THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Hospital-based FQHC Outstationing Administrative Costs, Section 8.700.8
Rule Number:	MSB 12-06-28-A
Division / Contact / Phone:	Financial & Administrative Services Office, Safety Net Programs Section / Cindy Arcuri / (303) 866-3996

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 12-06-28-A, Revision to the Medical Assistance Rule Concerning Reimbursement for Hospital-based FQHC Outstationing Administrative Costs, Section 8.700.8
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) 8.700.8, 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*

At §8.700.8.B.1, please replace current text with new paragraph text provided.
After §8.700.8.B.1, please add a new paragraph 2. with the text provided.
At §8.700.8.D.2, please replace current text with new paragraph text provided.
All text in this document in purple was provided to the public and to the board for context only and should not be revised.
This change is effective 10/30/2012.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Hospital-based FQHC Outstationing Administrative Costs, Section 8.700.8
Rule Number:	MSB 12-06-28-A
Division / Contact / Phone:	Financial & Administrative Services Office, Safety Net Programs Section / Cindy Arcuri / (303) 866-3996

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 ensures the Department's process for claiming federal financial participation for eligible administrative outstationing expenditures associated with determining eligibility for Medicaid beneficiaries at Denver Health Medical Center's hospital-based Federally Qualified Health Clinics (FQHCs) will be accepted by CMS as consistent with federal regulations on timely filing of Medicaid claims.

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:

45 Code of Federal Regulations (CFR) § 95.1, related to timely filing of claims for Medicaid reimbursement; and

Section 1902 (a)(55) of the Social Security Act, as implemented by federal regulations at 42 CFR § 435.904 related to the outstationing requirement.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);

Initial Review	**08/10/2012**	Final Adoption	**09/14/2012**
Proposed Effective Date	**10/30/2012**	Emergency Adoption	

DOCUMENT #01

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Reimbursement for Hospital-based FQHC Outstationing Administrative Costs, Section 8.700.8
Rule Number:	MSB 12-06-28-A
Division / Contact / Phone:	Financial & Administrative Services Office, Safety Net Programs Section / Cindy Arcuri / (303) 866-3996

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.

   Federal regulations require certain hospitals and federally qualified health clinics (FQHCs) to provide Medicaid applicants with eligibility determination services. If the State is not permitted to amend this rule to modify its claiming process to ensure acceptance by CMS as consistent with federal timely filing limits, Denver Health Medical Center's FQHCs could experience decreased reimbursement for this mandatory service. This could result in a delay for many Medicaid beneficiaries in qualifying for Medicaid coverage at Denver Health Medical Center's FQHCs.

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

   Delays and inconveniences in applying for Medicaid may result in delays in receiving health care for beneficiaries.

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.

   Presently, the contracted State Medicaid auditor calculates Denver Health Medical Center's cost to provide outstationing Medicaid services for beneficiaries using audited cost report data. Under this proposed rule, it is likely that the Department would also contract with the State Medicaid auditor to calculate those costs for the interim payment using the filed, unaudited cost report. That interim payment will then be adjusted and finalized using audited cost report data, once made available. The estimated cost of this additional calculation would be $4,000 to $5,000 per cost reporting period. The Department would bear all costs of this potential new contract work for the State Medicaid auditor.

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

In 2006, the last year for which the State has received audited, actual uncompensated costs associated with providing federally-required outstationing Medicaid eligibility determination services for beneficiaries, Denver Health Medical Center’s FQHCs’s uncompensated costs were $5.3 million. The Medicaid federal financial participation rate for this administrative function is

50%. Therefore, the quantitative impact of the proposed rule to Denver Health Medical Center is nearly $2.7 million, annually. This conservatively assumes that Denver Health Medical Center's uncompensated costs for outstationing remain constant at $5.3 million. This is a conservative estimate in that Medicaid caseloads have increased significantly since 2006; reasonably, the costs of providing outstationing services have also increased, accordingly. Therefore, the cost of inaction would be at least $2.7 million to Denver Health Medical Center each year.

