation is not portable and cannot move with the client shall not be covered unless prior authorized in accordance with Operating Agency procedures.

h. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i. improve entrance or egress to a residence; or,
ii. configure a bathroom to accommodate a wheelchair.

i. Any request to add square footage to the home shall be prior authorized in accordance with Oo~~o~~perating Aa~~a~~gency procedures.

j. All devices and adaptations shall be provided in accordance with applicable state or local building codes ~~and/~~or applicable standards of manufacturing, design and installation. Medicaid state plan, EPSDT or third party resources shall be utilized prior to authorization of waiver services.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver without an exception granted by the ~~operating agency~~Operating Agency. Costs that exceed this limitation may be approved by the ~~operating agency~~Operating Agency for devices to ensure the health, and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with ~~operating agency~~Operating Agency procedure.

6. Homemaker services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of homemaker services:

a. Basic homemaker **services include cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.**

i) Assistance may take the form of hands-on assistance including actually performing a task for the client or cueing to prompt the client to perform a task.

ii) Lawn care, snow removal, air duct cleaning, and animal care are specifically excluded under the HCBS-SLS waiver and shall not be reimbursed.

b. Enhanced homemaker services **includes basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning**

i) Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.
ii) The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task:

1) When such support is incidental to the habilitative services being provided, and

2) To increase the independence of the client.

iii) Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the client.
iv) Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.

7. Mentorship services are provided to clients to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising and ~~includes~~include:

a. Assistance in interviewing potential providers,

b. Assistance in understanding complicated health and safety issues,

c. Assistance with participation on private and public boards, advisory groups and commissions, and

d. Training in child and infant care for clients who are parenting children.

e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.

f. Mentorship services are limited to one hundred and ninety two (192) units (forty eight (48) hours) per service plan year. One (1) unit is equal to fifteen (15) minutes.

g. Units to provide training to clients for child and infant care shall be prior authorized beyond the one hundred and ninety two (192) units per service plan year in accordance with O~~o~~perating A~~a~~gency procedures.

8.Non-medical transportation services enable clients to gain access to day habilitation, prevocational and supported employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

a. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the service plan.

b. Non-medical transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-medical transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip charge assessed each way ~~for~~ to and from day habilitation and supported employment services.

c. Transportation provided to destinations other than to day program or supported employment is limited to four (4) trips per week reimbursed at mileage band one~~.~~

d. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. the applicable mileage band. Non-medical traMedicaid State Plan, defined at 42 C.F.R. §440.170(A).

9. Personal Emergency Response System (PERS) is an electronic device that enables clients to secure help in an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to a signal a response centeronce a "help" button is activated. The response center is staffed by trained professionals.

a. ~~.~~The client and the client's case manager shall develop a protocol for identifying who ~~is~~should to be contacted if~~/when~~ the system is activated.

10.Personal C~~c~~are is assistance to enable a client to accomplish tasks that the client would ~~may~~ complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task. Personal care services include:

a. Assistance with basic self care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.

b. Assistance with money management,

c. Assistance with menu planning and grocery shopping, and

d. Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine or~~/~~as needed medical, dental and therapy appointments, support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.

e. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.

f. If the annual functional needs assessment identifies a possible need for skilled care then the client shall obtain a home health assessment.

11.Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or behavioral need. Professional services include:

a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.

b. Movement therapy **includes the use of music ~~and/~~or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.**

c. Massage **includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes watsu.**

d. Professional services can be reimbursed only when:

i) The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,
ii) The intervention is related to an identified medical or behavioral need, and
iii) The Medicaid State plan therapist or physician identifies the need for the service, establishes the goal for the treatment and ~~shall~~ monitors the progress of that goal at least quarterly.

e. ~~Professional services used for~~ Aa pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes.

f. The following services are excluded under the HCBS Waiver from reimbursement;

i) Acupuncture,
ii) Chiropractic care,
iii) Fitness trainer ~~(personal trainer),~~=
iv) Equine therapy,
v) Art therapy,
vi) Warm water therapy,
~~vii) Therapeutic riding,~~
viii)Experimental treatments or therapies, and.

ix) Yoga.

12.Respite service is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.

a. Respite may be provided:

i) In the client's home and private place of residence,
ii) The private residence of a respite care provider, or
iii) In the community.

b. Respite shall be provided according to ~~an~~ individual or group rates as defined below:

i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.
ii) Individual Day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24-hour period.
iii) ~~Group: respite service is provided to the client along with other individuals, who may or may not have a disability.~~
iv) Overnight Group: the client receives respite in a setting which is defined as a facility that offers 24 hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.
v) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.

c. The following limitations to respite services shall apply:

i) Federal financial participation shall not ~~to~~ be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR~~ccr~~ 503-1, Section 16.221. by the state that is not a private residence.
ii) Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.
iii) Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight group respite rate shall not exceed the respite daily rate.

13. Specialized ~~medical equipment~~Medical Equipment and S~~s~~upplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized medical equipment and supplies include:

a. kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing;

c. maintenance and upkeep of specialized medical equipment purchased through the HCBS-SLS waiver.

d. The following items are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement:

i) Items that are not of direct medical or remedial benefit to the client are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement. These include but are not limited to; vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

~~**a. Devices, controls or appliances that enable the client to increase the client's ability to perform activities of daily living,**~~

~~**b. Devices, controls or appliances that enable the client to perceive, control or communicate within the client's environment,**~~

~~**c. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items,**~~

~~**d. Durable and non-durable medical equipment not available under the Medicaid state plan that is necessary to address client functional limitations, or**~~

~~**e. Necessary medical supplies in excess of Medicaid state plan limitations or not available under the Medicaid state plan.**~~

~~f. All items shall meet applicable standards of manufacture, design and installation.~~

~~g. Specialized medical equipment and supplies exclude those items that are not of direct medical or remedial benefit to the client.~~

14.Supported Eemployment services includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting.

a. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client.

b. Supported employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those individuals who are

providing services to the client, to the same extent that individuals without disabilities employed in comparable positions would interact.

c. Supported employment is work outside of a facility-based site, that is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities,

d. Supported employment is provided in community jobs, enclaves or mobile crews.

e. Group employment including mobile crews or enclaves shall not exceed eight clients.

f. Supported employment includes activities needed to sustain paid work by clients including supervision and training.

g. When supported employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a client as a result of the client's disabilities.

h. Documentation of the client's application for services through the Colorado ~~department~~Department of Human Services Division for V~~v~~ocational R~~r~~ehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. § 1401~~.~~ ~~*et seq*~~ ~~ET SEQ~~).

i. Supported employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

j. Supported employment shall not take the place of nor shall it duplicate services received through the D~~d~~ivision for V~~v~~ocational R~~r~~ehabilitation.

k. The limitation for supported employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of supported employment and shall not be reimbursed:

i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,
ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a client's supported employment.

15. Vehicle modifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation; to accommodate the special needs of the client; are necessary to enable the client to integrate more fully into the community; and to ensure the health, and safety of the client.

a. Upkeep and maintenance of the modifications are allowable services.

b. Items and services specifically excluded from reimbursement under the HCBS Waiver include:

i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client,

ii) Purchase or lease of a vehicle, and

iii) Typical and regularly scheduled upkeep and maintenance of a vehicle.

c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Oo~~p~~erating Aa~~d~~gency may approve a higher amount. Such requests shall ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.

16. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least 21 years of age

a. Lasik and other similar types of procedures are only allowable when:

b. The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and

c. Prior authorized in accordance with Operating Agency procedures.

8.500.95 SERVICE PLAN:

8.500.95.A The case management agency shall complete a service plan for each client enrolled in the HCBS Waiver in accordance with 10 CCR ~~C.C.R.~~ 2505-10, SECTION[S1] ~~§~~ 8.400.

8.500.95.B The service plan shall:

1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver services or through other means,

2.Be in accordance with the ~~department~~Department's rules, policies and procedures, and
3.Include updates and revisions at least annually or when warranted by changes in the client's needs.

8.500.95.CThe service plan shall document that the client has been offered a choice:

1. Between waiver services and institutional care,
2. Among waiver services, and
3. Among qualified providers.

8.500.~~94~~96 WAITING LIST PROTOCOL

8.500.96.A When the federally approved waiver capacity has been met, p~~P~~ersons determined eligible to receive services under the HCBS-SLS ~~federally approved capacity and cost effectiveness limits of the waiver~~, shall be eligible for placement on a waiting list for services.

8.500.96.B~~A.~~ Waiting lists for persons eligible for the HCBS-SLS waiver program shall be administered by the Community Centered Boards, uniformly administered throughout the State and in accordance with these rules and the ~~and the Department of Human Services, Developmental Disabilities Services (DHS/DDS)~~Operating Agency's procedures ~~guidelines~~.

8.500.96.C~~B~~ ~~.~~ Persons determined eligible shall be placed on the waiting list for services in the Community Centered Board service area of residency.

8.500.96.D~~C.~~ Persons who indicate a serious intent to move to another service area should services become available shall be placed on the waiting list in that service area. Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in the ~~the DHS/DDS guidelines~~ Operating Agency's procedures for placement on a waiting list in a service area other than the area of residency.

8.500.96.E~~D.~~ The date used to establish a person's placement on a waiting list shall be:

1. ~~the~~The date on which eligibility for developmental disabilities services in Colorado was originally determined; or

2. ~~the~~The fourteenth (14th) ~~birthdate~~birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.

8.500.96.F~~E.~~ As openings become available in the HCBS-SLS waiver program in a designated service area, persons shall be considered for services in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:

1. Emergency situations where the health, safety, and welfare of the person or others is greatly endangered and the emergency cannot be resolved in another way. Emergencies are defined as follows:

a. Homeless: the person does not have a place to live or is in imminent danger of losing his/her place of abode.

b. Abusive or Neglectful Situation: the person is experiencing ongoing physical, sexual, or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.

c. Danger to Others: the person's behavior and/or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

d. Danger to Self: a person's medical, psychiatric and/or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.

e.2. The Legislature has appropriated funds specific to individuals and/or to a specific class of persons.

Ff. If an eligible individual is placed on a waiting list for SLS waiver services, a written notice, including information regarding the client appeals process, shall be sent to the individual and/or his/her legal guardian in accordance with the provisions of Section S8.057, *et seq*., of this Staff Manual.

8.500.95 ENROLLMENT

Community Centered Boards shall submit to the State the following document; enroll a person into the SLS program:

A. A copy of the Individual Choice Statement; and

B. A Copy of me Individualized Plan (IP); and

C. A Prior Authorization Request; and

D. A completed ULTC 100.2 and form.

An individual shall only be considered enrolled after prior authorization completed by the State and only for the time period approved.

8.500.97 SERVICE DESCRIPTIONS (Continued)

A. Personal Assistant Services (Continued)

3. Mentorship activities such as planning, decision-making, assistance with his/her participation on private and public boards, advisory groups and commissions, person specific training costs associated with providing unique supported living services to an individual, and

child and infant care assistance for parent(s) who themselves have a developmental disability; and

4. Community accessibility services support the abilities and skills necessary to enable the individual to access the community and/or provide the basis for building skills which will assist the individual to access the community. These types of services include socialization, adaptive skills, personnel to accompany and support the individual in all types of community settings, supplies, travel including arranging and providing transportation, and providing necessary resources for participation in activities and functions in the community.

B. Professional Services

Professional services are those services, including evaluation and assessment, provided for a person with a developmental disability which require the service provider to be licensed or certified in a particular occupational skill area such as an occupational therapist, registered nurse, speech/language pathologist, psychologist, etc.

The following types of professional services can be included under this waiver when they are not available under the regular Medicaid State Plan or third party payment:

1. Communication services to maintain or improve communication skills such as speech/language therapy, or interpreter services;

2. Counseling services including individual and/or group counseling, behavioral interventions, diagnostic evaluations or consultations;

3. Therapeutic services such as occupational or physical therapy including diagnostic evaluations or consultations needed to sustain the overall functioning of an individual; and

4. Personal care functions requiring professional care by an RN, LPN, Physician's Assistant or other such licensed or certified medical personnel. This may also include operating medical equipment.

C. Dental Services

Dental costs when dental problems are sufficient to lead to more generalized disease due to infection or improper care or nutrition. (Note: The intent of this service is to provide, at a minimum, routine preventative dental care).

D. Habilitation Services

Services designed to assist individuals in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community-based settings. This service includes:

1. Specialized habilitation services focus on enabling the individual to attain his or her maximum functional level, and are coordinated with any physical, occupational, or speech therapies listed in the Individualized Plan. These services include such training as self-feeding, toileting, and self-care, self-sufficiency and maintenance skills. These services are highly therapeutic in nature, highly individualized with sensory stimulation and integration as major components.

In addition, specialized habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

2. Pre-vocational services not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or Section 602(16) and (17) of the Individuals with Disabilities Education Act (IDEA). Pre-vocational services are available only to individuals who have previously been discharged from a Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), Nursing Facility (NF) or ICF/MR.

Pre-vocational services are designed to assist individuals with developmental disabilities in acquiring and maintaining work habits and work-related skills. Pre-vocational services are intended to have a more generalized result as opposed to vocational training for a specific job. Individuals must have a demonstrated earning capacity of less than 50 percent of the federal minimum wage, as determined in accordance with certification standards promulgated by the U.S. Department of Labor.

Pre-vocational services encompass the following types of work-related activities:

a. teaching an individual such concepts as following directions, attending to task, task completion, communication, decision-making, and problem -solving; and

b. training in the areas of safety, self-advocacy, and mobility; and

c. intervention and training needed to benefit from prevocational services which would allow common barriers to participation to be avoided; and

d. travel training services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to pre-vocational services and supports identified in the Individualized Plan. When compensated, individuals are paid at less than 50 percent of the minimum wage.

3. Supported Employment/Community Integrated Employment (CIE) services and supports are paid employment in an integrated work setting for individuals with developmental disabilities for whom competitive employment at or above the minimum wage is unlikely and who because of their disabilities need considerable ongoing support to perform in a regular work setting. A variety of regular work settings are used, particularly worksites in which persons without disabilities are employed.

Community Integrated Employment services and supports encompass the following types of activities designed to assist eligible individuals to access and sustain employment in a regular work setting:

a. individualized assessment which may include community orientation and job exploration; and

b. individualized job development and placement services that produce an appropriate job match for the individual and his/her employer; and

c. ongoing support, training, and facilitation in obtaining a job, job skill acquisition, job retention, career development, and work-related activities; and

d. intervention and training needed to benefit from community integrated employment services and other supports which would help to remove or diminish common barriers to participation in employment and the building of community relationships; and

e. travel services may include providing, arranging, transporting, or accompanying a person with developmental disabilities to services and supports identified in the Individualized Plan.

4. The activities provided under the definition of community integrated employment services and supports are not typically available as Section 110 services. Community Integrated Employment services and supports will provide supplemental and additional support to Colorado Rehabilitation Services during the time an individual receives transition services. Community Integrated Employment services and supports will provide long-term support for post-Colorado Rehabilitation Services, The services provided under the waiver are different from those provided by Colorado Rehabilitation Services.

a) Community Integrated Employment services and support are available only to individuals who have previously been discharged from a Nursing Facility (previously called a skilled nursing facility) or Intermediate Care Facility for the Mentally Retarded (previously called an Intermediate Care Facility).

b) Community Integrated Employment specifically excludes incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer o beneficiaries to encourage or subsidize employer's participation in a community integrated employment program; or

2. Payments that are passed through to beneficiaries of community integrated employment programs; or

3. Payments for vocational training that is not directly related to a beneficiary's community integrated employment program.

4. Transportation may be provided between the recipient's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the recipient receives habilitation services in more than one place) as a component part of habilitation

services. When this cost is identified in the Individualized Plan, the cost of this transportation may be included in the rate paid to providers of the appropriate type of habilitation services.

E. Environmental Engineering

Environmental engineering consists of devices and adaptations identified in the Individualized Plan which are necessary to overcome environmental barriers which people with disabilities face in their daily lives, whether in their home or in their community. Such devices or adaptations minimize or eliminate the need for ongoing human assistance.

Environmental engineering can be included under this waiver when such devices or adaptations are not available under the regular Medicaid State Plan or third party payment.

Environmental engineering is available to make daily living easier by adapting or supplementing the person's environment through such means as:

1. Adaptations to living quarters including showers, toilets, control switches for the home, kitchen equipment for the preparation of special diets and accessibility such as ramps and railings; and

2. Mobility devices to help people move around including wheelchairs (general use and customized) and van adaptations; and

3. Expressive and receptive communication augmentation including electronic communication boards; and

4. Skill acquisition supports which make learning easier including adapted computers, games, or age appropriate toys; and

5. Safety enhancing supports including security or emergency response systems, and specialized clothing (e.g., Velcro) if the cost is above and beyond that of normal personal needs expenses; and

6. Specialized medical equipment, nondurable medical equipment and supplies; and

7. Assessing the need for, arranging for, providing and maintaining such devices and/or adaptations.

Excluded items and services shall include those adaptations or devices for the person's environment which are not associated with a direct medical or remedial need of the individual such as carpeting, roof repair, central air conditioning, regular clothing, etc. All devices and adaptations shall be provided in accordance with applicable State or local building codes and/or applicable standards of manufacturing, design and installation.

8.500.97 CLIENT RESPONSIBILITIES

8.500.97.A A client or the client's his or her family or guardian is responsible for to:

1.Providing accurate information regarding the client's ability to complete activities of daily living,

2. Assisting in promoting the client's independence,

3. ~~Cooperate with the providers and case manager.~~

4. Cooperating in the determination of financial eligibility,

5. Notifying the case manager within thirty (30) days after:

a. Changes in the client's support system, medical condition and living situation including any hospitalizations, emergency room admissions,

b. Placement to a nursing home ~~placements~~ or intermediate care facility for the mentally retarded (ICF-MR) ~~placements~~,

c. The client has not received an HCBS waiver service during one (1) month

d. Changes in the client's care needs,

e. Problems with receiving HCBS-SLS waiver services, ,, and

f. Changes that may affect Medicaid financial eligibility including prompt report of changes in income or assets.~~.~~

8.500.~~98~~ 98 ~~SERVICE~~ PROVIDER~~S~~ REQUIREMENTS

~~A. Supported Living Services shall be provided by or through agencies that meet the following criteria:~~

8.500.98.A A private for profit or not for profit agency or government agency shall meet minimum provider qualifications as set forth in the HCBS-SLS waiver and shall:,

1. Conform to all state established standards for the specific services they provide under HCBS-SLS,

~~1. Have been designated by the Department of Human Services, Developmental Disabilities Services to be a Community Centered Board; and~~

2.~~.~~ ~~Have received and/or maintained~~ Maintain program approval and certification from the Operating Agency, ~~from the Department of Human Services, Developmental Disabilities Services for the provision of Supported Living Services; and~~

3. Maintain and abide by all the terms of their Medicaid provider agreement with the ~~department~~Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,

~~3. Have a Medicaid Provider Agreement; and~~

a. All State authorized on-site program reviews, whether for the purpose of program approval, on-going program monitoring, or State-initiated financial and program audits; and

B.4. Provider agencies shall not dDiscontinue or refuse HCBS-SLS services to a client unless only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

5. Have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S., as amended.

6.When applicable, maintain the required licenses from the Colorado Department of Public Health And Environment, and
7.Maintain client records to substantiate claims for reimbursement according to Medicaid standards.
8.500.98.B HCBS-SLS providers shall comply with:

4.1. Have agreed to comply with aAll applicable the provisions of Title 27,Article 10.5, C.R.S. et seq.(1995 Supp.), and the rules and regulations promulgated there under, including cooperation with the following activitiesas set forth in 2 CCR 503-1, 16.100 *et seq.*:

c. 2. AnyAll federal program reviews and financial audits of the HCBS-SLS waiver services, program; and

b. 3. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits, All State efforts to collect and maintain information on the SLS waiver program, whether required for federal or state program review and evaluation efforts, including information collection; and

d. 4. Requests from the County Departments of Social/Human Services shall be authorizedto access, as required, to the records of persons clients receiving services held by case management agencies as required to determine or re-determine Medicaid eligibility.; and

e. All efforts by the case management agency to review the provider's programs, either generally or specifically for particular persons receiving services; and

f. All long-term care determinations and continued stay reviews conducted by the Department of Human Services/Developmental Disabilities Services Utilization Review Contractor.

5. Requests from the county departmentDepartments of Social/Human Services, to access records of clients receiving services held by case management agencies as required to determine and re-determine Medicaid eligibility;.

~~5~~6. Requests by the D~~d~~epartment or the O~~o~~perating A~~a~~gency to collect, review and maintain individual or agency information on the HCBS-SLS waiver, and

~~6~~7.Requests by the case management agency to monitor service delivery through targeted case management activities.