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

   Rather than contracting with the State Medicaid auditor to perform additional cost calculations as described in point #4, the Department could make an interim payment within the 8-quarter timely filing period based on other estimates. However, it is likely that other methodologies for estimating the interim outstationing payment would not result in a payment amount that was as close to the audited costs that the interim payment must be eventually reconciled to. Therefore, it would be most cost-effective to contract with the State Medicaid auditor to calculate an interim payment based on filed cost report data. This would likely result in a reconciliation payment to final, audited costs, with lower variance from the initial, interim payment. A more stable payment is preferred by Denver Health Medical Center for budgeting and cash flow purposes.

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 other methodologies were considered. The process of making an interim payment within the timely filing period and then later reconciling this payment to audited costs is a common methodology that has been preferred by CMS in other supplemental payments the Department makes to providers.

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A

The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process. This outstationing payment shall be made based upon actual cost with a reasonable cost-per-application limit to be established by the Department. The reasonable cost-per application limit shall be based upon the lower of the amount allocated to county departments of social services for comparable functions or a provider-specific workload standard. In no case shall the outstationing payment for FQHCs exceed a maximum cap of $60,000 per facility per year for all administrative costs associated with outstationing activities.

8.700.8.B

1. Hospitals with ~~H~~hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting ~~clients~~ potential beneficiaries in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center ~~clinics~~ shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center ~~FQHCs~~ shall provide the s~~S~~tate's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures ~~under 42 C.F.R., Section 433.51~~. Such certifications shall be sent to the Safety Net ~~Financing~~ Programs Manager. ~~42 C.F.R., Section 433.51, 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, CO 80203-1714. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library~~.

2. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. Effective with the hospital cost report year 2010 and forward, the Department will make an interim payment to Denver Health Medical Center for estimated reasonable costs associated with outstationing activities based on the costs included in the as-filed Medicare cost report. This interim payment will be reconciled to actual costs after the cost report is audited. Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the interim estimated administrative costs and the final audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

8.700.8.C

To receive payment, FQHCs shall submit annual logs of applicant information to the Department with their cost report. Applicant logs shall include the applicant's name, date of application, and social security number if available.

8.700.8.D

Reimbursement for outstationing administrative costs shall be determined according to the following guidelines:

1. Freestanding FQHCs shall report on a supplementary schedule the administrative and general direct pass-through costs associated with outstationing activities. The Department shall allocate appropriate overhead costs (not separately identified) to calculate the total facility outstationing administrative expenses incurred. Freestanding FQHCs shall receive an annual lump sum retrospective payment based on the audited cost report.

2. Hospitals with h~~H~~ospital-based FQHCs shall submit the administrative and general pass through direct and indirect costs associated with outstationing activities on an extra line on the Medicaid Cost Report ~~(related to Worksheet A - Trial Balance).~~ and submit all other source documentation to compute allowable outstationing costs. Hospitals with h~~H~~ospital-based FQHCs shall receive ~~an annual lump sum retrospective~~ payment in accordance with 8.700.8.B. The reimbursement shall be separately identified on the Medicaid Settlement Sheet.

THIS PAGE IS NOT FOR PUBLICATION

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 11-12-09-B, Home and Community-Based Services for Persons with Brain Injury (HCBS-BI)
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) 8.515 - 8.516, 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*

This is a complete re-write of an existing rule. Please remove all current text from §8.515.00 HOME AND COMMUNUNITY BASED SERVICES FOR PEOPLE WITH BRAIN INJURY through the end of §8.516.20.D.
Please insert all new text provided from §8.515 HOME AND COMMUNITY BASED SERVICES FO RPERSONS WITH BRAIN INJURY through the end of §8.515.10.
This change is effective 10/30/2012.