8.500.99 TERMINATION OR DENIAL OF HCBS-SLS MEDICAID PROVIDER AGREEMENTS

8.500.99.A The ~~department~~Department may deny or terminate an HCBS-SLS Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq*.

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-SLS services,

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider,

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper client notification,

5. Emergency termination of any provider agreement shall be in accordance with procedures at 10 ~~ccr~~CCR 2505-10, section 8.050, and

8.500.99.B The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the D~~d~~epartment, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

8.500.100 ORGANIZED HEALTH CARE DELIVERY SYSTEM

8.500.100.A The Organized Health Care Delivery System (OHCDS) for the HCBS-SLS w~~W~~aiver is the Community Centered Board as designated by the Operating Agency in accordance with § 27-10~~10.5-103.C.R.S. 27-10.5 ET SEQ~~.

8.500.100.B The OHCDS is the Medicaid provider of record for a client whose services are delivered through the OHCDS,

8.500.100.C The OHCDS shall maintain a Medicaid provider agreement with the D~~d~~epartment to deliver HCBS according to the current federally approved waiver.

8.500.100.D The OHCDS may contract or employ for delivery of HCBS Waiver services.

8.500.100.E The OCHDS shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS Waiver,

2. Ensure that services are delivered according to the waiver definitions and as identified in the client's service plan,

3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

4. Monitor the health and safety for HCBS clients receiving services from a subcontractor.

8.500.100.F The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients,

4. Negotiate rates that are in accordance with the Operating Aagency's established fee for service rate schedule and ~~operating agency~~Operating Agency procedures,

   a. ~~.~~Manually priced items that have no maximum allowable reimbursement rate assigned, nor a manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

5. Collect and maintain the data used to develop provider rates and ensure data includes costs for services to address the client's needs, that are allowable activities within the HCBS service definition and that supports the established rate,

6. Maintain documentation of provider reimbursement rates and make it available to the ~~department~~Department, its Operating Aagency ~~and/~~or Centers for Medicare and Medicaid Services (CMS), and

7. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.500.101 PRIOR AUTHORIZATION REQUESTS

8.500.101.A Prior authorization requests (PAR) shall be in accordance with 10 C.C.R. 2505-10, ~~§~~ Section 8.058.

8.500.101.B A prior authorization request shall be submitted to the ~~operating agency~~Operating Agency through the ~~department~~Department's designated information management system.

8.500.101.C The case management agency shall comply with the policies and procedures for the p~~ar~~ PAR review process as set forth by the ~~department~~Department ~~and/or~~or the ~~operating agency~~Operating Agency.

8.500.101.D The case management agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:

1. Consistent with the client's documented medical condition and functional capacity as indicated in the functional needs assessment,

2. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved waiver, and

3. Not duplicative of another authorized service, including services provided through:

a. Medicaid State plan benefits,
b. Third party resources,
c. Natural supports,
d. Charitable organizations, or
e. Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10 § 8.058.4.

~~8.500.102~~ SERVICE PLAN AUTHORIZATION LIMITS (SPAL) ~~Service Plan Authorization Limits (SPAL)~~

8.500.102.A The service plan authorization limit (SPAL) sets an ~~annual maximum total dollar~~upper payment limit of total funds ~~amount~~ available to purchase services to ~~address~~meet a client's ongoing service needs within one (1) service plan year.

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations and vehicle modifications.

8.500.102.C The total of all HCBS-SLS services in one service plan shall not exceed the overall authorization limitation as set forth in the federally approved HCBS-SLS waiver.

8.500.102.D Each SPAL is assigned a specific dollar amount determined through an analysis of historical utilization of authorized waiver services, total reimbursement for services, and the spending authority for the HCBS-SLS waiver. Adjustments to the SPAL amount may be determined by the Department and Operating Agency as necessary to manage waiver costs.

8.500.102.E Each SPAL is associated with six support levels determined by an algorithm which analyzes a client's level of service need as determined by the SIS ~~Supports Intensity Scale (SIS)~~ assessment and additional factors including exceptional medical and behavioral support needs and identification as a community safety risk. ~~and in accordance with 2 CCRccr 503-1, Ssection 1600. *citation to be determined*~~

8.500.102.F The SPAL determination shall be implemented in a uniform manner statewide and the SPAL amount is not subject to appeal.

8.500.103 RETROSPECTIVE REVIEW PROCESS

8.500.103.A Services provided to a client are subject to a retrospective review by the ~~department~~Department and the ~~operating agency~~Operating Agency. This retrospective review shall ensure that services:

1.Identified in the service plan are based on the client's identified needs as stated in the functional needs assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a client are in accordance with the service plan, and

4.Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

8.500.103.B When the retrospective review identifies areas of non compliance, the case management agency ~~and/~~or provider shall be required to submit a plan of correction that is monitored for completion by the ~~department~~Department and the ~~operating agency~~Operating Agency.

8.500.103.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.500.103.D When the provider has received reimbursement for services and the review by the ~~department~~Department or ~~operating agency~~Operating Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, ~~and/or~~or termination of provider status

8.500.104 PROVIDER REIMBURSEMENT

8.500.104.A Providers shall submit claims directly to the ~~department~~Department's fiscal agent through the Medicaid management information system (MMIS); ~~and/or~~or through a qualified billing agent enrolled with the ~~department~~Department's fiscal agent.

8.500.104.B Provider claims for reimbursement shall be made only when the following conditions are met:

1. Services are provided by a qualified provider as specified in the federally approved ~~APPROVED~~ HCBS-SLS waiver,

2. Services have been prior authorized,

3.Services are delivered in accordance with ~~to~~ the frequency, amount, scope and duration of the service as identified in the client's service plan, and

4.Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.104.C Provider claims for reimbursement shall be subject to review by the ~~department~~Department and the ~~operating agency~~Operating Agency. This review may be completed after payment has been made to the provider.

8.500.104.D When the review identifies areas of non compliance, the provider shall be required to submit a plan of correction that is monitored for completion by the ~~department~~Department and the ~~operating agency~~Operating Agency.

8.500.104.E When the provider has received reimbursement for services and the review by the ~~department~~Department or ~~operating agency~~Operating Agency identifies that the service delivered or the claim submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, ~~and/or~~or termination of provider status.

8.500.104.F Except where otherwise noted, payment is based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are published in the provider bulletin accessed through the Department's fiscal agent's web site.

8.500.~~99~~ 105 INDIVIDUAL RIGHTS

8.500.105.A ~~The rights of a person receiving Supported Living Services are established in~~ The rights of a client in the HCBS-SLS Waiver shall be in accordance with Sections 27-10.5-112 through 131, C.R.S. ~~Title 27, Article 10.5, Sections 112 through 131, C.R.S. (1995 Supp.),~~ ~~and the rules and regulations regarding these rights are promulgated with the Department of Human Services, Developmental Disabilities Services, rules and regulations, Chapter 6.~~

8.500.106 **APPEAL RIGHTS**

8.500.106.A The CCB shall provide the long term care notice of action form to applicants and clients within ~~one~~ ten (10) business days regarding their appeal rights in accordance with 10 CCR 2505-10, Section ~~§~~ 8.057 *et seq* ~~ET SEQ~~. When:

1. The applicant is determined to not have a developmental disability,
2. The applicant is found eligible or ineligible for LTC services,
3. The applicant is determined eligible or ineligible for placement on a waitlist for Medicaid LTC services,
4. An adverse action occurs that affects the client's waiver enrollment status,
5. An adverse action occurs that affects the provision of the client's waiver services, or
6. The applicant or client requests such information.

8.500.106.B The CCB shall represent their decision at the office of administrative courts as described in 10 CCR ~~C.C.R.~~ 2505-10, Section ~~§~~ 8.057 *et seq* ~~ET SEQ~~ when CCB has made a denial or adverse action against a client.

8.500.106.C The CCB shall notify all providers in the client's service plan within ~~one~~ ten (10) business day of the adverse action.

8.500.106.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten ~~one~~ (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.106.E The applicant or client shall be informed of an adverse action if the client is determined ineligible as set forth in client eligibility and the following:

~~-~~1. The client cannot be served safely within the cost containment as identified in the HCBS-SLS Waiver,

2.The client is placed in an institution for treatment with a duration that continues for more than thirty (30) days,
3. The client is detained or resides in a correctional facility, or
4.The client enters an institute for mental health with a duration that continues for more than thirty (30) days.

8.500.106.F The client shall be notified, pursuant to 10 CCR 2505~~2~~-10, Section 8.057.2.A, when the following results in an adverse action that does not relate to HCBS-SLS waiver client eligibility requirements:

1.A waiver service is reduced, terminated or denied because it is not a demonstrated need in the functional needs assessment,
2.A waiver service is terminated or denied because is not available through the current federally approved waiver,
3.A service plan or waiver service exceeds the limits as set forth in the in the federally approved waiver,
~~-~~4.The client or client representative has failed to schedule an appointment for the functional needs assessment, service plan, or six (6) month visit with the case manager two (2) times in a thirty (30) day consecutive period,
5. The client or client representative has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,
6. The client enrolls in a different long term care program, or
7.The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.

a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual ~~Section~~ 9 CCR 2503-1, Section 3.140.2, , shall not be terminated unless one or more of the other client eligibility criteria are no longer met.

8.The client voluntarily withdraws from the waiver. The client shall be terminated from the waiver effective upon the day after the date on which the client's request is documented.

8.500.106.G The CCB shall not send the LTC notice of action form when the basis for termination is death of the client, but shall document the event in the client record. The date of action shall be the day after the date of death.

8.500.~~101~~ 107 QUALITY ASSURANCE

8.500.107.A. The monitoring of services provided under the HCBS-SLS ~~Supported Living Services~~ waiver and the health and well-being of ~~service recipients~~clients shall be the responsibility of the ~~Department of Human Services, Developmental Disabilities Services~~Operating Agency, under the oversight of the Department ~~of Health Care Policy and Financing~~.

8.500.107.B. The ~~Department of Human Services, Developmental Disabilities Services~~Operating Agency shall conduct on-site surveys or cause to have on-site surveys to be done in accordance with guidelines established by ~~Developmental Disabilities Services~~ the Department or~~f~~ the Operating Agency. The survey shall include a review of applicable ~~Colorado Department of Human Services, Developmental Disabilities Services~~Operating Agency rules and regulations and standards for HCBS-SLS.

8.500.107.C. The Department of Human Services, Developmental Disabilities ServicesOperating Agency, shall ensure that the case management agency/community centered board fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with assurances required of these programs.

8.500.107.D. The Department of Human Services, Developmental Disabilities ServicesOperating Agency, shall maintain or cause to be maintained, for three years, complete files of all records, documents, communications, survey results, and other materials which pertain to the operation and service delivery of the SLS waiver program.

8.500.107.E. Developmental Disabilities ServicesThe Operating Agency shall recommend to the Department of Health Care Policy and Financing the suspension of payment denial and/or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to Developmental Disabilities Servicesthe Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.107.F. After receiving the denial and/oror termination recommendation and reviewing the supporting documentation, the Department of Health Care Policy and Financing shall take the appropriate action.

8.500.102 POST ELIGIBILITY TREATMENT OF INCOME (PETI)

For individuals who are determined to be Medicaid eligible for the SLS waiver through the application of the 300% income standard as described at §8.110.8, the case manager shall allow an amount equal to the 300% standard as the personal maintenance allowance (no other deductions are necessary). The PETI assessment form shall be completed monthly by the case management agency to ensure that the individual's income does not exceed the maximum allowed for continued eligibility.

8.500.108 CLIENT PAYMENT-POST ELIGIBILITY TREATMENT OF INCOME

8.500.108.A A client who is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard at 10 CCR 2505-10 §8.1100.710.8, is required to pay a portion of the client's income toward the cost of the client's HCBS-SLS services after allowable income deductions.

8.500.108.B This post eligibility treatment of income (PETI) payment assessment shall:

1.Be calculated by the case management agency during the client's initial assessment and continued stay review assessment for HCBS-SLS services.

2.Not exceed the cost of HCBS-SLS services for the month for which payment is being made.

3.Be recomputed, as often as needed, by the case management agency in order to ensure the client's continued eligibility for the HCBS-SLS waiver monthly.

4.Be collected and receipted by the case management agency as instructed by the Department.

8.500.108.C In calculating PETI ~~payment~~assessment, the case management agency must deduct the following amounts, in the following order, from the client's total income including amounts disregarded in determining Medicaid eligibility:

1.A maintenance allowance equal to three hundred percent (300%) of the current SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty five dollars ($245) per month; and

2.For a client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

3.For a client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate AFDC grant level; and

4.Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

a. Health insurance premiums ~~(~~other than Medicare~~)~~, deductibles~~,~~ or coinsurance charges, ~~(~~including Medicaid copayments~~)~~

b. Necessary medical or remedial care recognized under state law but not covered under the Medicaid State Plan.

8.500.108.D Case management agencies are responsible for informing clients of their PETI obligation on a form prescribed by the Operating Agency.

8.500.108.E PETI payments and the corresponding assessment forms are due to the Operation Agency during the month following the month for which they are assessed.

~~8.500.108.F Case management agencies must submit all PETI assessments, on the specified form, to the Operating Agency to within thirty five (35) calendar days of the end of the month for which they were assessed.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistnace Rule Concerning Home and Community Based Services Children's Extensive Supports, Section 8.503
Rule Number:	MSB 11-07-07-B
Division / Contact / Phone:	Long Term Benefits / John R. Barry / 3173

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 11-07-07-B, Revision to the Medical Assistnace Rule Concerning Home and Community Based Services Children's Extensive Supports, Section 8.503
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) 8.503, 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 from §8.503 through §8.503.63.G with the new text provided. This change is effective 11/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistnace Rule Concerning Home and Community Based Services Children's Extensive Supports, Section 8.503
Rule Number:	MSB 11-07-07-B
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STATEMENT OF BASIS AND PURPOSE

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

   This rule is changed to incorporate the requirements of the existing HCBS Waiver implemented in July 2009. The existing rule is outdated and incorporates the terminated waiver and no longer represents the plan for services delivered under the provisions of the current federally approved waiver. Additionally, rules including language specific to proposed waiver amendments have been included for consideration by MSB pending the approval of Centers for Medicare and Medicaid Services.

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:

   Title 1915 (c) federal "Social Security Act"

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-6-404
   25.5-6-409

Initial Review	**09/09/2011**	Final Adoption	**10/14/2011**
Proposed Effective Date	**11/30/11**	Emergency Adoption	

DOCUMENT # 12

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistnace Rule Concerning Home and Community Based Services Children's Extensive Supports, Section 8.503
Rule Number:	MSB 11-07-07-B
Division / Contact / Phone:	Long Term Benefits / John R. Barry / 3173

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.

   Eligible clients receiving HCBS-CES may be minimally effected by the proposed rule. Each client's Service Plan has already included changes as a result of the federally approved waiver effective July 1, 2009. It is not expected that the rules amended as a result of the incorporation of the existing waiver will have a negative effect on clients. The implementation of the HCBS-CES waiver on July 1, 2009 resulted in a change of services for some clients. This was due to the redefinition of some services in the federally approved HCBS waiver.

   It is not expected that the inclusion of rules for proposed amendments to the HCBS-CES waiver will have a negative effect on clients. The amendments are under consideration by CMS for approval. The amendments include measures to increase efficiencies and to keep the cost of service delivery within the budget. Although a proposed limitation to Behavioral Assessment has been submitted, it is not expected that this will result in a decrease of service to clients.

   Clarification of provider qualifications and specific procedures within Behavioral Services may have an impact on providers. Qualifications are now aligned with the level of service needed which may result in reduced revenue for the provider.

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 implementation of the HCBS-CES waiver on July 1, 2009 did result in service changes and denials for some clients. The implementation of these rules will not create additional adjustments.

   Approximately 197 clients receive Behavioral Services. The proposed changes in this service may effect clients differently but will result in more effective use of funds by clear definition of the service and provider qualifications.

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

There are no costs to the Department associated with implementation and enforcement and no impact to state revenue.

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

   The rules to implement the proposed HCBS waiver amendments will not increase cost. These rules address, in part, a projected total cost that exceeds the annual appropriation from the General Assembly. A portion of the budget shortfall for FY 12 is attributed to increased utilization of specific services in the HCBS waivers for this current year. The Department's inaction may result in implementation of other measures to reduce costs to ensure expenses do not exceed the spending authority. These actions may include rate reductions, reduction of alternative or additional services, or termination of some services.

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

   There is no additional cost expected with these proposed rules.

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

   The proposed rules are to align the existing HCBS waiver document into rule. This is both necessary and required. The proposed changes to implement HCBS waiver amendments for Behavioral Services are contingent on the CMS approval of the proposed HCBS waiver amendments. Once the amendments are approved, these rules will be necessary and required. Alternatives considered to these waiver amendments include rate reductions, alternative or additional service reductions, and the termination of some services. The proposed HCBS waiver amendments are determined to be the method that has the least amount of negative impact on clients and providers.

8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (CES)

8.503 DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) means basic self care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, transferring, and needing supervision to support behavior, medical needs and memory cognition.

ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-CES waiver or a HCBS waiver service.

APPLICANT means an individual who is seeking a Long Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

AUTHORIZED REPRESENTATIVE (AR) means an individual designated by the client, parent or legal guardian of a minor, if appropriate, who has the judgment and ability to direct CDASS on the client's behalf and meets the qualifications as defined at 10 CCR 2505-10 Sections 8.510.6 and 8.510.7.

CLIENT means an individual who has met Long Term client representative may be (A) a legal representative including but not limited to a court appointed guardian, a parent of a minor child, or a spouse, or (B) an individual, family member or friend selected by the parent or guardian of the client to speak for or act on the clients' behalf.

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which, when designated pursuant to Section 27-10.5-101, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-101, C.R.S. *et seq.*, and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.

COST CONTAINMENT means limiting the cost of providing care in the community to 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, and Medicaid ~~s~~State ~~p~~Plan benefits including long term home health services and targeted case management services.

COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the client.

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.

DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single state Medicaid agency.

DEVELOPMENTAL DELAY means ~~an~~ child ~~infant or toddler, birth~~ who is:

Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:

Eequivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age,

Eequivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development,

H~~h~~as an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or

B~~The child b~~irth up to age three (3) ~~years of age and~~ who lives with a parent who has been determined to have a developmental disability by a Community Centered Board.

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include Cerebral palsy, Epilepsy, Autism or other neurological conditions when such condition result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, unless otherwise specifically stated, the federal definition “Developmental Disability” found in 42 U.S.C. Section 6000 *et seq*.

"~~i~~Impairment of general intellectual functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. when an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

"~~a~~Adaptive behavior similar to that of a person with mental retardation" means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. these adaptive behavior

limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.
"~~s~~Substantial intellectual deficits" means an intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the ~~o~~Operating ~~a~~Agency for H~~h~~ome and ~~c~~Community ~~b~~Based ~~s~~Services- ~~c~~Children's ~~e~~Extensive ~~s~~Support (HCBS-CES) to persons with developmental delays or disabilities within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of the Medicaid S~~s~~tate ~~p~~Plan for a Medicaid eligible client up to 21 years of age.

FAMILY means a relationship as it pertains to the client and is defined as:

~~a~~A mother, father, brother, sister or any combination,
~~e~~Extended blood relatives such as grandparent, aunt, uncle, cousin,
~~a~~An adoptive parent,

~~o~~One or more individuals to whom legal custody of a person with a developmental disability has been given by a court,

~~a~~A spouse or,

~~t~~The client's child~~ren~~.

FISCAL MANAGEMENT SERVICE ORGANIZATION means the entity contracted with the ~~d~~Department as the employer of record for attendants, to provide personnel management services, fiscal management services and skills training to a parent or guardian or authorized representative of a client receiving CDASS.

FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for Long Term Care services as determined by the D~~d~~epartment'~~partmentces as determine for f a e employer of rec~~

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the ~~u~~Uniform ~~l~~Long ~~t~~Term ~~c~~Care instrument and medical verification on the ~~p~~Professional ~~m~~Medical ~~i~~Information ~~p~~Page to determine if the applicant or client meets the institutional ~~l~~Level ~~o~~Of ~~c~~Care (LOC).

GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. ~~g~~Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not a guardian ad litem.

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a

client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or ~~i~~Intermediate ~~c~~Care ~~f~~Facility for the ~~m~~Mentally ~~r~~Retarded (ICF/MR).

INSTITUTION means a hospital, nursing facility, facility or ICF/MR for which the ~~d~~Department makes Medicaid payments under the state plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF/MR) means a publicly or privately operated facility that provides health and habilitation services to a client with developmental disabilities or related conditions.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the client'lientthe.~~that provid~~

LEVEL OF CARE (LOC) means the specified minimum amount of assistance a client must require in order to receive services in an institutional setting under the Medicaid ~~s~~State ~~p~~Plan.

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 ~~a~~Act.

LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or, ~~i~~Intermediate ~~c~~Care ~~f~~Facilities for the ~~m~~Mentally ~~r~~Retarded (ICF/MR), or Home and Community Based Services (HCBS), Long Term Home Health Services, the program of All-Inclusive Care for the Elderly, Swing Bed and Hospital Back Up program (HBU).

MEDICAID ELIGIBLE means the applicant or client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination.

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

NATURAL SUPPORTS means informal relationships that provide assistance and occur in the client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services-for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES)~~)~~ waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the HCBS-DD, HCBS-SLS and HBCS-CES waivers.

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the ~~d~~Department, the ~~o~~Operating ~~a~~Agency, a state fiscal agent or the ~~c~~Case ~~m~~Management ~~a~~Agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional ~~l~~Level ~~o~~Of ~~c~~Care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1, Section 16.200 *et seq*., that has received program approval to provide HCBS-CES waiver services.

RELATIVE means a person related to the client by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the ~~d~~Department or the O~~o~~perating ~~a~~Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service.

SERVICE PLAN means the written document that specifies identified and needed services, regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the ~~d~~Department and the ~~o~~Operating ~~a~~Agency's rules set forth in 10 CCR 2505-10, Section 8.400.

SUPPORT is any task performed for the client where learning is secondary or incidental to the task itself or an adaptation is provided.

TARGETED CASE MANAGEMENT SERVICES (TCM) means a Medicaid ~~s~~State ~~p~~Plan benefit for a target population which includes: facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources including but not limited to medical, social, educational and other resources to ensure non-duplication of HCBS waiver services and the monitoring of the effective and efficient provision of HCBS waiver services across multiple funding sources.

THIRD PARTY RESOURCES means services and supports that a client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the Department of Health Care Policy and Financing to review the HCBS-CES waiver applications for determination of eligibility based on the additional targeting criteria.

WAIVER SERVICE means optional services defined in the current federally approved waiver documents and do not include Medicaid ~~s~~State ~~p~~Plan benefits.

~~A. The Children's Extensive Support (CES) waiver services are provided through a 1915(c) Home and Community-Based Services Waiver for children who have a developmental disability, or for children under the age of five who are at risk of a developmental delay, in an Intermediate Care Facility for the Mentally Retarded (ICF/MR); or who are at risk of institutionalization and are subject to the availability of appropriate services and supports within existing resources.~~

~~B. The services provided under this program serve as an alternative to ICF/MR services for children from birth through seventeen years of age who meet the targeting criteria and the Level of Care Screening Guidelines. Services provided through this Children's Extensive Support Waiver (CES) shall be provided in the home or community when deemed appropriate and adequate by the child's physician, and shall be limited to:~~

~~1. Personal Assistance; and~~

~~2. Home Modification; and~~

~~2. Home Modification; and~~

~~3. Specialized Medical Equipment and Supplies, and~~

~~4. Professional Services; and~~

~~5. Community Connections.~~

8.503.10 ~~PROGRAM~~ HCBS-CES WAIVER ADMINISTRATION

~~A. CES services or children with developmental disabilities shall be provided in accordance with these rules and regulations.~~

~~B. The Children's Extensive Support waivers for children with developmental disabilities shall be administered by the Department of Human Services, Developmental Disabilities Services under the oversight of the Department of Health Care Policy and Financing.~~

~~C. CES waiver services do not constitute an entitlement to services, from either the Department of Health Care Policy and Financing or the Department of Human Services.~~

~~1. CES waiver shall be subject to annual appropriations by the Colorado General Assembly.~~

~~2. The Department of Human Services, Developmental Disabilities Services shall limit the utilization of the Children's Extensive Support waivers based on the federally approved capacity and cost effectiveness of the waiver and the total appropriations, and shall limit the enrollment when utilization of the CES waiver program is projected to exceed the spending authority.~~

~~D. Designated Community Centered Boards will be responsible for performing all functions related to the provision of the Children's Extensive Support waiver, pursuant to 27-10.5-105, et seq, C.R.S. (1995 Supp.).~~

8.503.10.A THIS SECTION HEREBY INCORPORATES THE TERMS AND PROVISIONS OF THE FEDERALLY-APPROVED HOME AND COMMUNITY BASED SERVICES-CHILDREN'S EXTENSIVE SUPPORT (HCBS-CES) WAIVER CO.4180.R03.00, AS IT MAY BE AMENDED PERIODICALLY. TO THE EXTENT THAT THE TERMS OF THAT FEDERALLY-APPROVED WAIVER ARE INCONSISTENT WITH THE PROVISIONS OF THIS SECTION, THE WAIVER WILL CONTROL

8.503.10.~~A~~B HCBS-CES WAIVER FOR CLIENTS AGES BIRTH THROUGH SEVENTEEN YEARS OF AGE WITH DEVELOPMENTAL DELAYS OR DISABILITIES IS ADMINISTERED THROUGH THE DESIGNATED ~~O~~OPERATING ~~A~~AGENCY.

~~.~~8.503.10.~~B~~C. HCBS-CES WAIVER SERVICES SHALL BE PROVIDED IN ACCORDANCE WITH THE FEDERALLY APPROVED HCBS-CES WAIVER DOCUMENT AND THESE RULES AND REGULATIONS, AND THE RULES AND REGULATIONS OF THE COLORADO DEPARTMENT OF HUMAN SERVICES, DIVISION FOR DEVELOPMENTAL DISABILITIES, 2 CCR 503-1 AND PROMULGATED IN ACCORDANCE WITH THE PROVISIONS OF SECTION 25.5-6-404(4), C.R.S.~~.~~

8.503.10.~~C~~D~~.~~. IN THE EVENT A DIRECT CONFLICT ARISES BETWEEN THE RULES AND REGULATIONS OF THE DEPARTMENT AND THE OPERATING AGENCY, THE RULES AND REGULATIONS OF THE DEPARTMENT SHALL CONTROL.

8.503.10.~~D~~E~~.~~. HCBS-CES WAIVER SERVICES ARE AVAILABLE ONLY TO ADDRESS NEEDS IDENTIFIED IN THE ~~F~~FUNCTIONAL ~~N~~NEEDS ~~A~~ASSESSMENT AND AUTHORIZED IN THE SERVICE PLAN AND WHEN THE SERVICE OR SUPPORT IS NOT AVAILABLE THROUGH THE MEDICAID ~~S~~STATE ~~P~~PLAN, EPSDT, NATURAL SUPPORTS, OR THIRD PARTY PAYMENT SOURCES.

8.503.10.~~E~~F~~.~~. HCBS-CES WAIVER:

1. ~~s~~Shall not constitute an entitlement to services from either the Department or the Operating Agency,
2. ~~s~~Shall be subject to annual appropriations by the Colorado general assembly,
3. ~~s~~Shall limit the utilization of the HCBS-CES waiver based on the federally approved capacity, cost containment, the maximum costs and the total appropriations, and,
4. ~~m~~May limit the enrollment when utilization of the HCBS-CES waiver program is projected to exceed the spending authority.

8.503.20 ~~PROGRAM~~ GENERAL PROVISIONS

8.503.20.A THE FOLLOWING PROVISIONS SHALL APPLY TO THE HCBS-CES WAIVER.

1. HCBS-CES waiver services are provided as an alternative to ICF/MR services for an eligible client to assist the family to support the client in the home and community.

2. HCBS-CES waiver is waived from the requirements of ~~S~~section 1902(a) (10) (b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the state of Colorado.

3. A client enrolled in the HCBS-CES waiver shall be eligible for all other Medicaid services for which the client qualifies and shall first access all benefits available under the Medicaid ~~s~~State ~~p~~Plan or Medicaid EPSDT prior to accessing services under the HCBS-CES waiver. Services received through the HCBS-CES waiver may not duplicate services available through the Medicaid ~~S~~state ~~p~~Plan.

~~Colorado requested and was granted authority to provide the following services under Children's Extensive Support waivers:~~

~~A. CES services shall be provided as an alternative to institutional placement for children with developmental disabilities and include personal assistance, home modification, specialized medical equipment and supplies, professional services, and community connection services.~~

~~B. The Children's Extensive Support program is waived from the requirements of Section 1902(a)(10)(B) (comparability of services) and Section 1902(a)(l) (statewideness) of the Social Security Act Therefore, the availability and comparability of services may not be consistent throughout the State of Colorado.~~

~~C. Children eligible for services under the CES waivers shall be eligible for all other Medicaid services for which they qualify and shall first access all benefits available under the regular Medicaid State Plan and/or Medicaid EPSDT coverage prior to accessing funding for those same services under the CES waivers.~~

~~D. Case management agencies shall provide case management services under administrative activity including: assessment of the individual's needs to determine if CES waiver services are appropriate; completion of the Individualized Plan (IP); and submission of the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for CES waiver services. These Individualized Plans shall be subject to review by the Department of Health Care Policy and Financing.~~

~~D. The provision of Children's Extensive Support services may be subcontracted by the CES agency to other qualified agencies, professionals, individuals or vendors in order to provide additional opportunities for individual choice and the use of general services.~~

~~E. The individual receiving services and/or his/her designated client representative, family or guardian are responsible for cooperating in the determination of financial eligibility, including prompt~~

~~reporting of changes in income or resources; cooperating with the case management agency and service providers as agreed to in the Individualized Plan; and choosing between CES waiver services and institutional care.~~

8.503.30 CLIENT ELIGIBILITY

8.503.30.A TO BE ELIGIBLE FOR THE HCBS-CES WAIVER, AN INDIVIDUAL SHALL MEET THE TARGET POPULATION CRITERIA AS FOLLOWS:

1. Is unmarried and less than eighteen years of age,

2. Be determined to have a developmental disability which includes developmental delay if under five (5) years of age,

3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and cost containment limits of the HCBS-CES waiver,

4. Meet ICF/MR level of care as determined by the F~~f~~unctional ~~n~~Needs ~~a~~Assessment,

5. Meet the Medicaid financial determination for LTC eligibility as specified at 10 CCR 2505-10, Section 8.100 *et* ***seq.*** and,

6. Reside in an eligible HCBS-CES waiver setting as defined as the following:

   a.) ~~w~~With biological, adoptive parent(s), or legal guardian,

   b.) ~~i~~In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement that must be approved by the HCBS-CES waiver administrator:

i.) ~~t~~The case manger will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or supports requested during the time the client is not residing in the family home.

7. Be determined to meet the ~~f~~Federal ~~s~~Social ~~s~~Security ~~a~~Administration's definition of disability,

8. Be determined by the Utilization Review Contractor (URC) to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:

a.) ~~t~~The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:

i. ~~a~~A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition or situation. ~~s~~Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six months,

ii.) ~~a~~A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six months, or

iii. ~~c~~Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

b). The above conditions shall be evidenced by third party statement or data that is corroborated by written evidence that:

i) ~~t~~The individual's behavior or medical needs have been demonstrated, or

ii.) ~~i~~In the instance of an annual reassessment, that in the absence of the existing interventions or preventions provided through the HCBS-CES waiver that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criteria listed above.

c Examples of acceptable evidence shall not be older than six months and shall include but not be limited to any of the following:

i.) ~~m~~Medical records,

ii) ~~p~~Professional evaluations and assessments,

iii.) ~~i~~Insurance claims,

iv) ~~b~~Behavior pharmacology clinic reports,

v.) ~~p~~Police reports,

vi) ~~s~~Social ~~s~~services reports, or

vii.) ~~o~~Observation by a third party on a regular basis.

8.503.30.B THE CLIENT SHALL MAINTAIN ELIGIBILITY BY MEETING THE HCBS-CES WAIVER ELIGIBILITY AS SET FORTH IN 10 CCR 2505-10, SECTION 8.503 AND THE FOLLOWING:

1. Receives at least one (1) HCBS-CES waiver service each calendar month,

2. Is not simultaneously enrolled in any other HCBS waiver, and

3. Is not residing in a hospital, nursing facility, ICF/MR, other institution or correctional facility.~~.~~

~~A. Children who meet all of the following program eligibility requirements will be determined eligible:~~

~~1. The child has not reached his/her 18th birthday; and~~

~~2. The child is living at home with his/her biological, adoptive parent(s) or guardian, or is in an out-of-home placement including an ICF/MR, hospital or nursing facility and can be returned home with the provision of CES services; and~~

~~3. The child, if age five or older, has a developmental disability; or if less than five years of age, has a developmental delay, as determined by a community centered board (CCB); and~~

~~4. Children enrolled in the 1915(c) waiver shall be eligible for Supplemental Security Income (SSI).~~

~~5. The quality and quantity of medical services and supports identified in the Individualized Plan (IP) are provided pursuant to a physician's order to meet the needs of the child in the home setting and~~

~~6. The income of the child shall not exceed 300% of the current maximum SSI standard maintenance allowance and~~

~~7. The resources of the child shall not exceed the maximum SSI allowance and~~

~~8. Enrollment of a child under this rule shall result in an overall savings when compared to the ICF/MR cost as determined by the State and~~

~~9. The Utilization Review Contractor (URC) certifies that the child meets the Level of Care for ICF/MR placement; and~~

~~10. The child demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of medical status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically age appropriate and due to one or more of the following conditions:~~

~~(a) A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition/situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others is evidenced by actual events and the events occurred within the past six months.~~

~~(b) Significant pattern of serious aggressive behaviors toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events, and the events occurred within the past six months.~~

~~(c) Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.~~

~~11. The above conditions shall be evidenced by parent statement/data that is corroborated by written evidence that:~~

~~(a) The child's behavior(s) or medical need(s) have been demonstrated; or~~

~~(b) In the instance of an annual reassessment, it can be established that in the absence of the existing interventions or preventions provided through the CES Waiver that the intensity and frequency of the behavior or medical need would resume to a level that would meet the criteria listed above.~~

~~(c) Examples of acceptable evidence shall include but not be limited to any of the following: medical records, professional evaluations and assessments, educational records, insurance claims, Behavior Pharmacology Clinic reports, police reports, social services reports or observation by a third party on a regular basis.~~

~~12. The child receives at least one waiver service each month.~~

~~B. Pursuant to the terms of the Children's Extensive Support Waiver (CES), the number of individuals who may be served each year in the CES Program shall be limited to the federally approved capacity of the waiver.~~

8.503.40 HCBS-CES WAIVER SERVICES

8.503.40.A THE FOLLOWING SERVICES ARE AVAILABLE THROUGH THE HCBS-CES WAIVER WITHIN THE SPECIFIC LIMITATIONS AS SET FORTH IN THE FEDERALLY APPROVED HCBS-CES WAIVER:

1. **Adaptive ~~t~~Therapeutic ~~r~~Recreational eEquipment and ~~f~~Fees are services which assist a client to recreate within the client's community. These services include recreational equipment that is adapted specific to the client's disability and not those items that a typical age peer would commonly need as a recreation item.**

a. **~~t~~The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.**

b. **~~a~~Adaptive recreational equipment may include adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and**

other types of equipment appropriate for the recreational needs of a client with a developmental disability.

c. ~~a~~A pass for admission to recreation centers for the client only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.

d. ~~a~~Adaptive therapeutic recreation fees include those for water safety training.

e The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. ~~e~~Entrance fees for zoos,

i.) ~~m~~Museums,

ii.) ~~b~~Butterfly pavilion,

iii.) ~~m~~Movie, theater, concerts,

iv.) ~~p~~Professional and minor league sporting events,

v.) ~~o~~Outdoors play structures,

vi. ~~b~~Batteries for recreational items; and,

vii. ~~p~~Passes for family admission to recreation centers.

f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (~~$~~1,000.00) dollars per service plan year.

2. Assistive ~~t~~Technology includes services, supports or devices that assist a client to increase maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:

a. ~~t~~The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,

b ~~s~~Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

c. ~~t~~Training or technical assistance for the client, or where appropriate, the family members, guardians, care-givers, advocates, or authorized representatives of the client,

d. Wwarranties, repairs or maintenance on assistive technology devices purchased through the HCBS-CES waiver, and

e. ~~skill acquisition devices which are proven to be a cost effective and efficient means to meet the need and which make learning easier, such as A~~adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized ~~by the~~ in accordance with the ~~o~~Operating ~~a~~Agency's procedures.

f Assistive ~~t~~Technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid ~~s~~State ~~p~~Plan or third party resource.

g Assistive ~~t~~Technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

h When the expected cost is to exceed two thousand five hundred (~~$~~2,500) dollars per device three estimates shall be obtained and maintained in the case record.

i. Training and technical assistance shall be time limited, goal specific and outcome focused.

j The following items and services are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. ~~p~~Purchase, training or maintenance of service animals,

ii. ~~c~~Computers,

iii. ~~i~~In home installed video monitoring equipment,

iv. ~~m~~Medication reminders,

v. ~~h~~Hearing aids,

vi ~~i~~Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of games ,

vii. training, or adaptation directly related to a school or home educational goal or curriculum; or

viii. items considered as typical toys for children.

k. The total cost of ~~h~~Home ~~a~~Accessibility ~~a~~Adaptations, ~~v~~Vehicle ~~m~~Modifications, and ~~a~~Assistive ~~t~~Technology shall not exceed ten thousand ($10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety

of the client or that enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the ~~o~~Operating ~~a~~Agency's procedures. :

i. ~~The o~~Operating ~~a~~Agency shall respond to exception requests within thirty (30) days of receipt.

3. Behavioral ~~S~~services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

a. Behavioral ~~s~~Services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

b. A client with a co-occurring diagnosis of developmental disabilities and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral ~~s~~Services include:

i. Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.

a) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service must be established.

ii. Behavioral Plan ~~a~~Assessment Services include observations, interviews of direct staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

1) Behavioral plan assessment services are limited to forty (40) units and one assessment per service plan year. One unit is equal to fifteen (15) minutes of service.

iii. Individual and group counseling services include psychotherapeutic or psychoeducational intervention that:

1.) ~~I~~is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2.) ~~p~~Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

iv. Behavioral ~~l~~Line ~~s~~Services **include direct implementation of the behavioral plan under the supervision and oversight of a behavioral consultant, for intervention to address social or emotional issues or with an identified challenging behavior that puts the individual's health and safety or the safety of others at risk.**

~~4~~. Community ~~C~~connector ~~s~~Services are intended to provide assistance to the client to enable the client to integrate into the client's residential community and access naturally occurring resources. Community connector services shall:

a. ~~s~~Support the abilities and skills necessary to enable the client to access typical activities and functions of community life such as those chosen by the general population.

b. ~~u~~Utilize the community as a learning environment to assist the client to build relationships and natural supports in the client's residential community.

c. ~~b~~Be provided to a single client in a variety of settings in which clients interact with individuals without disabilities, and

d. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.

5. Home A~~a~~ccessibility ~~a~~Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health~~,~~ and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include:

a. ~~t~~The installation of ramps,

b. ~~w~~Widening or modification of doorways,

c. ~~m~~Modification of bathroom facilities to allow accessibility, and assist with needs in activities of daily living.

d. ~~t~~The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment or supplies that are necessary for the health and safety of the client, and

e. ~~s~~Safety enhancing supports such as basic fences or basic door and window alarms;

f. The following items are specifically excluded from ~~h~~Home ~~a~~Accessibility ~~a~~Adaptations and shall not be reimbursed:

i. ~~a~~Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,

ii.) ~~c~~Carpeting,

iii.) ~~r~~Roof repair,

iv.) ~~c~~Central air conditioning,

v.) ~~a~~Air duct cleaning,

vi.) ~~w~~Whole house humidifiers,

vii.) ~~w~~Whole house air purifiers,

viii.) ~~i~~Installation and repair of driveways and sidewalks,

viii.) ~~m~~Monthly or ongoing home security monitoring fees,

ix.) ~~h~~Home furnishings of any type,

x.) ~~a~~Adaptations to rental units when the adaptation is not portable and cannot move with the renter, and

xi.) ~~l~~Luxury upgrades.

g. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i. ~~i~~Improve entrance or egress to a residence; or,

ii. ~~c~~Configure a bathroom to accommodate a wheelchair.

h. Any request to add square footage to the home shall be prior authorized in accordance with ~~o~~Operating ~~a~~Agency procedures.

i. All devices and adaptations shall be provided in accordance with applicable state or local building codes and applicable standards of manufacturing, design and installation. Medicaid ~~s~~State ~~p~~Plan, EPSDT or third party resources shall be utilized prior to authorization of HCBS-CES waiver services.

j. The total cost of ~~h~~Home ~~a~~Accessibility ~~a~~Adaptations,~~-~~ V~~v~~ehicle ~~m~~Modifications, and ~~a~~Assistive ~~t~~Technology shall not exceed ten thousand ($10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the ~~o~~Operating ~~a~~Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health~~,~~ and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with ~~o~~Operating ~~a~~Agency procedure.