*to be completed by MSB Board Coordinator

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Home and Community-Based Services for Persons with Brain Injury (HCBS-BI)
Rule Number:	MSB 11-12-09-B
Division / Contact / Phone:	Long Term Supports and Services Operations / Tyler Deines / 303 866-2266

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 HCBS-BI waiver program provides assistance to eligible individuals with brain injuries that require long term supports and services in order to remain in a community setting.

Since the implementation of this program, there have been numerous changes to the operations and processes for providing HCBS-BI services. The proposed amendment is intended to improve the efficiency of the waiver program operations, to correct dated or inaccurate references to statutes and regulations, to provide guidance and clarification on case management functions, to remove or correct duplicative and/or conflicting regulations, and to remove unnecessary barriers to participant access and provider enrollment.

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:

Social Security Act, Section 1915(c) (42 U.S.C. § 1396n)
42 C.F.R. 441.300 - 441.310

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);
   25.5-6-701 et seq., C.R.S.

Initial Review	**08/10/2012**	Final Adoption	**09/14/2012**
Proposed Effective Date	**11/10/2012**	Emergency Adoption	

DOCUMENT #02

THIS PAGE IS NOT FOR PUBLICATION

Title of Rule:	Home and Community-Based Services for Persons with Brain Injury (HCBS-BI)
Rule Number:	MSB 11-12-09-B
Division / Contact / Phone:	Long Term Supports and Services Operations / Tyler Deines / 303 866-2266

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.

   Applicants and participants of the HCBS-BI waiver program and their families, case management agencies, HCBS-BI waiver service providers will benefit from the clarification, efficiencies, and elimination of barriers afforded by the proposed rule.

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

   The implementation of this rule could create efficiencies in the eligibility determination, service planning, and service delivery processes. This could result in increased access to HCBS-BI services and/or service providers for HCBS-BI waiver participants and remove unnecessary barriers for HCBS-BI service provider participation.

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 associated with the implementation or enforcement of this rule.

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

   There no costs associated with inaction.

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

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

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

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

8.515 Home and Community-Based Services For Persons with Brain Injury (HCBS-BI)

8.515.1 LEGAL BASIS

The Home and Community-Based Services for Persons with Brain Injury (HCBS-BI) program is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, ~~(~~42 U.S.C. § 1396a (2011)~~)~~. This waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, ~~(~~42 U.S.C. § 1396n (2011). 42 U.S.C. §§ 1396a and 1396n ~~-~~are incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material.

This regulation is adopted pursuant to the authority in Section 25.5-1-303~~1~~, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Sections 24-4-101 et seq., C.R.S. and the Home and Community-Based Services for Persons with Brain Injury Act, ~~Colorado Medical Assistance Act,~~ Sections 25.5-6-701 et seq., C.R.S.

Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO 80203. Additionally, any incorporated material in these rules may be examined at any State depository library.

8.515.2 DEFINITIONS OF SERVICES PROVIDED

Adult Day Services means services as defined at Section 8.515.70

Behavioral Programming and Education means services as defined at Section 8.516.40.

Counseling Services means services as defined at Section 8.516.50.

Day Treatment means services as defined at Section 8.515.80.

Electronic Monitoring Services means services as defined at Section 8.488.

Home Modification means services as defined at Section 8.493.

Independent Living Skills Training (ILST) means services as defined at Section 8.516.10.

Non-Medical Transportation Services means services as defined at Section 8.494.

Personal Care means services as defined at Section 8.489.

Respite Care means services as defined at Section 8.492.

Specialized Medical Equipment and Supplies means services as defined at Section 8.515.50.

Substance Abuse Counseling means services as defined at Section 8.516.60.

Supported Living ~~Program~~ means services delivered by a community-based residential program that has been certified by the Department to provide the services defined at Section 25.5-6-703(8), C.R.S.

Transitional Living Program means services as defined at Section 8.516.30.