6. Homemaker S~~s~~ervices are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of ~~h~~Homemaker ~~s~~Services:

a. ~~b~~Basic ~~h~~Homemaker ~~s~~Services includes cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.

i ~~t~~This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task.

ii. ~~l~~Lawn care, snow removal, air duct cleaning and animal care are specifically excluded under HCBS-CES waiver and shall not be reimbursed.

b. ~~e~~Enhanced ~~h~~**H**omemaker ~~s~~**S**ervices **include ~~b~~Basic ~~h~~Homemaker S~~s~~ervices with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning.**

i. ~~h~~Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.

ii. ~~t~~The provider shall be physically present to provide step by step verbal or physical instructions throughout the entire task:

1) ~~w~~When such support is incidental to the habilitative services being provided,

2) ~~t~~To increase independence of the client,

c. ~~i~~Incidental ~~b~~Basic ~~h~~Homemaker ~~s~~Service may be provided in combination with ~~e~~Enhanced ~~h~~Homemaker ~~s~~Services; however, the primary intent must be to provide habilitative services to increase independence of the client.

d. ~~e~~Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.

7. Parent ~~e~~Education provides unique opportunities for parents or other care givers to learn how to support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. P~~p~~arent ~~e~~Education includes:

a. ~~e~~Consultation and direct service costs for training parents and other care givers in techniques to assist in caring for the client's needs, including sign language training,

b. ~~s~~Special resource materials,

c. ~~e~~Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the client's disability,

d. ~~e~~Cost of membership to parent support or information organizations and publications designed for parents of children with disabilities.

e. The maximum service limit for parent education is one thousand (1,000) units per service plan year.

f. . The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i). ~~t~~Transportation,

ii). ~~l~~Lodging,

iii). ~~f~~Food, or

iv). ~~m~~Membership to any political organizations or any organization involved in lobby activities.

8.. Personal ~~c~~Care is assistance to enable a client to accomplish tasks that the client may complete without assistance if the client did not have a disability. ~~t~~This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task.

a. Personal care services include assistance with basic self care tasks that include performing hygiene activities, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.

b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required it shall be provided by the HCBS-CES waiver only to the extent the Medicaid State Plan or third party resource does not cover the service.

c. If the annual ~~f~~Functional ~~n~~Needs ~~a~~Assessment identifies a possible need for skilled care then the client shall obtain a home health assessment.

9.. **P**Professional **S**~~s~~ervices **are provided by a licensed, certified, registered or accredited professional and the intervention is related to an indentified medical or behavioral need. Professional services include:**

a. **Hippotherapy: includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.**

b. **~~m~~Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.**

c. **~~m~~Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes WATSU.**

d. Professional services can be reimbursed only when:

i). ~~t~~The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,

ii). ~~t~~The intervention is related to an identified medical or behavioral need; and

iii). ~~t~~The Medicaid state plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

iv). ~~t~~The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

1) ~~a~~Acupuncture,

2) ~~c~~Chiropractic care,

3) ~~f~~Fitness training (personal trainer),

4) ~~e~~Equine therapy,

5) ~~a~~Art therapy,

6) ~~w~~Warm water therapy,

7) ~~t~~Therapeutic riding,

8) ~~e~~Experimental treatments or therapies, and

9) ~~y~~Yoga.

10. Respite is **provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.**

a. ~~r~~Respite may be provided:

i.) ~~-I~~in the client's home, private residence,

ii.) ~~t~~The private residence of a respite care provider, or

iii.) ~~i~~In the community.

b. ~~r~~Respite is to be provided in an age appropriate manner.

i.) The eligible client age twelve (12) or older may receive respite during the time the care-giver works because same age typical peers do not need ongoing supervision at that age and the need for the respite is based on the client's disability.

ii.)~~.~~ A client eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children.

c. When the cost of care during the time the parents works is more for an eligible client, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care.

d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible client when supervision is needed so the primary caretaker can take the client to receive a state plan benefit or a HCBS-CES waiver service.

e. Respite shall be provided according to an individual or group rates as defined below:

~~a.~~ **i) ~~i~~**Individual**: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.**

~~b.~~ **ii) ~~i~~**Individual day**: the client receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty four (24)-hour period. A full day is ten (-10) hours or greater within a twenty four (24)- hour period.**

~~c.~~ iii) ~~o~~Overnight group: **the client receives respite in a setting which is defined as a facility that offers twenty four (24)-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty four (24)-hour period shall not exceed the respite daily rate.**

~~d.~~ iv) ~~g~~Group: **the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a twenty four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:**

~~i.~~ 1) ~~s~~**Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling.**

~~e~~**f. F~~f~~ederal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1 Section 16.221 by the state that is not a private residence.**

~~f~~**g. ~~t~~The total amount of respite provided in one service plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The ~~o~~Operating ~~a~~Agency may approve a higher amount based on a need due to the client's age, disability or unique family circumstances.**

~~g~~**h. ~~o~~Overnight group respite may not substitute for other services provided by the provider such as ~~p~~Personal ~~c~~Care, ~~b~~Behavioral ~~s~~Services or services not covered by the HCBS-CES waiver.**

~~h~~**i. R~~r~~espite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.**

~~i~~**j. T~~t~~he purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a client. Therefore, additional respite units beyond the service limit will not be approved for clients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.**

~~41~~11. Specialized ~~m~~Medical ~~e~~Equipment and ~~s~~Supplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized M~~m~~edical ~~e~~Equipment and ~~s~~Supplies include:

a. ~~k~~Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. ~~s~~Specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing;

c. ~~m~~Maintenance and upkeep of specialized medical equipment purchased through the HCBS-CES waiver.

d. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i) ~~i~~Items that are not of direct medical or remedial benefit to the client ~~are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement. these include but are not limited to;~~ vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

12. Vehicle ~~m~~**M**odifications **are adaptations or alterations to an automobile or van that is the client's primary means of transportation, to accommodate the special needs of the client, are necessary to enable the client to integrate more fully into the community and to ensure the health, and safety of the client.**

a. Upkeep and maintenance of the modifications are allowable services.

b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include:

i) ~~a~~Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client,

ii) ~~p~~Purchase or lease of a vehicle, and

iii) ~~t~~Typical and regularly scheduled upkeep and maintenance of a vehicle

c. The total cost of ~~h~~Home ~~a~~Accessibility ~~a~~Adaptations, ~~v~~Vehicle ~~m~~Modifications, and ~~a~~Assistive ~~t~~Technology shall not exceed ten thousand ($10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the ~~o~~Operating ~~a~~Agency. Costs that exceed this limitation may be approved for services, items or devices to ensure the health~~,~~ and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no unnecessary duplication.

13. Vision service

a. Vision therapy is a sequence of activities individually prescribed and monitored by a ~~d~~Doctor of ~~o~~Optometry or ~~o~~Ophthalmology to develop efficient visual skills and processing. It is based on the results of standardized tests, the needs of the client and the client's signs and symptoms. It is used to treat eye movement disorders, inefficient eye teaming, misalignment

of the eyes, poorly developed vision, focusing problems and visual information processing disorders to enhance visual skills and performing visual tasks.

b. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i) ~~e~~Eye glasses as a benefit under Medicaid State Plan,

ii) ~~c~~Contacts, or

iii) ~~g~~General vision checks

c. Vision therapy is provided only when the services are not available through the Medicaid State Plan or EPSDT and due to not meeting the need for medical necessity as defined in ~~h~~Health ~~c~~Care ~~p~~Policy and ~~f~~Financing rules at 10 CCR 2505-10,Section 8.208.1 or available through a third party resource.

8.503.50 SERVICE PLAN

8.503.50.A THE CASE MANAGEMENT AGENCY SHALL COMPLETE A SERVICE PLAN FOR EACH CLIENT ENROLLED IN THE HCBS-CES WAIVER IN ACCORDANCE WITH 10 CCR 2505-10 SECTION 8.400.

1. The service plan shall:

a. ~~a~~Address the client's assessed needs and personal goals, including health and safety risk factors either by HCBS-CES waiver services or any other means,

b. ~~b~~Be in accordance with the ~~d~~Department's and the ~~o~~Operating ~~a~~Agency's rules, policies and procedures,

c. ~~b~~Be entered and verified in the ~~d~~Department prescribed system within ten (10) business days,

d. ~~d~~Describe the types of services to be provided, the amount, frequency and duration of each service and the type of provider for each service,

e. ~~i~~Include a statement of agreement, and.

f. ~~b~~Be updated or revised at least annually or when warranted by changes in the HCBS-CES waiver client's needs,

2. The ~~s~~service ~~p~~Plan shall document that the client has been offered a choice:

a. ~~b~~Between HCBS-CES waiver services and institutional care,

b. ~~a~~Among HCBS-CES waiver services, and

c. ~~a~~Among qualified providers.

8.503.~~4~~60 WAIT~~ING~~ LIST PROTOCOL

8.503.60.A WHEN THE HCBS-CES WAIVER REACHES CAPACITY FOR ENROLLMENT, A CLIENT DETERMINED ELIGIBLE FOR HCBS-CES WAIVER BENEFITS SHALL BE PLACED ON A STATEWIDE WAIT LIST IN ACCORDANCE WITH THESE RULES AND THE OPERATING AGENCY'S PROCEDURES.

1. The Community Centered Board shall determine if an applicant has developmental delay if under age five (5), or developmental disability if over age five (5) prior to submitting the HCBS-CES waiver application to the utilization review contractor. Only a client who is determined to have a developmental delay or developmental disability may apply for HCBS-CES waiver.

2. In the event a client who has been determined to have a developmental delay is placed on the wait list prior to age five (5), and that client turns five (5) while on the HCBS-CES waiver wait list, a determination of developmental disability must be completed in order for the client to remain on the wait list.

3. The case management agency shall complete the ~~f~~Functional ~~n~~Needs ~~a~~Assessment, as defined in ~~d~~Department rules, to determine the client's L~~l~~evel ~~o~~Of C~~c~~are. ~~.~~

4. The case management agency shall complete the HCBS-CES waiver application with the participation of the family. The completed application and a copy of the ~~f~~Functional ~~n~~Needs ~~a~~Assessment that determines the client meets the ICF/MR level of care shall be submitted to the ~~u~~Utilization ~~r~~Review ~~c~~Contractor within fourteen (14) calendar days of parent signature.

5. ~~s~~Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the utilization review contractor.

6. The utilization review contractor shall review the HCBS-CES waiver application. In the event the utilization review contractor needs additional information, the case management agency shall respond within two (2) business days of request.

7. Any client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide wait list in the order in which the utilization review contractor received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the client's appeal rights in accordance with 10 CCR 2505-10, S~~s~~ection 8.057. ~~of this manual.~~

8. The case management agency will create or update the consumer record to reflect the client is waiting for the HCBS-CES waiver with the wait list date as determined by the utilization review contractor.

~~A. Children determined eligible for services under the CES Program, which are not immediately available within the federally approved capacity limits of the waiver, shall be eligible for placement on a waiting list in the order in which the Utilization Review Contractor received the eligible application. Applicant children denied program enrollment shall be informed of their appeal rights in accordance with Section 8.057 of this manual.~~

~~B. When an opening/slot becomes available, the first child on the waiting list shall be reassessed for eligibility by the Utilization Review Contractor and, if determined to still be eligible, shall be assigned that opening/slot.~~

8.503.70 ENROLLMENT

8.503.70.A WHEN AN OPENING BECOMES AVAILABLE FOR AN INITIAL ENROLLMENT TO THE HCBS-CES WAIVER IT SHALL BE AUTHORIZED IN THE ORDER OF PLACEMENT ON THE WAITING LIST. AUTHORIZATION SHALL INCLUDE AN INITIAL ENROLLMENT DATE AND THE END DATE FOR THE INITIAL ENROLLMENT PERIOD.

1. The case management agency shall complete the HCBS-CES waiver application and the ~~f~~Functional ~~n~~Needs ~~a~~Assessment in the family home with the participation of the family. The completed application and a copy of the F~~f~~unctional ~~n~~Needs ~~a~~Assessment shall be submitted to the ~~u~~Utilization ~~r~~Review ~~c~~Contractor within thirty (30) days of the authorized initial enrollment date.

a. ~~i~~If it has been less than six (6) months since the review to determine wait list eligibility by the ~~u~~Utilization ~~r~~Review ~~c~~Contractor and there has been no change in the client's condition, the case management agency shall complete the ~~f~~Functional ~~n~~Needs ~~a~~Assessment and the parent may submit a letter to the case management agency in lieu of the HCBS-CES waiver application stating there has been no change.

b. ~~i~~If there has been any change in the client's condition the case management agency shall complete a ~~f~~Functional ~~n~~Needs ~~a~~Assessment and the HCBS-CES waiver application which shall be submitted to the ~~u~~Utilization ~~r~~Review ~~c~~Contractor.

3. Services and supports shall be implemented pursuant to the service plan within 90 days of the parent or guardian signature.

4. All continued stay review enrollments shall be completed and submitted to the utilization review contractor at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

8.503.80 CLIENT RESPONSIBILITIES

8.503.80.A THE PARENT OR LEGAL GUARDIAN OF A CLIENT IS RESPONSIBLE TO ASSIST IN THE ENROLLMENT OF THE CLIENT AND COOPERATE IN THE

PROVISION OF SERVICES. FAILURE TO DO SO SHALL RESULT IN THE CLIENT'S TERMINATION FROM THE HCBS-CES WAIVER. THE PARENT OR LEGAL GUARDIAN SHALL:

1. ~~p~~Provide accurate information regarding the client's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions.

2. ~~c~~Cooperate with providers and case management agency requirements for the HCBS-CES waiver enrollment process, continued stay review process and provision of services;

3. ~~c~~Cooperate with the local ~~d~~Department of ~~h~~Human ~~s~~Services in the determination of financial eligibility;

4. C~~c~~omplete the HCBS-CES waiver application with fifteen calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a continued stay review, at least thirty (30) days prior to the end of the current certification period;

5. ~~c~~Complete the ~~s~~Service ~~p~~Plan within thirty calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the U~~u~~tilization ~~r~~Review ~~c~~Contractor;

6. N~~n~~otify the case manager within thirty (30) days after changes:

a. ~~i~~In the client's support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF/MR placements;

b. T~~t~~hat may affect Medicaid financial eligibility such as prompt report of changes in income or resources;

c. W~~w~~hen the client has not received an HCBS-CES waiver service for one calendar month;

d. ~~i~~In the client's care needs; and,

e. In the receipt of any HCBS-CES waiver services.

8.503.90 PROVIDER REQUIREMENTS

8.503.90.A A private for profit or not for profit agency or government agency shall ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver and shall:

1. ~~c~~Conform to all state established standards for the specific services they provide under HCBS-CES waiver,

2. ~~m~~Maintain program approval and certification from the ~~o~~Operating ~~a~~Agency,

3. ~~m~~Maintain and abide by all the terms of their Medicaid provider agreement with the ~~d~~Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, ~~s~~Section 8.130,

4. ~~d~~Discontinue HCBS-CES waiver services to a client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide HCBS-CES waiver services,

5. ~~h~~Have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S., as amended,

6. ~~w~~When applicable, maintain the required licenses and certifications from the Colorado Department of Public Health and Environment, and

7. ~~m~~Maintain client records to substantiate claims for reimbursement according to Medicaid standards.

8.503.90.B HCBS-CES~~ces~~ waiver service providers shall comply with:

1. All applicable provisions of 27, Article 10.5, C.R.S., *et seq*. and all rules and regulations as set forth in 2 CCR 503-1, Section 16.100 *et seq*.,

2. All federal or state program reviews or financial audit of HCBS-CES waiver services,

3. The ~~o~~Operating ~~a~~Agency's on-site certification reviews for the purpose of program approval, on-going program monitoring or financial and program audits,

4. Requests from the County Departments of Human Services to access records of clients and to provide necessary client information to determine and re-determine Medicaid financial eligibility,

5. Requests by the ~~d~~Department of the ~~o~~Operating ~~a~~Agency to collect, review and maintain individual or agency information on the HCBS-CES waiver, and

6. Requests by the case management agency to monitor service delivery through targeted case management activities.

8.503.100 TERMINATION OR DENIAL OF HCBS-CES MEDICAID PROVIDER AGREEMENTS

8.503.100.A The ~~d~~Department may deny or terminate an HCBS-CES waiver Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq*..

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-CES waiver services.

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior client notification.

5. The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the ~~d~~Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with procedures at 10 CCR 2505-10, Section 8.050.

~~**8.503.50 RESPONSIBILITIES OF THE COUNTY DEPARTMENT OF SOCIAL/ HUMAN SERVICES**~~

~~A. The County Department of Social/Human Services shall obtain an application for medical assistance, including an MS-10 form for private insurance coverage, from each applicant, not already Medicaid eligible, through his/her parent or guardian. In addition, the County Department of Social/Human Services shall obtain or determine and record all of the following on initial enrollment and at least annually thereafter, or more frequently if necessary due to changes in income, medical or living situation:~~

~~1. Written confirmation from the District Office, Social Security Administration, that the applicant is eligible or ineligible for SSI payments due to the deeming of parental income and/or resources; or~~

~~2. Written confirmation from the District Office, Social Security Administration that the applicant is ineligible for SSI payments due to the child's own income and/or resources level; and Certification that the applicant's own income does not exceed 300% of the current SSI standard maintenance allowance on a monthly basis.~~

~~B. In the event that the County Department of Social/Human Services is able to provide sufficient documentation to recommend approval of eligibility, either at the time of the initial application or during the redetermination process, the County Department shall notify the family in writing and forward a copy, within fifteen (15) working days, to the Community Centered Board (CCB), the recognized case management agency in the family service area.~~

~~C. In the event that the County Department is unable to obtain sufficient documentation to recommend approval of eligibility, either at the time of the initial application or during the redetermination process, the County Department shall deny the applicant's request. The County Department~~

shall notify the applicant, his/her parents or guardian in writing of the denial and of the applicant's right to an appeal in accordance with the procedures found in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1) Administrative Procedures

1. The County Department shall notify the case manager within five (5) working days of any changes in the child's income, which affect the applicant's eligibility status.

2. An applicant shall not be enrolled in the program or have his/her name placed on the waiting list without a case manager being assigned to the case by a CCB.

8.503.60 RESPONSIBILITIES OF THE COMMUNITY CENTERED BOARD

The Community Centered Board (CCB) shall make a determination of eligibility for developmental disabilities services for any child interested in applying for the CES Program.

8.503.61 DEFINITIONS

8.503.62 Case management services shall be defined as assistance on behalf of an eligible recipient to secure other needed services and supports to enable him/her to remain at home or in a non-institutional setting as an alternative to ICFMR placement when it is cost-effective to do so. Case management services shall include the following:

1. Documenting that the child's eligibility for Home and Community Based Services has been determined; and

2. Assessing the child's health care and social needs for CES services; and

3. Developing and implementing an Individualized Plan [§8.507.70]; and

4. Developing an Individual Support Plan (ISP) of services and projected costs [§8.507.80]; and

5. Coordinating and monitoring service delivery; and

6. Evaluating the effectiveness of services provided in the Plan; and

7. Reassessing the child's eligibility and need for CES services; and

8. Ensuring the child's parents) or guardian is informed of all Medicaid services available to the child including EPSDT Program services; and

9. Notifying the child's parents/guardian of adverse actions and appeal rights on a Department designed form at least ten (10) calendar days prior to the effective date of such action.

Case management agency shall be defined as the Community Centered Board (CCB) in the service area where the child and family reside which has been approved through the Department of Human Services.

8.503.63 RESPONSIBILITIES OF THE CASE MANAGEMENT AGENCY

A. A child's parent(s) or guardian may request assistance applying for the CES Program from the CCB or County Department of Social/Human Services in their service area.

B. Upon receipt of a referral, the CCB shall be responsible to provide the following services:

1. Arrange for a case manager to be assigned; and

2. Inform the parent(s) or guardian of the purpose of the CES Program, the eligibility process, the minimum documentation required and the necessary agencies to contact; and

3. Begin assessment activities within ten (10) calendar days of receipt of the referral; and

4. Assist the parent(s) or guardian in completing the CES Application Packet and ensure completion of the ULTC 100 form; and

5. Arrange for and complete at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible, within thirty (30) calendar days of receipt of the referral; and

6. Refer the child, as needed, to the County Department of Social/Human Services to determine eligibility for Medicaid or other services and benefits as appropriate, e.g., the EPSDT Program, and deliver services in coordination with the County Department; and

1 Ensure that the child has been determined to meet the eligibility criteria for developmental disabilities services, and has a denial letter, if necessary, for SSI benefits; and

2. Submit the completed CES Application Packet Statement and the ULTC 100 form to the Utilization Review Contractor for an eligibility determination.

E. If there is an opening in the CES Program, the Utilization Review Contractor shall send an approved and date certified ULTC 100 form to the CCB. If the child has been on the waiting list, the Utilization Review Contractor shall first verify the continued eligibility of the child. The CCB shall notify the parent(s) or guardian and arrange for the development of the Individualized Plan (IP) and an Individualized Support Plan (ISP) within thirty (30) calendar days.

F. If the child is eligible but there is no opening in the CES Program, the Utilization Review Contractor shall notify the CCB that the child has been placed on the waiting list and the order in which the child was placed on the list. The CCB shall notify the parent(s) or guardian within ten (10) calendar days.

G. If the child is not Medicaid eligible, in his/her own right, and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department of Social/Human Services or other community agencies for possible services, as appropriate, within ten (10) working days of notification of denial.

8.503.70 INDIVIDUALIZED PLAN

8.503.71 DEFINITION

An Individualized Plan (IP) shall include information about why the child requires services and supports. All services and supports required to meet the needs in the home shall be listed. The purpose and the expected outcome of the services shall be included in the IP.

8.503.72 CONTENT OF THE INDIVIDUALIZED PLAN

A. The Individualized Plan shall consist of a Child's Needs Section, a Plan Section and a Purpose Section.

1. Child's Needs Section shall identify and list specific (medical and/or behavioral) conditions and/or other areas in which services and supports are required to maintain the child in the community/home setting. The areas of need shall include, but not be limited to, the following:

   (a) Medical needs; and

   (b) Functional needs; and,

   (c) Home/environmental needs.

2. Plan Section shall identify and quantify all services and supports required to meet the needs of the child, including case management services. The service listing shall identify the payment sources (i.e. family or informal supports, parental out-of-pocket expenditures, private insurance).

3. Purpose Section shall be a statement of a measurable goal that the case manager, child's parent(s) or guardian and service providers expect to obtain during the period covered by the Individualized Plan.

B. The Individualized Plan shall include the date and signatures of both the case manager and parent or guardian of the child.

C. The case manager shall calculate the total costs to the CES Waiver, utilizing the Individual Support Plan (ISP) document. The costs to implement the Individualized Plan shall not include case management services.

8.503.73 REVISIONS TO INDIVIDUALIZED PLAN

A. When a change in the Individualized Plan results in an increase in the cost of services/supports being provided, the case manager shall seek telephone approval from the Department of Human Services (DHS)/Develop mental Disabilities Services (DDS) Medicaid Section. Final authorization is contingent upon submission of a revised Individualized Plan and Individual Support Plan (ISP) within ten (10) working days.

B. When a change results in a decrease in services/supports and the overall costs, a revised Individualized Plan and Individual Support Plan (ISP) shall be submitted the DHS/DDS Medicaid Section within ten (10) working days.

8.503.74 INDIVIDUALIZED SUPPORT PLAN (ISP)

8.503.75 DEFINITION

An individual support plan (ISP) provides an explanation of how the services/supports will assist the child to continue to reside within the family home. The plan shall provide a complete listing of CES services/supports to be provided to the child, including the frequency of the services/supports to the child, the agency providing the services/supports, and the cost of the services/supports.

8.503.76 PURPOSE

The purpose of the individual support plan shall be to:

A. Provide an assessment of non-CES services and natural supports that assist the child to continue to live in the family home; and

B. Identify the needs and preferences of the child/family which, when met, will allow the child to continue to live in the family home; and

C. Identify safety, nutritional and medical needs to be addressed; and

D. Develop a plan of services and supports from qualified CES providers, chosen by the individual/family, that enable the child to continue to live in the family home.

8.503.77 REIMBURSEMENT

Only services/supports specifically listed on the ISP shall be available for reimbursement under CES.

8.503.78 RELATIONSHIP BETWEEN ISP AND IP

A. The Individualized Plan (IP) shall be the overall coordinating service plan for children with developmental disabilities who are receiving or on a waiting list for services/supports funded by Developmental Disabilities Services (DDS).

B. The IP has many similar features to the ISP, i.e., evaluation and assessment of needs, description of services, etc. When appropriate, the IP can reference information included on the ISP, and vice versa, in order to reduce duplication of effort.

C. Children receiving other DDS funded services, in addition to CES, shall have the IP as the overall coordinating plan. Children receiving CES, as the sole service program shall have the ISP be the primary service plan while the IP shall contain all needed elements and reference the ISP as the service plan.

8.503.110 ORGANIZED HEALTH CARE DELIVERY SYSTEM

8.503.110.A THE ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) FOR HCBS-CES WAIVER IS THE COMMUNITY CENTERED BOARD AS DESIGNATED BY THE ~~O~~OPERATING ~~A~~AGENCY IN ACCORDANCE WITH SECTION 27-10.5-103, C.R.S.

1. The OHCDS is the Medicaid provider of record for a client whose services are delivered through the OHCDS.

2. The OHCDS shall maintain a Medicaid provider agreement with the ~~d~~Department to deliver HCBS-CES waiver services according to the current federally approved waiver.

3. The OHCDS may contract or employ for delivery of HCBS-CES waiver services.

4. The OCHDS shall:

   a. ~~e~~Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver,

   b. ~~e~~Ensure that services are delivered according to the HCBS-CES waiver definitions and as identified in the client's service plan,

   c. ~~e~~Ensure the contractor maintains sufficient documentation to support the claims submitted, and

   d. ~~m~~Monitor the health and safety of HCBS-CES waiver clients receiving services from a subcontractor.

5. The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

   a. ~~e~~Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

b. ~~e~~Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

c. ~~e~~Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients

d. ~~n~~Negotiate rates that are in accordance with the ~~d~~Department's established fee for service rate schedule and ~~o~~Operating ~~a~~Agency procedures,

i.) ~~m~~Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

e. ~~c~~Collect and maintain the data used to develop provider rates and ensure data includes costs for the services to address the client's needs, that are allowable activities within the HCBS-CES waiver service definition and that supports the established rate, and

f. ~~m~~Maintain documentation of provider reimbursement rates and make it available to the ~~d~~Department, its ~~o~~Operating ~~a~~Agency and Centers for Medicare and Medicaid Services (CMS).

g. R~~r~~eport by ~~a~~August 31 of each year, the names, rates and total payment made to the contractor.

8.503.120 PRIOR AUTHORIZATION REQUESTS

8.503.120.A PRIOR AUTHORIZATION REQUESTS (PAR) SHALL BE IN ACCORDANCE WITH 10 CCR 2505-10, SECTION 8.058.

1. A ~~p~~Prior ~~a~~Authorization ~~r~~Request shall be submitted to the ~~o~~Operating ~~a~~Agency through the ~~d~~Department's designated information management system.

2. The case management agency shall comply with the policies and procedures for the PAR~~par~~ review process as set forth by the ~~d~~Department and the ~~o~~Operating ~~a~~Agency.

3. The case management agency shall submit the PAR~~par~~ in compliance with all applicable regulations and ensure requested services are:

a. ~~c~~Consistent with the client's documented medical condition and functional capacity as indicated in the ~~f~~Functional ~~n~~Needs ~~a~~Assessment,

b. ~~a~~Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved HCBS-CES waiver, and

c. ~~n~~Not duplicative of another authorized service, including services provided through:

i.) Medicaid State Plan benefits,

ii.) ~~t~~Third party resources,

iii.) ~~n~~Natural supports,

iv.) ~~c~~Charitable organizations, or

v.) ~~o~~Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10, Section 8.058.4.

8.503.130 RETROSPECTIVE REVIEW PROCESS

8.503.130.A SERVICES PROVIDED TO A CLIENT ARE SUBJECT TO A RETROSPECTIVE REVIEW BY THE ~~D~~DEPARTMENT AND THE ~~O~~OPERATING ~~A~~AGENCY. THIS RETROSPECTIVE REVIEW SHALL ENSURE THAT SERVICES:

1. **Identified in the service plan is based on the client's identified needs as stated in the ~~f~~Functional ~~n~~Needs ~~a~~Assessment,**

2. **Have been requested and approved prior to the delivery of services,**

3. **Provided to a client are in accordance with the service plan, and**

4. **Provided are within the specified HCBS service definition in the federally approved HCBS-CES waiver.**

8.503.130.B THE CASE MANAGEMENT AGENCY OR PROVIDER SHALL BE REQUIRED TO SUBMIT A PLAN OF CORRECTION THAT IS MONITORED FOR COMPLETION BY THE ~~D~~DEPARTMENT AND THE ~~O~~OPERATING ~~A~~AGENCY WHEN AREAS OF NON-COMPLIANCE ARE IDENTIFIED IN THE RETROSPECTIVE REVIEW.

8.503.130.C The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.503.130.D When the provider has received reimbursement for services and the review by the ~~d~~Department or ~~o~~Operating ~~a~~Agency identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.503.140 PROVIDER REIMBURSEMENT

8.503.140.A PROVIDERS SHALL SUBMIT CLAIMS DIRECTLY TO THE ~~D~~DEPARTMENT'S FISCAL AGENT THROUGH THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS) OR THROUGH A QUALIFIED BILLING AGENT ENROLLED WITH THE ~~D~~DEPARTMENT'S FISCAL AGENT.

1. **Provider claims for reimbursement shall be made only when the following conditions are met:**

a. **~~s~~Services are provided by a qualified provider as specified in the federally approved HCBS-~~CES~~ CES waiver,**

b. **~~s~~Services have been prior authorized,**

c. **~~s~~Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the client's service plan, and**

d. **~~r~~Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.**

2. Provider claims for reimbursement shall be subject to review by the ~~d~~Department and the Operating Agency. This review may be completed after payment has been made to the provider.

3. When the review identifies areas of non compliance, the provider shall be required to submit a plan of correction that is monitored for completion by the ~~d~~Department and the Operating Agency.

4. When the provider has received reimbursement for services and the review by the ~~d~~Department or ~~o~~Operating ~~a~~Agency identifies that the service delivered or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

~~**8.503.80 COST CONTAINMENT**~~

~~**8.503.81 DEFINITION**~~

~~The cost containment function of the case manager shall be to ensure, on an individual child basis, the cost of providing CES services is a cost effective alternative compared to the equivalent cost of appropriate ICF/MR institutional level of care. The case manager shall identify costs as part of each Individualized Plan to be submitted to the Department of Human Services for review. The Department of Human Services shall be responsible for ensuring that, on average, each plan is within the federally approved cost containment requirements of the waiver.~~

~~8.503.82 REQUIREMENTS~~

~~A. If services must be added or units of service increased, the case manager shall submit a revised Individualized Plan including an ISP demonstrating continued cost-effectiveness.~~

~~B. The Department of Human Services shall approve or disapprove the revised maximum authorization for services within thirty (30) calendar days of receipt of the revised IP and ISP. If there is an emergency need, the case manager shall telephone the Developmental Disabilities Services Medicaid Section at the Department of Human Services and request an expedited review.~~

~~C. Children in the CES program shall continue to meet the cost containment criteria during subsequent periods of eligibility.~~

~~D. The case manager shall send a copy of the Individualized Plan and the Individual Support Plan to the primary physician for review. The primary physician must attest that in his/her opinion, the quantity and quality of care planned for the child in the community/home is sufficient for the child's needs by signing the Individual Support Plan and returning it to the COB.~~

~~**8.503.90 DOCUMENTATION: Program Enrollment**~~

A. The completed enrollment forms shall be submitted to the Developmental Disabilities Services Medicaid Section at the Department of Human Services within thirty (30) calendar days of receipt of the approved ULTC 100 form from the Utilization Review Contractor indicating that an opening has been designated for the child. A complete packet includes:

1. A copy of the Individual Choice Statement; and

2. A copy of the Individualized Plan; and

3. A copy of the Individual Support Plan; and

4. A copy of the Utilization Review Contractor approved ULTC 100 form.

B. After review by Developmental Disabilities Services, if all requirements are met, the Individual Support Plan shall be returned to the CCB with the authorization signature from the State.

C. The case manager shall submit the following enrollment forms to the County Department of Social/Human Services for activation of a State Medicaid Identification Number:

1. A copy of the Individual Choice Statement;

2. A copy of the State authorized Individual Support Plan;

3. A copy of the Utilization Review Contractor approved ULTC 100 form; and

4. A copy of the SSI denial letter, if needed.

D. The effective date/enrollment date shall be no earlier than the start date on the Utilization Review Contractor approved ULTC 100 form. An approved ULTC 100 form does not constitute Program Enrollment. No services may be authorized prior to the date of enrollment.

E. An Individualized Plan, ULTC 100, and Individual Support Plan shall be valid for no more than a twelve (12) month period.

8.503.100 SERVICE DESCRIPTIONS

A. Personal Assistance Services

1. Child Care Services:

The temporary care of a child which is necessary to keep a child in the home and avoid institutionalization.

2. Personal Supports:

Personal supports shall include assistance with bathing and personal hygiene, eating, dressing and grooming, bowel and bladder care, menstrual care, transferring, basic first aid, giving medications, operating and maintaining medical equipment for a child who cannot perform these functions alone due to the developmental disability or medical condition.

3. Household Services:

Household services shall include assistance in performing housekeeping tasks, which, due to the needs of the child with a developmental disability, are above and beyond the tasks generally required in a home and/or increase the parent(s) ability to provide care needed by the child with a developmental disability.

B. Home Modification Services

1. Home modification services may include those services which assess the need for, arrange for and provide modifications and/or improvements to the family home of a child with a developmental disability to help ensure the child's safety, security and accessibility in the home and community.

2. Home modification services include devices and services to make daily living easier, such as adapted showers or toilets, adaptations that make places accessible such as ramps and railings, and reinforcing or fencing for the child's protection.

3. Home Modification Services shall exclude those adaptations or improvements to the home that are not of direct medical or remedial benefit to the waiver client, such as carpeting, roof repair, central air conditioning, etc. All services shall be provided in accordance with applicable State or local building codes.

C. Specialized Medical Equipment and Supplies:

Specialized medical equipment and supplies services shall be provided only if these services are not available under Medicaid EPSDT coverage, Medicaid State Plan, benefits, other third party liability coverage or other federal or state funded programs, services or supports.

1. Assistive Technology Services:

Assistive technology services shall include the evaluation of the child's need for assistive technology related to the disability; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and training the child and/or family to use the devices effectively.

Assistive technology services shall include devices and services that will help a child with a developmental disability and the child's family to overcome barriers related to the disability that they face in their daily lives. This may include the use of devices to help the child move around such as wheelchairs, wheelchair adaptations, and adaptations for vans (e.g., lifts for vans or roof storage for wheelchairs), devices that help the child communicate such as electronic communication devices; devices that make learning easier such as adapted games, toys or computers; and devices that control the environment such as switches.

2. Other Equipment and Supplies:

a. Kitchen equipment required for the preparation of special diets if this results in a cost saving over prepared foods.

b. General care items such as distilled water for saline solutions, supplies such as eating utensils, etc., required by a child with a developmental disability and related to the disability.

c. Specially designed clothing (e.g., Velcro) if the costs over and above the costs generally incurred for a child's clothing.

D. Professional Services:

Professional services shall be provided only if these services are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, other third party liability coverage or other federal or state funded programs, services or supports. Professional services shall include:

1. Counseling and therapeutic services including individual and/or group counseling, behavioral or other therapeutic interventions related to the child's disability, needed to sustain the overall functioning of the child with a developmental disability; and

2. Consultation and direct service costs for training parents and other care providers in techniques to assist in caring for the child's needs. This includes acquisition of information for family members of children with developmental disabilities from support organizations and special resource materials, e.g., publications designed for parents of children with developmental disabilities; and

3. Diagnostic, evaluation and testing services necessary to determine the child's health and mental status and the related social. psychological and cognitive needs and strengths, including genetic counseling and family planning; and

4. Personal care functions requiring assistance by an RN, LPN, Certified Nurse Aide or Home Health Aide and not otherwise available under Medicaid EPSDT coverage, third party liability coverage, or other state funded programs, services or supports. These services may also include operating and maintaining medical equipment.

E. Community Connection Services:

The Community Connector shall explore community services appropriate to the individual in their community, natural supports available to the individual, match and monitor community connections to enhance socialization and community access capability. This shall include:

1. Recreational and Leisure Activities (for the child with a developmental disability). Recreational programs that allow the child with a developmental disability to experience typical community leisure time activities increase their ability to participate in these activities and develop appropriate physical and psychological social skills. (This benefit shall be limited to $500 per year).

2. Recreational equipment, such as a floatation collar for swimming, a bowling ramp, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a child with a developmental disability.

8.503.110 MAINTENANCE OF CASE RECORDS

The case manager shall maintain a record of each child referred to the CES program. The record shall include the initial assessment materials, documentation of all contacts by the case manager, copies of the home health agency plan of care, if applicable, and documentation of the disposition of the referral.

A. For each CES child enrolled, the case manager shall create and maintain a case record including:

1. Identifying information; and

2. Documentation that eligibility for Medicaid has been determined by the County Department of Social/Human Services; and

3. Documentation of the Utilization Review Contractor's level of care determination; the child's initial assessment materials including a copy of the CES Application Packet, the Individual Choice Statement, documentation of the disposition of the referral, Individualized Plan, and the Individual Support Plan; SS1 denial letter, if applicable; and verification of eligibility for developmental disabilities services; and

4. Documentation of case management.

B. Case management agencies shall follow requirements and regulations contained in Section 8.409.33 in the Department of Health Care Policy and Financing Staff Manual, Volume 8.

C. Case activity, including documentation of monitoring shall be included in the case record. All services, including case management, shall be evaluated as to effectiveness in reaching the goal of the Individualized Plan.

D. Whenever the case manager fails to comply with any regulation for case management services for the CES Program, due to circumstances outside the case manager's control, the circumstances shall be documented in the case record.

8.503.120 REDETERMINATION OF ELIGIBILITY

Redetermination of eligibility for CES services shall be made as follows:

A. At least annually and one (1) month prior to the expiration of the ULTC-100 form, the case manager shall ensure that a new ULTC-100 form is submitted to the Utilization Review Contractor. The case manager shall initiate a level of care review more frequently when warranted by significant changes in the child's situation.

B. At least annually, the case manager shall document verification of the child's Medicaid eligibility with the County Department of Social/Human Services income maintenance technician.

C. If the child is not Medicaid eligible and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department of Social/Human Services or other community agencies for possible services, as appropriate, within ten (10) working days of notification of denial.

8.503.121 REASSESSMENT

A reassessment to redetermine or confirm a child's eligibility for the CES Program shall be conducted, at a minimum, every twelve (12) months and the following shall be renewed/revised and sent to the Developmental Disabilities Services Medicaid Section at the Department of Human Services no later than fifteen (15) working days prior to the expiration of the previous/current ULTC-100 form:

A. ULTC-100 form;

B. Individualized Plan; and,

C. Individual Support Plan.

8.503.130 TRANSFER PROCEDURES BETWEEN CASE MANAGEMENT AGENCIES

A. The sending Case Management Agency (CMA) shall complete the following procedures to transfer a child to another CMA:

1. Contact the receiving case management agency by telephone and give notification that the child is planning to transfer, negotiate an appropriate transfer date and provide information; and

2. If it is an inter-county transfer, notify the income maintenance technician to follow inter-county transfer procedures as outlined in the Colorado Department of Human Services Income Maintenance Staff Manual (9CCR 2503-1), Inter-county Transfer Section 3.140.3; and

3. Forward copies of pertinent records and forms to the receiving case management agency within five (5) working days of the child's transfer; and

4. Notify the Utilization Review Contractor and the Developmental Disabilities Services Medicaid Section at the Department of Human Services of the transfer within thirty (30) calendar days, using a State-designed form.

B. For any CES child transferring to a new case management agency, the receiving case management agency shall complete the following procedure:

1. Conduct a face-to-face visit with the child within ten (10) working days of the child's transfer; and

2. Review and revise the Individualized Plan and the Individual Support Plan, and change or coordinate services and providers as necessary.

8.503.140 TERMINATION FROM CES

A. The child shall be terminated from the CES Program when one of the following occurs:

1. The child no longer meets any one of the eligibility criteria at 8.503.30 of these rules; or

2. The cost of services and supports provided in the home or community exceed the cost effectiveness of the program; or

3. The parent/guardian chooses ICF/MR rather than the CES program; or

4. The family chooses to discontinue the CES program (e.g., moves out of state, no longer needs the Medicaid coverage); or

5. The child enrolls into another HCBS waiver program or is admitted for a long term stay in an institution (e.g. hospital or NF); or

6. The child expires.

B. The case manager shall inform the child's parent(s) or guardian in writing on a form provided by the Department of the termination from the CES Program, ten (10) calendar days before the effective date of

the termination; and shall inform the child's parent(s) or guardian of his/her appeal rights as contained in the HOME AND COMMUNITY BASED SERVICES - CLIENTS RIGHTS section of this Staff Manual.

C. Whenever a child is terminated from the CES Program, the case manager shall notify all providers listed on the Individual Support Plan within ten (10) working days prior to the effective date of termination; and shall notify the Utilization Review Contractor and the Developmental Disabilities Services Medicaid Section at DHS within ten (10) calendar days, on a State-designed form.