8.515.3 GENERAL DEFINITIONS

Brain Injury means an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional and behavioral difficulties of a non-progressive nature and is limited to the following International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes:

310 – 310.9 Specific nonpsychotic mental disorders due to brain damage

348.1 Anoxic brain damage

348.4 Compression of the brain

349.82 Toxic encephalopathy

430 Subarachnoid hemorrhage

431 Intracerebral hemorrhage

433 Occlusion and stenosis of precerebral arteries

436 Acute, but ill-defined cerebrovascular disease

437 – 437.9 Other and ill-defined cerebrovascular disease

438 – 438.9 Late effects of cerebrovasular disease

800 – 800.9 Fracture of vault of skull

801 – 801.9 Fracture of base of skull

803 – 803.9 Other and unqualified skull fractures

804 – 804.9 Multiple fractures involving skull or face with other bones

850 – 850.9 Concussion

851 – 851.9 Cerebral laceration and contusion

852 – 8.52.5 Subarachnoid, subdural, and extradural hemorrhage, following injury

853 – 853.1 Other unspecified intracranial hemorrhage following injury

854 – 854.1 Intracranial injury of other and unspecified nature

905 Late effects of musculoskeletal and connective tissue injuries

907 Late effects of injuries to the nervous system

959.01 Head injury, unspecified

Case Management Agency means the agency designated by the Department to provide the Single Entry Point Functions detailed at Section 8.393.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Service Plan means the plan developed by the case manager in coordination with the HCBS-BI client and/or the legal guardian to identify and document the HCBS-BI services, other Medicaid services, and any other non-Medicaid services or supports that the HCBS-BI client requires in order to live successfully in the community.

8.515.4 SCOPE AND PURPOSE

The HCBS-BI program provides those services listed at Section 8.515.2 to eligible individuals with brain injury that require long term supports and services in order to remain in a community-based setting.

8.515.5 ELIGIBLE PERSONS

HCBS-BI program enrollment and services shall be offered only to individuals determined by the Department or its agent to have met all eligibility requirements in this Section 8.515.5.

8.515.5.A LEVEL OF CARE

Eligible individuals shall be determined by the Department or its agent to require one of the following levels of care:

1. Hospital Level of Care as evidenced by all of the following:

    a. The individual's brain injury shall have occurred no more than six months prior to application;

    b. The individual shall have been referred to the Case Management Agency while receiving inpatient care in an acute care or rehabilitation hospital for the treatment of the individual's brain injury;

    c. The individual shall have been determined by the Department or its agent to have a significant functional impairment as evidenced by a comprehensive functional assessment using the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15;

    d. The individual shall have a prognosis for continued functional improvement;

    e. The individual shall require goal oriented therapy with medical management by a physician;

    f. The individual cannot be therapeutically managed in a community-based setting without significant supervision and structure, specialized therapy, and support services.

2. Nursing Facility Level of Care as evidenced by all of the following:

    a. The individual shall have been determined by the Department or its agent to have a significant functional impairment as evidenced by a comprehensive functional assessment using the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15;

b. The individual shall require long term support services at a level comparable to those services typically provided in a nursing facility; and

c. The individual has maximized his or her acute and rehabilitation potential.

8.515.5.B TARGET GROUP

Eligible individuals shall be determined by the Department or its agent to meet all of the following target group criteria:

1. The individual shall have a diagnosis of Brain Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) of the ULTC 100.2 assessment tool.

2. Age Limit

a. Individuals enrolled in the hospital level of care shall be aged between 16 and 64 years.

b. Individuals enrolled in the nursing facility level of care shall be aged 16 years and older and shall have sustained the brain injury between the ages of 16 and 64 years.

8.515.5.C FINANCIAL ELIGIBILITY

Individuals must meet the financial requirements for long term care medical assistance eligibility specified at Section 8.100.7.