D. The case manager shall provide appropriate referrals to other community agencies, including the County Department of Social/Human Services, if the child needs continued assistance to remain in the community, within five (5) working days of written notice of termination.

E. The reasons for termination and all agency referrals shall be documented in the child's case record.

8.503.150 MONITORING AND COORDINATION

A. Case managers shall document whether and how the services provided are meeting the child's needs, as defined in the Individualized Plan and Individual Support Plan, and ensure that the child continues to meet cost containment criteria. This monitoring shall include conducting child, parent/guardian and provider interviews and reviewing cost data and any written reports received from service providers. The case manager shall, at a minimum; document at least once every two (2) months whether and how the services are meeting the individual's needs as defined in the IP.

B. Case managers shall be responsible to coordinate information with the parents) or guardian, primary physician, service providers, County Department of Social/Human Services, CCB, Social Security Administration and others, as necessary, to ensure the effective delivery of services and support for the child.

8.503.160 GENERAL CERTIFICATION PROCEDURES FOR CASE MANAGEMENT AGENCIES (CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM - CES)

A. All CMAs for the CES Program shall be Community Centered (CDHS). The procedures and certification standards shall be Regulations, Chapter 2 (2 CCR 503-1).

B. Community Centered Boards are required to apply for certification as a CES Specific Medicaid provider and have a provider agreement with the Colorado Department of Human Services.

C. Case management agencies shall meet all standards in the case management program section of the Colorado Department of Human Services Rules and Regulations, Chapter 5 (2 CCR 503-1).

D. The qualifications for a case manager shall be those described in Department of Human Services, Developmental Disabilities Services Rules and Regulations, Section 15.6.4.

E. Case management agencies shall maintain records that document their claims for case management services.

8.503.161 RENEWAL OF CASE MANAGEMENT AGENCIES CERTIFICATION (CES)

Renewal of case management agencies certification shall be in accordance with established procedures of the Colorado Department of Human Services.

~~**8.503.162 TERMINATION OR NON-RENEWAL OF PROVIDER AGREEMENTS WITH CASE MANAGEMENT AGENCIES (CES)**~~

~~Termination or non-renewal of Provider Agreements with case management agencies (CES) shall be in accordance with established procedures of the Colorado Department of Human Services.~~

~~**8.503.170 SERVICE PROVIDERS**~~

~~Children's Extensive Support services shall be provided by or through agencies that meet the following criteria:~~

~~A. Have been designated by the Department of Human Services, Developmental Disabilities Services to be a Community Centered Board; and~~

~~B. Have received and/or maintained program approval from the Department of Human Services, Developmental Disabilities Services for the provision of Children's Extensive Support services; and~~

~~C. Have a Medicaid Provider Agreement; and~~

~~D. Have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S. (1995 Supp.), and the rules and regulations promulgated thereunder, including cooperation with the following activities:~~

~~1. All State authorized on-site program reviews, whether for the purpose of program approval, ongoing program monitoring, or State initiated financial and program audits; and~~

~~2. All State efforts to collect and maintain information on the CES waiver program, whether required for federal or state program review and evaluation efforts, including information collection; and~~

~~3. Any federal program reviews and financial audits of the CES waiver program; and~~

~~4. County Departments of Social/Human Services shall be authorized access, as required, to the records of persons receiving services held by case management agencies to determine or redetermine Medicaid eligibility; and~~

~~5. All efforts by the case management agency to review the provider's programs, either generally or specifically for particular persons receiving services; and~~

~~6. All long-term care determinations and continued stay reviews conducted by the Utilization Review Contractor.~~

~~E. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.~~

~~**8.503.180 INDIVIDUAL RIGHTS**~~

~~The rights of a person receiving Children's Extensive Support services are established in Title 27, Article 10.5, Sections 112 through 131, C.R.S. (1995 Supp,), and the rules and regulations regarding these rights are promulgated in the Department of Human Services, Developmental Disabilities Services, rules and regulations, Chapter 6.~~

8.503.150 CLIENT RIGHTS

8.503.150. A Client rights should be in accordance with Sections 27-10.5-112- through 131 C.R.S.

8.503.~~190~~ 160 APPEAL ~~PROCESS~~RIGHTS

~~An individual receiving CES waiver services has a right to the appeal process established in the Department of Human Services, Developmental Disabilities Services, rules and regulations, Section 7.2 and 10 CCR 2505-10, Section 8.057.~~

8.503.160.A THE CCB SHALL PROVIDE THE LONG TERM CARE NOTICE OF ACTION FORM (LTC 803) TO THE APPLICANT AND CLIENT'S PARENT OR LEGAL GUARDIAN WITHIN ~~ONE~~TEN (10) BUSINESS DAY REGARDING THE CLIENT'S APPEAL RIGHTS IN ACCORDANCE WITH 10 CCR 2505-10, SECTION 8.057 *ET SEQ*. WHEN:

1. **The ~~a~~Applicant is determined not to have a developmental delay or developmental disability,**
2. **The ~~a~~Applicant is determined eligible or ineligible for Medicaid LTC services,**
3. **The ~~a~~Applicant is determined eligible or ineligible for placement on a waitlist for Medicaid LTC services,**
4. **An ~~a~~Adverse ~~A~~action occurs that affects the client's HCBS-CES waiver enrollment status through termination or suspension,**
5. **An ~~a~~Adverse ~~a~~Action occurs that affects the provision of HCBS-CES waiver services or,**
6. **The ~~a~~Applicant or client requests such information.**

8.503.160.B THE CCB SHALL REPRESENT THEIR DECISION AT THE OFFICE OF ADMINISTRATIVE COURTS AS DESCRIBED IN 10 CCR 2505-10, SECTION~~S~~ 8.057 *ET SEQ*. WHEN THE CCB HAS MADE A DENIAL OR ADVERSE ACTION AGAINST A CLIENT.

8.503.160.C THE CCB SHALL NOTIFY ALL PROVIDERS IN THE CLIENT'S SERVICE PLAN WITHIN ONE (1) WORKING DAY OF THE ADVERSE ACTION.

8.503.160.D THE CCB SHALL NOTIFY THE COUNTY DEPARTMENT OF HUMAN~~/SOCIAL~~ SERVICES INCOME MAINTENANCE TECHNICIAN WITHIN ONE (1) BUSINESS DAY OF AN ~~A~~ADVERSE ~~A~~ACTION THAT AFFECTS MEDICAID FINANCIAL ELIGIBILITY.

8.503.160.E THE APPLICANT'S PARENT OR LEGAL GUARDIAN SHALL BE INFORMED OF AN ADVERSE ACTION IF THE APPLICANT OR CLIENT IS DETERMINED INELIGIBLE AS SET FORTH IN CLIENT ELIGIBILITY AND THE FOLLOWING:

1. **The applicant, parent or legal guardian fails to submit the Medicaid financial application for LTC to the financial eligibility site within thirty (30) days of LTC referral,**

2. A client, parent or legal guardian fails to submit financial information for re-determination for LTC to the financial eligibility site within the required re-determination timeframe,

3. The County Income Maintenance Technician has determined the client no longer meets financial eligibility criteria as set forth in 10 CCR 2505-10, Section 8.100,

4. The client cannot be served safely within the cost containment as identified in the HCBS-CES waiver,

5. The client requires twenty four (24) hour supports provided through Medicaid state plan,

6. The resulting total cost of services provided to the client, including T~~t~~argeted ~~c~~Case ~~m~~Management, home health and HCBS-CES waiver services, exceeds the cost containment as identified in the HCBS-CES waiver,

7. The client enters an institution for treatment with duration that continues for more than thirty (30) days,

8. The client is detained or resides in a correctional facility, and

9. The client enters an institute for mental illness with a duration that continues for more than thirty (30) days.

8.503.160.F THE CLIENT AND PARENT OR LEGAL GUARDIAN SHALL BE NOTIFIED, PURSUANT TO 10 CCR 2505-10, SECTION 8.057, WHEN THE FOLLOWING RESULTS IN AN ADVERSE ACTION THAT DOES NOT RELATE TO HCBS-CES WAIVER CLIENT ELIGIBILITY REQUIREMENTS:

1. A HCBS-CES waiver service is reduced, terminated or denied because it is not a demonstrated need in the ~~f~~Functional ~~n~~Needs ~~a~~Assessment or because it is not available through the current federally approved HCBS-CES waiver,

2. A service plan for HCBS-CES waiver services exceed the limits as set forth in the in the federally approved HCBS-CES waiver,

3. The parent or legal guardian has failed to schedule an appointment for the ~~f~~Functional ~~n~~Needs ~~a~~Assessment of the client, service plan, or 6 month visit two (2) times in a thirty (30) day consecutive period,

4. The parent or legal guardian has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,

5. The parent or legal guardian failed to complete the HCBS-CES waiver application within fifteen (15) calendar days of the authorized enrollment date as determined by the ~~o~~Operating ~~a~~Agency,

6. The parent or legal guardian fails to complete the service plan within thirty (30) calendar days of the authorized enrollment date as determined by the ~~o~~Operating ~~a~~Agency,

7. The parent or legal guardian refuses to use the home care allowance to pay for services, or uses the home care allowance payment for services not identified in the service agreement,

8. The parent or legal guardian refuses to sign the statement of agreement or other forms as required to receive services,

9. The client enrolls in a different long term care program,

10. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.

a. ~~a~~A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual 9 CCR 2503-1, Section 3.140.2~~Section 3.140.2~~, residence, shall not be discontinued unless one or more of the other client eligibility criteria are no longer met.

11. The parent or legal guardian voluntarily withdraws the client from HCBS-CES waiver. The client shall be discontinued from the program effective upon the day after the date on which the parent or legal guardian request is documented.

12. The CCB shall not send the LTC notice of action form when the basis for discontinuation is death of the client, but shall document the event in the client record and the date of action shall be the day after the date of death.

8.503.170 QUALITY ASSURANCE

8.503.170.A THE MONITORING OF HCBS-CES WAIVER SERVICES AND THE HEALTH AND WELL BEING OF SERVICE RECIPIENTS SHALL BE THE RESPONSIBILITY OF THE ~~O~~OPERATING ~~A~~AGENCY, UNDER THE OVERSIGHT OF THE ~~D~~DEPARTMENT.

1. The ~~o~~Operating ~~a~~Agency shall conduct reviews of each agency providing HCBS-CES waiver services or cause to have reviews to be performed in accordance with guidelines established by the ~~d~~Department or ~~o~~Operating ~~a~~Agency and~~/or d~~Department. The review shall apply rules and standards developed for programs serving clients with developmental disabilities.

2. The ~~o~~Operating ~~a~~Agency shall maintain or cause to be maintained for three (3) years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-CES waiver or the delivery of services under the HCBS-CES waiver. The ~~d~~Department shall have access to these records at any reasonable time.

3. The ~~o~~Operating ~~a~~Agency shall recommend to the ~~d~~Department the suspension of payment, the denial ~~and/~~or termination of the Medicaid provider agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a

corrective action plan to the ~~o~~Operating ~~a~~Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

4. After having received the denial ~~and/~~or termination recommendation and reviewing the supporting documentation, the ~~d~~Department shall take the appropriate action within a reasonable timeframe agreed upon by ~~both~~ the D~~d~~epartment~~s~~ and the Operating Agency..

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Persons with Developmental Disabilities, Section 8.500
Rule Number:	MSB 11-07-07-C
Division / Contact / Phone:	Long Term Benefits / John R. Barry / 3173

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 11-07-07-C, Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Persons with Developmental Disabilities, Section 8.500
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) 8.500, 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 from §8.500 through §8.500.8.86 with new text provided from §8.500 through §8.500.18.E. This change is effective 11/30/2011.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Persons with Developmental Disabilities, Section 8.500
Rule Number:	MSB 11-07-07-C
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STATEMENT OF BASIS AND PURPOSE

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

   This rule is changed to incorporate the requirements of the existing HCBS Waiver implemented in July 2009. The existing rule is outdated and incorporates the terminated waiver and no longer represents the plan for services delivered under the provisions of the current federally approved waiver. Additionally, rules including language specific to proposed waiver amendments have been included for consideration by MSB pending the approval of Centers for Medicare and Medicaid Services.

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:

   Title 1915 (c) federal "Social Security Act"

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2010);
   25.5-6-404
   25.5-6-409

Initial Review	**09/09/2011**	Final Adoption	**10/14/2011**
Proposed Effective Date	**11/30/2011**	Emergency Adoption	

DOCUMENT #13

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services for Persons with Developmental Disabilities, Section 8.500
Rule Number:	MSB 11-07-07-C
Division / Contact / Phone:	Long Term Benefits / John R. Barry / 3173

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.

   Eligible clients receiving HCBS-DD may be minimally effected by proposed rule. Each client's Service Plan has included changes as a result of the federally approved waiver effective July 1, 2009. It is not expected that the implementation of rules amended as a result of the incorporation of the existing waiver will have a negative effect on clients.

   The inclusion of rules for proposed amendments to the HCBS-DD waiver may have an effect on some clients. These proposed amendments are under consideration by CMS for approval. The amendments include measures to increase efficiencies and to keep the cost of service delivery within the budget. This may result in a decrease of services in Day Habilitation Services, Behavioral Services, and/or Dental Services to some clients.

Providers that serve clients in Day Habilitation Services may experience a decrease in the number of units available to deliver services to the same number of clients. It is expected that this may result in a decrease in overall revenue for a provider. Additionally, clarification of provider qualifications and specific procedures within Behavioral Services may have an impact on providers. Qualifications are now aligned with the level of service needed which may result in reduced revenue for the provider.

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

   The proposed amendment to Day Habilitation Services reduces the number of units available and effects approximately 928 clients for a projected cost reduction of $403,991 in the current year and a $2,087,896 per full year implementation.

   Approximately 1,129 clients receive Behavioral Services and the proposed rule may effect clients differently but will result in more effective use of funds by clear definition of the service and provider qualifications.

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

There are no costs to the Department associated with implementation and enforcement and no impact to state revenue.

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

The rules to implement the proposed HCBS waiver amendments will not increase cost. These rules address, in part, a projected total cost that exceeds the annual appropriation from the General Assembly. A portion of the budget shortfall for FY 12 is attributed to increased utilization of specific services in the HCBS waivers for this current year. The Department's inaction may result in implementation of other measures to reduce costs to ensure expenses do not exceed the spending authority. These actions may include rate reductions, reduction of alternative or additional services, or termination of some services

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

   There is no additional cost expected with these proposed rules.

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

   The proposed rules are to align the existing HCBS waiver document into rule. This is both necessary and required. The proposed changes to Day Habilitation Services and Supports, Behavioral Services and Dental Services are contingent on the CMS approval of the proposed HCBS waiver amendments. Once the amendments are approved, these rules will be necessary and required. Alternatives considered to these waiver amendments include rate reductions, alternative or additional service reductions, and the termination of some services. The proposed HCBS waiver amendments are determined to be the method that has the least amount of negative impact on clients and providers.

8.500 HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD) WAIVER

8.500.1 This section hereby incorporates the terms and provisions of the federally-approved Home and Community Based Services for Persons with Developmentally Disabilities waiver (HCBS-DD) CO.0007.R06.00, ~~as it may be amended periodically~~. To the extent that the terms of that federally-approved waiver are inconsistent with the provisions of this section, the waiver will control.

8.500.1 DEFINITIONS

~~Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver services shall be provided in a home or community based setting to persons with developmental disabilities who meet the level of care criteria for long term care programs for the developmentally disabled and who are eligible under the Medicaid waiver for programs for the developmentally disabled as a cost effective alternative to institutional placement.~~

ACTIVITIES OF DAILY LIVING (ADL) means basic self care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, ~~transferring from bed to chair, and~~ needing supervision to support behavior, medical needs and memory/cognition.

ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD Waiver or a HCBS Waiver service.

APPLICANT means an individual who is seeking a long term care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

CLIENT means an individual who has met long term care (LTC) eligibility requirements, is enrolled in and chooses to receive LTC services, and receives LTC services.

CLIENT REPRESENTATIVE means a person who is designated by the client to act on the client's behalf. A client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the client to speak for ~~and/~~or act on the client's behalf.

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to S~~s~~ection 27-10.5-105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under S~~s~~ection 27-10.5-101, C.R.S. *et seq*, and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.

COST CONTAINMENT means limiting the cost of providing care in the community to 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 and Medicaid state plan benefits including long term home health services and targeted case management.

COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the client.

DEPARTMENT means the Colorado Department of Health Care Policy aAnd Financing, the single State Medicaid agency.

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. § 6000, *et seq*., shall not apply.

"Impairment of General Intellectual Functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (seventy (70) or less assuming a scale with a mean of 100 and a standard deviation of fifteen (15)), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. When an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

"Adaptive Behavior Similar to That of a Person With Mental Retardation" means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

"Substantial Intellectual Deficits" means an intellectual quotient that is between seventy-one (71) and seventy-five (75) assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services for persons with Developmental Disabilities (HCBS-DD) within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means the child health component of ~~Medicaid State plan~~Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).~~.~~

FAMILY means a relationship as it pertains to the client and is defined as:
A mother, father, brother, sister or any combination,

Extended blood relatives such as grandparent, aunt, uncle, cousin,

An adoptive parent,

One or more individuals to whom legal custody of a client with a developmental disability has been given by a court

A spouse; or,

The client's children.

FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for long term care services as determined by the Department's prescribed instrument.
FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uuniform Llong Tterm Ccare instrument and medical verification on the Pprofessional Mmedical Iinformation Ppage to determine if the client meets the institutional level of care (~~loc~~LOC).

GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) clients receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment as a residential care facility or residential community home for persons with developmental disabilities and certified by the Operating Agency.

GUARDIAN means an individual at least twenty-one years (21) of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Guardianship may include limited, emergency or temporary substitute court appointed guardian but not a guardian ad litem.

Home And Community Based Services (HCBS) Waiver means services and supports authorized through a 1915 (c) waiver of the Ssocial Ssecurity Aact and provided in community settings to a client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR).

INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation services provided to three (3) or fewer clients in a single residential setting or in a host home setting that does not require licensure by the Colorado Department of Public Health and Environment. IRSS settings are certified by the Operating Agency.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the client's spouse.

INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) for which the Department makes Medicaid payment under the ~~Medicaid State plan~~Medicaid State Plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR) means a publicly or privately operated facility that provides health and habilitation services to a client with mental retardation or related conditions.

LEVEL OF CARE (LOC) means the specified minimum amount of assistance a client must require in order to receive services in an institutional setting under the Medicaid State Pplan.

LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services or the program of all-inclusive care for the elderly (pacePACE), swing bed and hospital back up program (HBU).

MEDICAID ELIGIBILE means an applicant or client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination.

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a client in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

NATURAL SUPPORTS means informal relationships that provide assistance and occur in the client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services-for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) ~~HCBS-DD, HCBS-SLS and HCBS-CES~~ waivers.

POST ELIGIBILITY TREATMENT OF INCOME (PETI) means the determination of the financial liability of an HCBS Waiver client as defined in 42 CFR 435.217.

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, the Operating Agency, a State Fiscal Agent or the Case Management Agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional level of care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 2 CCR 503-1 ~~CCR~~ 16.200 *et seq*., that has received program approval to provide HCBS-DD W~~w~~aiver services.

PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use, including vehicles for hire.

RELATIVE means a person related to the client by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department ~~and/~~or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service.

SERVICE PLAN means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department and the Operating Agency's rules set forth in 10 CCR 2505-10 Section 8.400~~-~~.

SUPPORT is any task performed for the client where learning is secondary or incidental to the task itself or an adaptation is provided.

SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

TARGETED CASE MANAGEMENT (TCM) means a ~~Medicaid State plan~~Medicaid State Plan benefit for a target population which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources.

THIRD PARTY RESOURCES means services and supports that a client may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to, community resources, services provided through private insurance, non-profit services and other government programs.

WAIVER SERVICE means optional services defined in the current federally approved waiver documents and do not include ~~Medicaid State plan~~Medicaid State Plan benefits.

8.500.~~2~~ 2 ~~PROGRAM~~ HCBS-DD WAIVER ADMINISTRATION

~~Home and Community Based Services for the Developmentally Disabled (HCB-DD) shall be provided in accordance with the federally approved waiver document and these rules and the rules and regulations of the Colorado Department of Human Services entitled RULES AND REGULATIONS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES and promulgated in accordance with the provisions of section 26-4-624, C.R.S. In the event a direct conflict arises between the rules and regulations of the Department of Health Care Policy and Financing and~~

~~the Department of Human Services, the provisions of section 26-4-624(5), C.R.S., shall apply and the regulations of the Department of Health Care Policy and Financing shall control.~~

~~The Home and Community Based Services for the Developmentally Disabled (HCB-DD) waiver program is administered by the Department of Human Services, Developmental Disabilities Services, under the oversight of the Department of Health Care Policy and Financing.~~

8.500.2.A HCBS-DD SHALL BE PROVIDED IN ACCORDANCE WITH THE FEDERALLY APPROVED WAIVER DOCUMENT AND THESE RULES AND REGULATIONS, AND THE RULES AND REGULATIONS OF THE COLORADO DEPARTMENT OF HUMAN SERVICES, DIVISION FOR DEVELOPMENTAL DISABILITIES, 2 CCR 503-1 AND PROMULGATED IN ACCORDANCE WITH THE PROVISION OF ~~SECTION 26-4-624~~ § 25.5-6-404(4), C.R.S.