8.515.5.D NEED FOR HCBS-BI SERVICES

1. Only clients that currently receive HCBS-BI services, or that have agreed to accept HCBS-BI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-BI program.

a. Case management is provided as an administrative function, not an HCBS-BI service, and shall not be used to satisfy this requirement.

b. The desire or need for any Medicaid services other than HCBS-BI services, as listed at Section 8.515.1, shall not satisfy this eligibility requirement.

2. Clients that have not received an HCBS-BI service for a period greater than 30 consecutive days shall be discontinued from the program.

8.515.5.E EXCLUSIONS FROM ELIGIBILITY

1. Individuals who are residents of nursing facilities, hospitals, or other institutional settings are not eligible to receive HCBS-BI services.

2. HCBS-BI clients that enter a nursing facility or hospital may not receive HCBS-BI services while admitted to the nursing facility or hospital.

a. HCBS-BI clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-BI program.

b. HCBS-BI clients entering a nursing facility for Respite Care as an HCBS-BI service shall not be discontinued from the HCBS-BI program.

8.515.5.F COST CONTAINMENT AND SERVICE ADEQUACY OF SERVICES

1. The client shall not be eligible for the HCBS-BI program if the case manager determines any of the following during the initial assessment and service planning process:

   a. The client's needs cannot be met within the Individual Cost Containment Amount.

   b. The client's needs are more extensive than HCBS-BI program services are able to support and/or that the client's health and safety cannot be assured in a community setting.

2. The client shall not be eligible for the HCBS-BI program at reassessment if the case manager determines the client's needs are more extensive than HCBS-BI program services are able to support and/or that the client's health and safety cannot be assured in a community setting.

3. If the case manager determines that the client's needs are more extensive than the HCBS-BI services are able to support and/or that the client's health and safety cannot be assured in a community setting, the case manager must document:

   a. The results of an Adult Protective Services assessment;

   b. A statement from the client's physician attesting to the client's mental competency status; and

   c. Any other documentation necessary to support the determination

4. The client may be eligible for the HCBS-BI program at reassessment if the case manager determines that HCBS-BI program services are able to support the client's needs and the client's health and safety can be assured in a community setting.

   a. If the case manager expects that the services required to support the client's needs will exceed the Individual Cost Containment Amount, the Department or its agent will review the service plan to determine if the client's request for services is appropriate and justifiable based on the client's condition.

      i. The client may request of the case manager that existing services remain intact during this review process.

      ii. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the client with:

         1) The client's appeal rights pursuant to Section 8.057; and

         2) Alternative options to meet the client's needs that may include, but are not limited to, nursing facility placement.

8.515.6 START DATE FOR SERVICES

8.515.6.A. The start date of eligibility for HCBS-BI services shall not precede the date that all of the requirements in~~at~~ Section 8.515.5, have been met. The first date for which HCBS-BI services may be reimbursed shall be the later the following:

1. The date at which financial eligibility is effective.

2. The date at which the Department or its agent has determined that the client has met all eligibility requirements at Section 8.515.5.

3. The date at which the client agrees to accept services and signs all necessary intake and service planning forms.

4. The date of discharge from an institutional setting.

8.515.7 PRIOR AUTHORIZATION OF SERVICES

8.515.7.A. All HCBS-BI services must be prior authorized by the Department or its agent.

8.515.7.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.515.7.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the client's documented medical condition and functional capacity;

2. Reasonable in amount, scope, frequency, and duration;

3. Not duplicative of the other services or supports included in the client's Service Plan;

4. Not for services for which the client is receiving funds to purchase; and

5. Do not total more than 24 hours per day of care.

8.515.7.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

8.515.7.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-BI services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR.

1. Payment for HCBS-BI services is also conditional upon:

a. The client's eligibility for HCBS-BI services;

b. The provider's certification status; and

c. The submission of claims in accordance with proper billing procedures.

8.515.7.F. The prior authorization of services does not constitute an entitlement to those services. All services provided and reimbursed must be delivered in accordance with regulation and be necessary to meet the client's needs.