8.500.2.B IN THE EVENT A DIRECT CONFLICT ARISES BETWEEN THE RULES AND REGULATIONS OF THE DEPARTMENT AND THE OPERATING AGENCY, THE PROVISIONS OF ~~SECTION 26-4-624(5)~~ § 25.5-6-404(4), C.R.S., SHALL APPLY AND THE REGULATIONS OF THE DEPARTMENT SHALL CONTROL.

8.500.2.C THE HCBS-DD WW~~W~~AIVER IS OPERATED BY THE DEPARTMENT OF HUMAN SERVICES, DIVISION FOR DEVELOPMENTAL DISABILITIES UNDER THE OVERSIGHT OF THE DEPARTMENT OF HEALTH CARE POLICY AND FINANCING.

8.500.2.D THE HCBS-DD WAIVER PROVIDES THE NECESSARY SUPPORT TO MEET THE DAILY LIVING NEEDS OF A CLIENT WHO REQUIRES ACCESS TO 24-HOUR SUPPORT IN A COMMUNITY-BASED RESIDENTIAL SETTING.

8.500.2.E HCBS-DD WAIVER SERVICES ARE AVAILABLE ONLY TO ADDRESS THOSE NEEDS IDENTIFIED IN THE FUNCTIONAL NEEDS ASSESSMENT AND AUTHORIZED IN THE SERVICE PLAN AND WHEN THE SERVICE ~~AND/~~OR SUPPORT IS NOT AVAILABLE THROUGH THE MEDICAID STATE PLAN, EPSDT, NATURAL SUPPORTS OR THIRD PARTY RESOURCES.

8.500.2.F THE HCBS-DD WAIVER:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments do not to exceed the federally approved capacity, and

4. May limit the enrollment when utilization of the HCBS-DD Waiver program is projected to exceed the spending authority.

8.500.3 ~~PROGRAM~~ GENERAL PROVISIONS

8.500.3.A The following provisions shall apply ~~in regards~~ to the Home and Community Based Services for persons with developmental disabilities ~~the Developmentally Disabled~~ (HCBS-DD) waiver.

1. Home and Community Based Services for persons with developmental disabilities ~~the Developmentally Disabled~~ (HCBS-DD) shall be provided as an alternative to ~~institutional placement~~ to ICF-MR services for an ~~for individuals~~ client with developmental disabilities. ~~and include personal care, habilitation residential programs, non-medical transportation, assistive technology, home modification, and habilitation day programs. Individuals eligible for these services shall be eligible for all other Medicaid services for which they qualify.~~

2. HCBS-DD is waived from ~~waiver services shall be waived from~~ the requirements ~~in~~ of Section 1902(a)(10)(B) of the Social Security Act concerning comparability of services. The availability of some services may not be consistent throughout the State of Colorado.

3. A client enrolled in the HCBS-DD Waiver shall be eligible for all other Medicaid services for which the client qualifies and shall first access all benefits available under the ~~Medicaid State plan~~Medicaid State Plan or Medicaid EPSDT prior to accessing services under the ~~HCBS-DD waiver~~HCBS-DD Waiver. Services received through the HCBS-DD Waiver may not duplicate services available through the state plan.

~~C. HCB-DD waiver services shall be structured to make various services available to individuals based on the level of care certification.~~

~~D. Case management agencies shall provide case management services including assessing the individual's needs to determine if HCB-DD waiver services are appropriate; completing the individual's Individualized Plan(IP); and submitting the Individualized Plan to the Department of Human Services, Developmental Disabilities Services, for review and approval for HCB-DD waiver services. These Individualized Plans shall be subject to review and approval of HCB-DD waiver services by the Department of Health Care Policy and Financing.~~

~~a. Every IP shall include a process by which the client receiving services may receive necessary care, for medical purposes, if the client's service provider is unavailable due to an emergency situation or to unforeseen circumstances. The client who is receiving the services and the client's family or guardian shall be duly informed of these alternative care provisions at the time the IP is initiated.~~

~~b. The case management agency shall not be required to provide services set forth in the IP for alternative care provisions that it is not otherwise required to provide to the client, but shall be required to include in the plan of care the contingency for such services.~~

E. The client receiving services is responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources; cooperating with the case manager and service providers as agreed to in the Individualized Plan; choosing between HCBDD waiver services and institutional care; and where assessed, remitting patient payments by the due date.

8.500.4 CLIENT ELIGIBLE PERSONS ELIGIBILITY

.41 Home and Community Based Services for the Developmentally Disabled (HCB-DD), under the HCB-DD waiver #007.91, shall be offered to individuals with developmental disabilities:

A. who meet the medical assistance eligibility criteria as specified at §8.110.8 in this manual; and,

B. who have been determined to meet the level of care criteria for long term care programs for the developmentally disabled; and,

C. who have been assessed as potentially appropriately served through the HCB-DD program through application of the Institutional Profile; and,

D. for whom a Plan of Care (POC) has been developed which conforms to the purchase of services limitations as provided herein; and,

E. provided the individual can be served within the federally approved capacity limits of the waiver; and,

F. who receive at least one waiver service each month.

.42 Persons determined eligible to receive services and supports under the HCB-DD waiver which are not immediately available within the federally approved capacity limits in the waiver, shall be eligible for placement on a waiting list for services and supports.

A. Waiting lists for persons eligible for the HCB-DD waiver program shall be maintained by the Community Centered Boards, uniformly administered throughout the state and in accordance with these and DHS/DDD rules and guidelines.

B. Persons determined eligible shall be placed on the waiting list for services and supports in the service area of residency.

C. Persons who indicate a serious intent to move to another service area should services and supports become available shall be placed on the waiting list in that service area. Placement on a waiting list in a service area other than the area of residency shall be in accordance with criteria established in DHS/DDD guidelines for placement on waiting lists in a service area other than area of residency.

D. The date used to establish a person's placement on a waiting list shall be:

~~1. The date on which eligibility for developmental disabilities services in Colorado was originally determined; or,~~

~~2. The fourteenth (14) birth date if a child is determined eligible prior to the age of fourteen and is waiting for adult services.~~

~~E. As openings become available in the HCB-DD waiver program in a designated service area, persons shall be considered for services and supports in order of placement on the local Community Centered Board's waiting list and with regard to an appropriate match to services and supports. Exceptions to this requirement shall be limited to:~~

~~1. Emergency situations where the health, safety and welfare of the person or others is greatly endangered and the emergency can not be resolved in another way. Emergencies are defined as follows:~~

~~a. Homeless : the person does not have a place to live or is in imminent danger of losing his/her place of abode.~~

~~b. Abusive or Neglectful Situation : the person is experiencing ongoing physical, sexual or emotional abuse or neglect in his/her present living situation and his/her health, safety or well-being are in serious jeopardy.~~

~~c. Danger to Others : the person's behavior and/or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision can not be provided by the current caretaker to ensure safety of persons in the community.~~

~~d. Danger to Self : a person's medical, psychiatric and/or behavioral challenges are such that s/he is seriously injuring/harming himself/herself or is in imminent danger of doing so.~~

~~2. The Legislature has appropriated funds specific to individuals and/or to a specific class of persons.~~

~~F. If an eligible individual is placed on a waiting list for HCB-DD waiver services, a written notice, including information regarding client appeals shall be sent to the individual and/or their legal guardian in accordance with the provisions of 10 CCR 2505-10 Section 8.057 et seq.~~

~~.43 Individuals with developmental disabilities who are residents of Nursing Facilities (NF's), Intermediate Care Facilities for the Mentally Retarded (ICF/MR's), or hospitals shall not be eligible for Home and Community Based Services for the Developmental Disabled (HCB-DD).~~

8.500.4.A To be eligible for the HCBS-DD Waiver an individual shall meet the target population criteria as follows:

1. Be determined to have a developmental disability,

2. Be eighteen (18) years of age or older,

3. Require access to services and supports twenty-four (24) hours a day,

4. Meet ICF-MR level of care as determined by the functional needs assessment, and

5. Meet the Medicaid financial determination for LTC eligibility as specified in 10 C.C.R. 2505-10, §Section 8.100, *et seq.*

8.500.4.B The client shall maintain eligibility by meeting the criteria as set forth in 10 CCR 2505-10, Section 8.500.6.A.1 and .2 ~~(1-2)~~ and the following:

1. Receives at least one (1) HCBS waiver service each calendar month.

2. Is not simultaneously enrolled in any other HCBS waiver.

3. Is not residing in a hospital, nursing facility, ICF-MR, correctional facility or other institution.

4. Is served safely in the community with the type and amount of waiver services available and within the federally approved capacity and cost containment limits of the waiver.

5. Resides in a GRSS or IRSS setting.

8.500.4.C When the HCBS-DD Waiver reaches capacity for enrollment, a client determined eligible for the waiver shall be eligible for placement on a wait list in accordance with these rules. ~~-~~ at 10 CCR 2505-10, Section 8.500.7.

8.500.5 HCBS-DD ~~Waiver Services~~WAIVER SERVICES

8.500.5.A The following services are available through the HCBS-DD Waiver within the specific limitations as set forth in the federally approved HCBS-DD Waiver.

1. ~~BEHAVIORAL SERVICES~~Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

b. A client with a co-occurring diagnosis of a developmental disability~~ies~~ and mental health diagnosis covered in the ~~Medicaid State plan~~Medicaid State Plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the ~~Medicaid State plan~~Medicaid State Plan, covered by a

third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral Services include:

~~i)~~ ~~BEHAVIORAL CONSULTATION SERVICES~~Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.

ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service ~~must~~ shall be established.

iii) Behavioral consultation services are limited to eighty (80) units per service plan year. One unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

v) Behavioral Plan Assessment Services are limited to forty (40) units and one (1) assessment per service plan year. One unit is equal to fifteen (15) minutes of service.

v). Individual and Group Counseling Services include psychotherapeutic or psycho educational intervention that:

1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

3) Counseling services are limited to two-hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of

daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral Line Services include direct ~~1:1~~ one-to-one implementation of the Behavioral Support Plan and is:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a client at risk of institutional placement and to address an identified challenging behavior that places the client's health and safety ~~and/~~or the safety of others at risk.

4) Behavioral Line Services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Requests for an ~~exception~~Behavioral Line Services shall be prior authorized in accordance with the Operating Agency's procedures.

2. Day H~~h~~abilitation Services and Supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical ~~and/~~or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence and personal choice.

b. Day Habilitation Services and Supports encompass three (3) types of habilitative environments~~:~~, specialized habilitation services, supported community connections, and prevocational services.

c. Specialized Habilitation (SH) services are provided to enable the client to attain the maximum functioning~~al~~ level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services:

i) Are provided in a non-integrated setting where a majority of the clients have a disability,

ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported Community Connections Services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan,

ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings,

iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan.

v) ~~Movies and A~~a~~a~~ctivities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational Services are provided to prepare a client for paid community employment. Services ~~include~~consist of teaching concepts including ~~compliance,~~ attendance, task completion, problem solving and safety, and are associated with performing compensated work.

i) Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for Prevocational Services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations.

iv) Prevocational Services are provided to support the client to obtain paid ~~or unpaid~~ community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid ~~or unpaid~~ community employment.

vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the ~~Idea~~ Individuals with Disabilities Education Act (IDEA) (20 U.S.C. § 1401 *et seq.*).

f. The number of units available for day habilitation services in combination with prevocational services is four thousand eight hundred (4,800). When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and

g. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One unit equals fifteen (15) minutes of service.

4. Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i). Dental insurance premiums and co-pays/co-insurance,

i) Periodic examination and diagnosis,

ii) Radiographs when indicated,

iv). Non-intravenous sedation,

v). Basic and deep cleanings,

vi). Mouth guards,

vii). Topical fluoride treatment, and

X). Retention or recovery of space between teeth when indicated.

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures

d. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval.

e. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail.

f. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical

necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, Section 8011.11 or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client.

g. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodotic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

h. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

i. Preventative and basic services are limited to $2,000 per service plan year. Major services are limited to $10,000 for the five (5) year renewal period of the waiver.

4. Non-Medical Transportation enables clients to gain access to Day Habilitation Services and Supports, Prevocational Services and Ssupported Eemployment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

a. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized and documented in the Service Plan.

b. Non-Medical Transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-Medical Transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip accessed each way ~~charge for~~ to and from day habilitation and supported employment services.

c. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. § 431.53 or transportation services under the ~~Medicaid State plan~~Medicaid State Plan, defined at 42 C.F.R. § 440.170(A).

5. Residential Habilitation Services and Supports (RHSS) are delivered to ensure the health and safety of the client and to assist in the acquisition, retention ~~and/~~or

improvement in skills necessary to support the client to live and participate successfully in the community.

a. Services may include a combination of lifelong, or extended duration supervision, training ~~and/~~or support that is essential to daily community living, including assessment and evaluation, and includes training materials, transportation, fees and supplies.

b. The living environment encompasses two (2) types that include individual Residential Services and Supports (IRSS) and Group Residential Services and Supports (GRSS).

c. All RHSS environments shall provide sufficient staff to meet the needs of the client as defined in the service plan.

d. The following RHSS activities assist clients to reside as independently as possible in the community:

i) Self-advocacy training, which may include training to assist in expressing personal preferences, increasing self-representation, increasing self-protection from and reporting of abuse, neglect and exploitation, advocating for individual rights and making increasingly responsible choices,

ii) Independent living training, which may include personal care, household services, infant and childcare when the client has a child, and communication skills,

iii) Cognitive services, which may include training in money management and personal finances, planning and decision making,

iv) Implementation of recommended follow-up counseling, behavioral, or other therapeutic interventions. Implementation of physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

v) Medical and health care services that are integral to meeting the daily needs of the client and include such tasks as routine administration of medications or tending to the needs of clients who are ill or require attention to their medical needs on an ongoing basis,

vi) Emergency assistance training including developing responses in case of emergencies and prevention planning and training in the use of equipment or technologies used to access emergency response systems,

vii) Community access services that explore community services available to all people, natural supports available to the client and develop methods to access additional services, supports, or activities needed by the client,

viii) Travel services, which may include providing, arranging, transporting or accompanying the client to services and supports identified in the service plan, and

ix) Supervision services which ensure the health and safety of the client ~~and/~~or utilize technology for the same purpose.

e. All direct care staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment~~,~~ and successfully complete a written test and a practical and competency test.

f. Reimbursement for RHSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of clients or to meet the requirements of the applicable life safety code.

6. Specialized Medical Equipment and Supplies include:

a. Devices, controls or appliances that enable the client to increase the client's ability to perform activities of daily living,

b. Devices, controls or appliances that enable the client to perceive, control or communicate within the client's environment,

c. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items,

d. Durable and non-durable medical equipment not available under the ~~Medicaid State plan~~Medicaid State Plan that is necessary to address client functional limitations, or

e. Necessary medical supplies in excess of ~~Medicaid State plan~~Medicaid State Plan limitations or not available under the ~~Medicaid State plan~~Medicaid State Plan.

f. All items shall meet applicable standards of manufacture, design and installation.

g. Specialized medical equipment and supplies exclude those items that are not of direct medical or remedial benefit to the client.

7. Supported Employment includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting.

a. Supported Employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client.

b. Supported Employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those individuals who are providing services to the client, to the same extent that individuals without disabilities employed in comparable positions would interact.

c. Supported Employment is work outside of a facility-based ~~site, that~~site, which is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities.

d. Supported Employment is provided in community jobs, enclaves or mobile crews.

e. Group Employment including mobile crews or enclaves shall not exceed eight (8) clients.

f. Supported Employment includes activities needed to sustain paid work by clients including supervision and training.

g. When Supported Employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a client as a result of the client's disabilities.

h. Documentation of the client's application for services through the Colorado Department of Human Services Division of Vocational Rehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under S~~s~~ection 110 of the R~~r~~ehabilitation A~~a~~ct of 1973 or the I~~i~~ndividuals with D~~d~~isabilities E~~e~~ducation C~~a~~ct (20 U.S.C. § 1401 *et seq*).

i. Supported Employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

j. Supported Employment shall not take the place of nor shall it duplicate services received through the D~~d~~ivision of V~~v~~ocational R~~r~~ehabilitation.

k. The limitation for Supported Employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of Supported Employment and shall not be reimbursed:

i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a client's supported employment.

8. Vision Services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least twenty-one (21) years of age.

a. Lasik and other similar types of procedures are only allowable when:

i) The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective.

ii) Prior authorized in accordance with Operating Agency procedures.

8.500.6 ~~Service Plan~~**SERVICE PLAN**

8.500.6.A THE CASE MANAGEMENT AGENCY SHALL COMPLETE A SERVICE PLAN FOR EACH CLIENT ENROLLED IN THE HCBS-DD WAIVER IN ACCORDANCE WITH 10 C.C.R . 2505-10 § SECTION 8.400.

~~8.500.6.B~~ THE SERVICE PLAN SHALL:

1. Address client'ss' assessed needs and personal goals, including health and safety risk factors, either by waiver services or through other means,

2. Be in accordance with the Department'ss' rules, policies and procedures, and

3. Include updates and revisions at least annually or when warranted by changes in the client's needs.

8.500.6.C THE SERVICE PLAN SHALL DOCUMENT THAT THE CLIENT HAS BEEN OFFERED A CHOICE:

1. Between waiver services and institutional care,

2. Among waiver services, and

3. Among qualified providers.

8.500.7 ~~Waiting List Protocol~~WAITING LIST PROTOCOL

8.500.7.A There shall be one waiting list for persons eligible for the HCBS-DD Waiver when the total capacity for enrollment or the total appropriation by the general assembly has been met.

8.500.7.B The name of a person eligible for the HCBS-DD Waiver program shall be placed on the waiting list by the community centered board making the eligibility determination.

8.500.7.C When an eligible person is placed on the waiting list for HCBS-DD Waiver services, a written notice of action including information regarding client rights and appeals shall be sent to the person ~~and/~~or the person's legal guardian in accordance with the provisions of 10 CCR 2505-10 ~~SECTION~~Section 8.057 *et seq.*

8.500.7.D The placement date used to establish a person's order on a waiting list shall be:

1. The date on which the person was initially determined to have a developmental disability by the community centered board; or

2. The fourteenth (14) birth date if a child is determined to have a developmental disability by the community centered board prior to the age of fourteen.

8.500.7.E As openings become available in the HCBS-DD Waiver program in a designated service area, that community centered board shall report that opening to the ~~O~~Operating ~~A~~Agency.

8.500.7.F Persons whose name is on the waiting list shall be considered for enrollment to the HCBS-DD Waiver in order of placement date on the waiting list. Exceptions to this requirement shall be limited to:

1. An emergency situation where the health~~,~~ and safety of the person or others is endangered and the emergency cannot be resolved in another way. Emergencies are defined by the following criteria:

   a. Homeless: the person does not have a place to live or is in imminent danger of losing the person's place of abode.

   b. Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in the person's present living situation and the person's health, safety or well-being is in serious jeopardy.

   c. Danger to others: the person's behavior ~~and/~~or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure safety of the person in the community.

d. Danger to self: a person's medical, psychiatric ~~and/~~or behavioral challenges are such that the person is seriously injuring/harming self or is in imminent danger of doing so.

8.500.7.G Enrollments may be reserved to meet statewide priorities that may include:

1. A person who is eligible for the HCBS-DD Waiver and is no longer eligible for services in the foster care system due to an age that exceeds the foster care system limits,

2. Persons who reside in long term care institutional settings who are eligible for the HCBS-DD Waiver and have a requested to be placed in a community setting, and

3. Persons who are in an emergency situation.

8.500.7.H Enrollments shall be authorized to persons based on the criteria set forth by the general assembly in appropriations when applicable.

8.500.8 ~~Client Responsibilities~~CLIENT RESPONSIBILITIES

8.500.8.A A client or guardian is responsible to:

1. Provide accurate information regarding the client's ability to complete activities of daily living,

2. Assist in promoting the client's independence,

~~3. Cooperate with providers and the case manager,~~

4. Cooperate in the determination of financial eligibility for Medicaid,

5. Notify the case manager within thirty (30) days after:

a. Changes in the client's support system, medical, physical or psychological condition or living situation including any hospitalizations, emergency room admissions, placement to a nursing home or intermediate care facility for the mentally retarded (ICF-MR) ,

b. The client has not received an HCBS waiver service during one (1) month,

c. Changes in the client's care needs,

d. Problems with receiving HCBS Waiver services,

e. Changes that may affect Medicaid financial eligibility including prompt reporting of changes in income ~~and/~~or assets.

8.500.~~5~~ 9 PROVIDER ~~S~~ REQUIREMENTS

~~.51 Home and Community Based services for the Developmentally Disabled (HCB-DD) programs shall be provided by agencies that meet the following criteria:~~

~~Have received and/or maintained program approval from the Department of Human Services, Developmental Disabilities Services for the provision of HCB- DD waiver services; and Have a Medicaid Provider Agreement; and~~

~~A. have agreed to comply with all the provisions of Title 27, Article 10.5, C.R.S., and all rules and regulations promulgated thereunder; and~~

~~B. have, if applicable, the current required licenses from the Colorado Department of Public Health and Environment.~~

~~8.500.52 Home and Community Based services for the Developmentally Disabled (HCB-DD) waiver providers shall cooperate in the following:~~

~~A. all state authorized on-site program reviews, whether for the purpose of program approval, on-going program monitoring, or state initiated financial and program audits; and~~

~~B. all state efforts to collect and maintain information on the HCB-DD waiver programs, whether required for federal or state program review and evaluation efforts, including information collection; and~~

~~C. any federal program reviews and financial audits of the HCB-DD waiver programs; and~~

~~D. providing access, by the County Departments of Social/Human Services, to records of persons receiving services held by case management agencies as required to determine and redetermine Medicaid eligibility; and~~

~~E. all efforts by the case management agency to review the provider's programs, whether generally or specifically for particular persons receiving services; and~~

~~F. all long term care determinations and continued stay reviews conducted by the Department of Human Services, Developmental Disabilities Services~~

~~G. Provider agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.~~

8.500.9.A A private or profit or not for profit agency or government agency shall meet the minimum provider qualifications as set forth in the HCBS Waiver and shall:~~,~~

1. Conform to all state established standards for the specific services they provide under HCBS-DD,

2. Maintain program approval and certification from the Operating Agency,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,

4. Discontinue services to a client only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services,

5. Have written policies governing access to duplication and dissemination of information from the client's records in accordance with state statutes on confidentiality of information at § 25.5-1-116, C.R.S., as amended,

6. When applicable, maintain the required licenses from the Colorado Department of Public Health and Environment, and

7. Maintain client records to substantiate claims for reimbursement according to Medicaid standards.

8. HCBS-DD providers shall comply with:

a. All applicable provisions of Section 27-~~,~~10.5, C.R.S. *et seq*, and all rules and regulations as set forth in 2 CCR 503-1, Section 16.~~100~~ *et seq.*,

b. All federal program reviews and financial audits of the HCBS-DD Waiver services,

c. The Operating Agency's on-site certification reviews for the purpose of program approval, on-going program approval, monitoring or financial and program audits,

d. Requests from the County Departments of Social/Human Services~~,~~ to access records of clients receiving services held by Case Management Agencies as required to determine and re-determine Medicaid eligibility;~~,~~

e. Requests by the Department or the Operating Agency to collect, review and maintain individual or agency information on the HCBS-DD Waiver, and

f. Requests by the Case Management Agency to monitor service delivery through targeted case management activities.

8.500.10 TERMINATION OR DENIAL OF HCBS-DD MEDICAID PROVIDER AGREEMENTS

8.500.10.A The Department may deny or terminate an HCBS-DD Medicaid Provider Agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action

plan within the prescribed period of time. The termination shall follow procedures at 10 CCR 2505-10, Section 8.130 *et seq*.

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-DD services.

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior client notification.

5. The provider fails to comply with requirements for submission of claims pursuant to 10 CCR 2505-10, Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with the procedures at 10 CCR 2505-10, Section 8.050.

8.500.11 ORGANIZED HEALTH CARE DELIVERY SYSTEM

8.500.11.A The Organized Health Care Delivery System (OHCDS) for the HCBS-DD Waiver is the Community Centered Board as designated by the Operating Agency in accordance with § ~~C.R.S.~~ 27-10.5-103 C.R.S. ~~et seq~~.

8.500.11.B The OHCDS is the Medicaid provider of record for a client whose services are delivered through the OHCDS.

8.500.11.C The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS according to the current federally approved waiver.

8.500.11.D The OHCDS may contract or employ for delivery of HCBS waiver services.

8.500.11.E The OCHDS shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS waiver,

2. Ensure that services are delivered according to the waiver definitions and as identified in the client's service plan,

3. Ensure the contractor maintains sufficient documentation to support the claims submitted, and

4. Monitor the health and safety for HCBS clients receiving services from a subcontractor.

8.500.11.F THE OHCDS IS AUTHORIZED TO SUBCONTRACT AND NEGOTIATE REIMBURSEMENT RATES WITH PROVIDERS IN COMPLIANCE WITH ALL

FEDERAL AND STATE REGULATIONS REGARDING ADMINISTRATIVE, CLAIM PAYMENT AND RATE SETTING REQUIREMENTS. THE OCHDS SHALL:

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to clients,

4. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and Operating Agency procedures,

a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a ~~-~~manufacturer's suggested retail price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

5. Collect and maintain the data used to develop provider rates and ensure that the data includes costs for services to address the client's needs, that are allowable activities within the HCBS service definition and that supports the established rate,

6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency ~~and/~~or Centers for Medicare and Medicaid Services (CMS), and

7. Report by A~~a~~ugust 31st of each year, the names, rates and total payments made to the contractor.

8.500.12 PRIOR AUTHORIZATION REQUESTS

8.500.12.A PRIOR AUTHORIZATION REQUESTS (PAR) SHALL BE IN ACCORDANCE WITH 10 C~~.~~C~~.~~R~~.~~ 2505-10, SECTION~~S~~ 8.058.

8.500.12.B A ~~PRIOR AUTHORIZATION REQUEST~~PAR SHALL BE SUBMITTED TO THE OPERATING AGENCY THROUGH THE DEPARTMENT'S DESIGNATED INFORMATION MANAGEMENT SYSTEM.

8.500.12.C THE CASE MANAGEMENT AGENCY SHALL COMPLY WITH THE POLICIES AND PROCEDURES FOR THE PAR REVIEW PROCESS AS SET FORTH BY THE DEPARTMENT AND~~/OR~~ THE OPERATING AGENCY.

8.500.12.D THE CASE MANAGEMENT AGENCY SHALL SUBMIT THE PAR IN COMPLIANCE WITH ALL APPLICABLE REGULATIONS AND ENSURE REQUESTED SERVICES ARE:

1. **Consistent with the client's documented medical condition and functional capacity as indicated in the functional needs assessment,**

2. **Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved waiver, and**

3. **Not duplicative of another authorized service, including services provided through:**

a. Medicaid State Plan benefits,

b. Third party resources,

c. Natural supports,

d. Charitable organizations, or

e. Other public assistance programs.

4. **Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10, Section ~~§~~ 8.058.4.**

8.500.13 RETROSPECTIVE REVIEW PROCESS

8.500.13.A SERVICES PROVIDED TO A CLIENT ARE SUBJECT TO A RETROSPECTIVE REVIEW BY THE DEPARTMENT AND THE OPERATING AGENCY. THIS RETROSPECTIVE REVIEW SHALL ENSURE THAT SERVICES:

1. **Identified in the service plan are based on the client's identified needs as stated in the functional needs assessment,**

2. **Have been requested and approved prior to the delivery of services,**

3. **Provided to a client are in accordance with the service plan, and**

4. **Provided are ~~-~~within the specified HCBS service definition in the federally approved HCBS-DD Waiver,**

8.500.13.B WHEN THE RETROSPECTIVE REVIEW IDENTIFIES AREAS OF NON COMPLIANCE, THE CASE MANAGEMENT AGENCY ~~AND/~~OR PROVIDER SHALL BE REQUIRED TO SUBMIT A PLAN OF CORRECTION THAT IS MONITORED FOR COMPLETION BY THE DEPARTMENT AND THE OPERATING AGENCY.

8.500.13.C THE INABILITY OF THE PROVIDER TO IMPLEMENT A PLAN OF CORRECTION WITHIN THE TIMEFRAMES IDENTIFIED IN THE PLAN OF CORRECTION MAY RESULT IN TEMPORARY SUSPENSION OF CLAIMS PAYMENT OR TERMINATION OF THE PROVIDER AGREEMENT.

8.500.13.D WHEN THE PROVIDER HAS RECEIVED REIMBURSEMENT FOR SERVICES AND THE REVIEW BY THE DEPARTMENT OR OPERATING AGENCY IDENTIFIES THAT IT IS NOT IN COMPLIANCE WITH REQUIREMENTS, THE AMOUNT REIMBURSED WILL BE SUBJECT TO THE REVERSAL OF CLAIMS, RECOVERY OF AMOUNT REIMBURSED, SUSPENSION OF PAYMENTS, ~~AND/~~OR TERMINATION OF PROVIDER STATUS.

8.500.14 PROVIDER REIMBURSEMENT

8.500.14.A PROVIDERS SHALL SUBMIT CLAIMS DIRECTLY TO THE DEPARTMENT'S FISCAL AGENT THROUGH THE MEDICAID MANAGEMENT INFORMATION SYSTEM (MMIS); ~~AND/~~OR THROUGH A QUALIFIED BILLING AGENT ENROLLED WITH THE DEPARTMENT'S FISCAL AGENT.

8.500.14.B PROVIDER CLAIMS FOR REIMBURSEMENT SHALL BE MADE ONLY WHEN THE FOLLOWING CONDITIONS ARE MET:

1. Services are provided by a qualified provider as specified in the federally-approved HCBS-DD Waiver,

2. Services have been prior authorized,

3. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the client's service plan, and

4. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the service plan and in accordance with the service definition.

8.500.14.C PROVIDER CLAIMS FOR REIMBURSEMENT SHALL BE SUBJECT TO REVIEW BY THE DEPARTMENT AND THE OPERATING AGENCY. THIS REVIEW MAY BE COMPLETED AFTER PAYMENT HAS BEEN MADE TO THE PROVIDER.

8.500.14.D WHEN THE REVIEW IDENTIFIES AREAS OF NON-COMPLIANCE, THE PROVIDER SHALL BE REQUIRED TO SUBMIT A PLAN OF CORRECTION THAT IS MONITORED FOR COMPLETION BY THE DEPARTMENT AND THE OPERATING AGENCY.

8.500.14.E WHEN THE PROVIDER HAS RECEIVED REIMBURSEMENT FOR SERVICES AND THE REVIEW BY THE DEPARTMENT OR OPERATING AGENCY IDENTIFIES THAT THE SERVICE DELIVERED OR THE CLAIMS SUBMITTED IS NOT IN COMPLIANCE WITH REQUIREMENTS, THE AMOUNT REIMBURSED WILL BE SUBJECT TO THE REVERSAL OF CLAIMS, RECOVERY OF AMOUNT REIMBURSED, SUSPENSION OF PAYMENTS, ~~AND/~~OR TERMINATION OF PROVIDER STATUS.

8.500.14.F Except where otherwise noted, payment is based on a statewide fee schedule. State developed fee schedule rates are the same for both public and private providers and the fee schedule and any annual/periodic adjustments to the fee schedule are

published in the provider bulletin accessed through the Department's fiscal agent's web site.

8.500.~~6~~ 15 INDIVIDUAL RIGHTS

8.500.15.A ~~The rights of a person receiving Home and Community Based Services are established in Title 27, Article 10.5, Sections 112 through 131, C.R.S., as amended. The rules and regulations regarding these rights are promulgated in Colorado Department of Health Care Policy and Financing, Section 8.484.20 of these rules, and the Department of Human Services, Division for Developmental Disabilities, Rules and Regulations, Chapter 6.~~ Individual rights shall be in accordance with 27-10.5-101 C.R.S. et seq.

8.500.16 ~~Appeal rights~~APPEAL RIGHTS

8.500.16.A THE CCB SHALL PROVIDE THE LONG TERM CARE NOTICE OF ACTION FORM TO APPLICANTS AND CLIENTS WITHIN ~~ONE~~TEN (~~10~~1) BUSINESS DAY~~S~~ REGARDING THEIR APPEAL RIGHTS IN ACCORDANCE WITH 10 CCR 2505-10, SECTION 8.057 *ET SEQ*. WHEN:

1. The applicant is determined to not have a developmental disability,

2. The applicant is found eligible or ineligible for LTC services,

3. The applicant is determined eligible or ineligible for placement on a waitlist for Medicaid LTC services,

4. An adverse action occurs that affects the client's waiver enrollment status,

5. An adverse action occurs that affects the provision of the client's waiver services, or

6. The applicant or client requests such information.

8.500.16.B The CCB shall represent their decision at the O~~o~~ffice of A~~a~~dministrative C~~c~~ourts as described in 10 C~~.~~C~~.~~R~~.~~ 2505-10, Section 8.057 *et seq*. when CCB has made a denial or adverse action against a client.

8.500.16.C THE CCB SHALL NOTIFY ALL PROVIDERS IN THE CLIENT'S SERVICE PLAN WITHIN ~~ONE~~TEN (~~10~~1) BUSINESS DAY OF THE ADVERSE ACTION.

8.500.16.D THE CCB SHALL NOTIFY THE COUNTY DEPARTMENT OF HUMAN/SOCIAL SERVICES INCOME MAINTENANCE TECHNICIAN WITHIN ~~ONE~~TEN (~~10~~1) BUSINESS DAY OF AN ADVERSE ACTION THAT AFFECTS MEDICAID FINANCIAL ELIGIBILITY.

8.500.16.E THE APPLICANT OR CLIENT SHALL BE INFORMED OF AN ADVERSE ACTION IF THE CLIENT IS DETERMINED INELIGIBLE AS SET FORTH IN CLIENT ELIGIBILITY AND THE FOLLOWING:

1. The client cannot be served safely within the cost containment as identified in the HCBS-DD Waiver,

2. The client is placed in an institution for treatment with a duration that continues for more than thirty (30) days,

3. The client is detained or resides in a correctional facility, or

4. The client enters an institute for mental health with a duration that continues for more than thirty (30) days.

8.500.16.F THE CLIENT SHALL BE NOTIFIED, PURSUANT TO 10 CCR 2502-10 ~~SECTION~~SECTION 8.057.2.A, WHEN THE FOLLOWING RESULTS IN AN ADVERSE ACTION THAT DOES NOT RELATE TO HCBS-DD WAIVER CLIENT ELIGIBILITY REQUIREMENTS:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the functional needs assessment,

2. A waiver service is terminated or denied because is not available through the current federally--approved waiver,

3. A service plan or waiver service exceeds the limits as set forth in the in the federally--approved waiver,

4. The client or client representative has failed to schedule an appointment for the functional needs assessment, service plan, or six (6) month visit with the case manager two (2) times in a thirty (30) day consecutive period,

5. The client or client representative has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,

6. The client enrolls in a different long term care program, or

7. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.

    a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to Income Maintenance Staff Manual at 9 CCR 2503-1, Section 3.140.2, , shall not be terminated unless one or more of the other client eligibility criteria are no longer met.

8. The client voluntarily withdraws from the waiver program. The client shall be terminated from the waiver effective upon the day after the date on which the client's request is documented.

8.500.16.G THE CCB SHALL NOT SEND THE LTC NOTICE OF ACTION FORM WHEN THE BASIS FOR TERMINATION IS DEATH OF THE CLIENT, BUT SHALL DOCUMENT THE EVENT IN THE CLIENT RECORD. THE DATE OF ACTION SHALL BE THE DAY AFTER THE DATE OF DEATH.

8.500.17 QUALITY ASSURANCE

8.500.17.A The monitoring ~~of Home and Community Based Services for the Developmentally Disabled (HCB-DD)~~ HCBS-DD Ww~~w~~aiver services and the health and well-being of service recipients shall be the responsibility of the ~~Department of Human Services, Developmental Disabilities Services~~Operating Agency, under the oversight of the Department ~~of Health Care Policy and Financing~~.

8.500.17.B The ~~Department of Human Services, Developmental Disabilities Services~~Operating Agency, shall conduct ~~on-site surveys~~reviews of each agency providing HCBS-DD Ww~~w~~aiver services or cause to have reviews to be performed in accordance with guidelines established by the Department or Operating Agency ~~and/or Department and Financing~~. The ~~survey~~ review ~~will include a review of applicable~~ shall apply rules and standards developed for programs serving individuals with developmental disabilities.

~~The Department of Human Services, Developmental Disabilities Services, shall ensure that the case management agency/community centered board fulfills its responsibilities in the following areas: development of the Individualized Plan, case management, monitoring of programs and services, and provider compliance with the assurances required of these programs.~~

8.500.17.C The ~~Department of Human Services, Developmental Disabilities Service;,~~Operating Agency shall maintain or cause to be maintained for three (3) years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-DD Ww~~w~~aiver programs or the delivery of services ~~under these programs~~. The Department ~~of Health Care Policy and Financing~~ shall have access to these records at any reasonable time.

8.500.17.D ~~Developmental Disabilities Services~~The Operating Agency shall recommend to the Department ~~of Health Care Policy and Financing~~ the suspension of payment, denial ~~and/~~or termination of the Medicaid Provider Agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond ~~with~~ by submitting a corrective action plan to ~~Developmental Disabilities Services~~the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

8.500.17.~~D~~E After having received the denial ~~and/~~or termination recommendation and reviewing the supporting documentation, the Department ~~of Health Care Policy and Financing~~ shall take the appropriate action within a reasonable timeframe agreed upon ~~by both Departments.~~ the Department and the Operating Agency

8.500.18 ~~PATIENT~~ CLIENT PAYMENT - POST ELIGIBILITY TREATMENT OF INCOME

8.500.18.A ~~Individuals~~ A client who ~~are~~ is determined to be Medicaid eligible through the application of the three hundred percent (300%) income standard ~~at~~ at 10 CCR 2505-10 § ~~8.110.8~~8.100.7.A, ~~are~~ is required to pay a portion of the~~ir~~ client's income toward~~s~~ the cost of the~~ir~~ client's HCBS-DD services after allowable income deductions.

8.500.18.B ~~.82~~ This ~~PETI (~~Post Eligibility Treatment of Income~~)~~(PETI) ~~payment~~assessment shall:

A.~~1.~~ ~~shall b~~Be calculated by the ~~case~~ Case ~~management~~ Management ~~agency~~ Agency using the form specified by the Operating Agency .

~~during the individual's initial and/or continued stay review for assessment for HCB-DD services;~~

~~B.~~2. Be calculated during the client's initial or continued stay review for HCB-DD services;

~~shall n~~Not exceed the cost of HCB~~S~~-DD services for the month for which payment is ~~being made;~~

~~C.~~ 3. ~~shall b~~Be recomputed as often as needed, by the case management agency in order to ensure the client's continued eligibility for the HCBS-DD waiver~~monthly~~~~annually, and~~;

~~D.~~4. ~~shall b~~Be ~~collected and receipted by the case~~ Case ~~management~~ Management ~~agency~~ Agency ~~as instructed by the State~~Department.

~~.83~~8.500.18.C In calculating PETI ~~payment~~assessment, the case management agency must deduct the following amounts, in the following order, from the individual's total income ~~(~~including amounts disregarded in determining Medicaid eligibility~~)~~:

A.~~1.~~ A maintenance allowance equal to 300% the c~~C~~urrent and/SSI-CS standard plus an earned income allowance based on the SSI treatment of earned income up to a maximum of two hundred forty five dollars ($245) per month; ~~and~~

B. ~~2.~~ For ~~an individual~~ a client with only a spouse at home, an additional amount based on a reasonable assessment of need but not to exceed the SSI standard; and

C.~~3.~~ For a~~n individual~~ client with a spouse plus other dependents at home, or with other dependents only at home, an amount based on a reasonable assessment of need but not to exceed the appropriate AFDC grant level; and

D. ~~4.~~ Amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party including:

~~1.~~a. ~~health~~Health insurance premiums (other than Medicare), deductibles. or coinsurance charges (including Medicaid copayments); and

~~2.~~b. ~~necessary~~Necessary medical or remedial care recognized under State law but not covered under the ~~State's~~ ~~Medicaid State plan~~Medicaid State Plan.

~~.84~~8.500.18.D Case ~~management~~ Management ~~agencies~~ Agencies are responsible for informing individuals of their PETI obligation on a form prescribed by the ~~Developmental Disabilities Services, Department of Human Services~~ Operating Agency.

~~.85~~8.500.18.E PETI payments and the corresponding assessment forms are due to the Operating Agency during the month following the month for which they are assessed.

~~.86~~8.500.18.F ~~Case management~~ Management ~~agencies~~ Agencies ~~must submit all PETI assessments, on the specified form, to the Operating Agency to the state on the form specified by the division, within thirty-five (35) calendar days of the end of the month for which they were assessed.~~