8.515.7.G. Services requested on the PAR shall be supported by information on the Service Plan and the ULTC-100.2 assessment.

8.515.7.H. The PAR start date shall not precede the start date of HCBS-BI eligibility in accordance with Section 8.515.6.

8.515.7.I. The PAR end date shall not exceed the end date of the HCBS-BI eligibility certification period.

8.515.8 WAITING LIST

8.515.7.A. Persons determined eligible for HCBS-BI services that cannot be served within the capacity limits of the HCBS-BI waiver shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the person's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.515.5 were determined to have been met and the HCBS-BI Program Administrator was notified.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the date of their waiting list placement.

8.515.9 CASE MANAGEMENT FUNCTIONS

The requirements at Section 8.393 shall apply to the Case Management Agencies performing the case management functions of the HCBS-BI program.

8.515.10 PROVIDER AGENCIES

HCBS-BI providers shall abide by all general certification standards, conditions, and processes established at Section 8.487.

8.515.00 HOME AND COMMUNITY BASED SERVICES FOR PEOPLE WITH BRAIN INJURY (HCBS-BI)

8.515.11 LEGAL BASIS

The Home and Community Based Services for people with Brain Injury (HCBS-BI) program in Colorado is authorized by a waiver of the amount, duration, and scope of service requirements contained in Section 1902 (a)(10)(B) of the Social Security Act. The rules governing the HCBS-BI program will be in effect after approval is received from the United States Department of Health and Human Services, under Section 1915 (c) of the Social Security Act. The HCBS-BI program is authorized under State law at 26-4-681 et seq., C.R.S. to 26-4-685, as amended.

8.515.13 DEFINITIONS OF SERVICES PROVIDED

HCBS-BI services are provided as an alternative to hospital and inpatient rehabilitation facility placement and include:

A. Adult Day Services means services as defined at Section 8.515.70, ADULT DAY SERVICES.

B. Assistive Equipment means devices, equipment and services as defined in Section 8.515.50, ASSISTIVE AND SPECIAL MEDICAL EQUIPMENT.

C. Behavioral Programming means, services as defined in Section 8.516.40. BEHAVIORAL PROGRAMMING.

D. Case Management means services as defined in Section 8.515.30. CASE MANAGEMENT.

E. Counseling and Training Including Substance Abuse Treatment and Family Counseling means services as defined in Section 8.516.60. COUNSELING.

F. Day Treatment means services as defined in Section 8.515.80. DAY TREATMENT.

G. Environmental Modification means services as defined in Section 8.5.6.00. ENVIRONMENTAL MODIFICATION.

H. Independent Living Skills Training means services as defined in Section 8.516.20, INDEPENDENT LIVING SKILLS. TRAINING.

I. Non-medical Transportation means services as defined at Section 8.524. NON-MEDICAL TRANSPORTATION.

J. Personal Care means, services, as defined at Section 8.515.60, PERSONAL CARE SERVICES.

K. Respite Care means services as defined at Section 8.515.90. RESPITE CARE.

L. Supported Living means services as defined at Section 8.514.14, Q in GENERAL DEFINITIONS-SUPPORTED LIVING.

M. Transitional Living means services as defined in Section 8.516:40. TRANSITIONAL LIVING.

8.515.14 GENERAL DEFINITIONS

A. Agency means any public or private entity that operates in a for-profit or nonprofit capacity, and has a defined administrative and organizational structure. Any sub-unit of such agency that is not geographically close enough to the agency to share administration and supervision on a frequent and adequate basis shall be considered a separate agency for purposes of certification and contracts.

B. Assessment means a comprehensive face-to-face interview with the client and appropriate collaterals (such as family members, friends and or caregivers) and an evaluation by the hospital discharge planner or case manager, with supported diagnostic information from the client's physician. and other rehabilitation therapists to determine the client's level of functional ability, service needs, potential to benefit from further rehabilitative intervention, available community resources, and potential funding sources.

C. Brain Injury is defined as an injury to the brain of traumatic or acquired origin, which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature, and includes the following ICD-9-CM codes:

- 310-310.9 specific non-psychotic mental disorders due to organic brain syndrome ;
- 348.1 Anoxic brain damage;
- 431.0 Intracerebral hemorrhage;
- 436-438 cerebrovascular disease, acute, but ill-defined, other and ill-defined, and late effects of disease;
- 800.00-800.9 fracture of vault of skull;
- 801-801.9 fracture of base of skull;
- 803-803.9 other and unqualified skull fractures;
- 804-804.99 multiple fracture involving skull or face with other bones;
- 850-850.9 concussion;
- 851-854.19 intracranial injury and hemorrhage following injury;
- 904.0-907.0 late effects of fracture of skull and face bones and late effect of intracranial injury without mention of skull fractures (if admission to acute hospitalization is for a different primary diagnosis);
- 349.82 toxic encephalopathy ;

- 198.3 -secondary malignant neoplasm of brain, spinal cord and other pans of nervous system.

Copies of the International Classification of Diseases Manual - Clinical Modification are available from the Brain Injury Program Coordinator. Office of Public and Private Initiatives of the Department of Health Care Policy and Financing at 1575 Sherman St. Denver. CO 80203. or may be examined at any State Publications Depository Library. Later amendments or additions are not included in this rule.

D. Case Management Agency means an agency which is certified and has a valid contract with the department to provide HCBS-BI case management.

E. Care Plan means a systematized arrangement of information which includes the client's needs: the HCBS-BI services and all other services which will be provided, including the funding source, frequency, amount and provider of each service: and the expected outcome or purpose of such services. This care plan shall be written on a state-prescribed care plan form and upon monthly reassessment of the client, shall be revised as dictated by the client's progress.

F. Categorically Eligible as it is used in relation to the HCBS-BI Program, means any person who is eligible for medical assistance or for a combination of financial and medical assistance: and who retains eligibility for medical assistance even when he or she is not a resident of a nursing facility or hospital or is not a recipient of an HCBS program. Persons who are eligible for financial assistance, but not for medical assistance, are not included in the definition of categorically eligible, as the term is used in relation to the HCBS-BI program. The term also excludes persons who are eligible for HCBS-BI as three hundred percent eligible persons, as defined in this section.

G. Congregate Facility means a residential facility that Provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services, and social care but do not require regular twenty four hour medical or nursing care.

H. Continued Stay Review means a re-evaluation by the URC/SEP agency to determine the continued functional necessity of that level of care. Continued stay reviews will be performed every six months, for the 1st year, and annually or when the URC/SEP case manager determines that the client no longer meets the level of care necessary for continued program eligibility.

I. Cost Ceiling means the determination that, on an individual client basis, the daily cost of providing HCBS-BI services does not exceed the equivalent daily cost of hospital facility care.

J. Department means the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

K. Home and Community Based Services for persons with Brain Injury (HCBS-BI) means service provided in a home or community based setting to individuals who are eligible for Medicaid for one of two levels of care:

1. Post acute care/long term care, for clients requiring hospital level of care without the provision of intensive HCBS-BI services that can be provided at no more than the cost of hospital care.

2. Supportive Living Program services for those requiring specialized nursing facility level of care without the provision of HCBS-BI services that can be provided at no more than the individual's calculated cost if institutionalized.

L. Independent Living Skills training means skills and therapies as defined at 26-4-683 (5), C.R.S.

M. Community Services may be provided in the client's residence, in the community or in a group living situation.

N. Intake/screening/referral for the HCBS-BI program means the initial contact with individuals by the URC/SEP case manager. This process shall include, but not be limited to, the following areas; an individual's

O. Provider Agency means an agency, as defined in this section, which is certified by the Department to provide one of the services listed at Section 8.393.61 DEFINITIONS OF SERVICES, with the exception of case management provided by a single entry point agency, which is considered an administrative function rather than a service. However, a single entry point agency may become a service provider if they meet all criteria at 8.393.61, PROVIDER OF DIRECT SERVICES.

P. Reassessment means a comprehensive face-to-face interview conducted with the client and appropriate collateral contacts, which includes an evaluation by the case manager, collection of supporting diagnostic information from the client's physician to determine the client's level of functioning, service needs, available resources, and potential funding resources.

Q. Supportive Living Care Campus means a residential campus that provides supported supportive living services.

R. Single Entry Point (SEP) entry point agency means an organization as described at Section 8.390.1,P, LONG TERM CARE SINGLE ENTRY POINT SYSTEM.

S. Supportive Living means assistance or support provided by a 24 hour residential facility or Supported Living Care Campus asked at 26-4-638(8), C.R.S. (2003).

T. Three hundred percent (300%) eligible means persons whose income does not exceed 300% of the SSI benefit level; who, except for the level of their income, would be eligible for an SSI payment; and who are not eligible for medical assistance (Medicaid) unless

they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty consecutive days.

8.515.15 ELIGIBLE PERSONS

A. HCBS-BI services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

Individuals must meet the financial eligibility criteria as specified in Section 8.110.5 MEDICAL ASSISTANCE ELIGIBILITY. The parental income of non-emancipated children between the ages of 16-18 will be counted in the determination of that child's eligibility for medical assistance.

2. Level of Care

Individuals 16-64 years of age who have a diagnosis of Brain Injury and who continue to require one of the following two levels of care shall be eligible:

a. Hospital level of care as evidenced by all of the following:

i. The client is currently receiving inpatient hospital care in an acute medical facility or rehabilitation facility and should be no more than six-months post Brain Injury.

ii. The client continues to require goal-oriented therapy with medical management by a physician with special training or experience in the field of Brain Injury rehabilitation.

iii. The client continues to require and benefit from medically necessary specialized rehabilitation services including at least two of the following: neuropsychological intervention, social work, life skills training, behavioral management, counseling, Respite Care, Personal Care, Non-Medical Transportation, adult day care, Day Treatment, Transitional Living, Assistive Equipment, Environmental Modification, speech therapy, physical therapy, occupational therapy, vocational rehabilitation, recreational therapy or home health services.

iv. The client cannot be therapeutically managed in the home without significant supervision and structure, specialized therapy and support services.

v. The client has a prognosis for continued functional improvement.

b. Specialized nursing facility level of care provided by a 24-hour Supportive Care facility or Campus as evidenced when:

i. The client continues to require and benefit from medically necessary specialized supportive services including at least two of the following: interpersonal and social life skills training, behavioral management and cognitive supports, counseling, improved household management, Personal Care, Non-Medical Transportation, adult day care, Day Treatment, Assistive Equipment, Environmental Modification, speech therapy, physical therapy, occupational therapy, , recreational therapy, medical management or home health services.

ii. The client requires long-term specialized daily assistance that cannot be provided in a nursing facility.

iii. The client's independence can be maximized in the community by provision of 24-hour supervision, structure and supportive services provided in a community-based facility by staff with specialized behavioral and cognitive management training.

iv. The client has maximized his or her acute and rehabilitation potential.

3. Receiving HCBS-BI Services

Once all other eligibility criteria have been established, only persons who actually receive at least one HCBS-BI service, or who have agreed to accept HCBS-BI services are eligible for the HCBS-BI program. Desire or need for home health services or other Medicaid services that are not HCBS-BI services, as listed at Section 8.515.13, will not satisfy this eligibility requirement. Case management is provided as an administrative function of the waiver program and is not a service of the waiver program; therefore, it cannot be used to satisfy this eligibility requirement. HCBS-BI recipients who have received no HCBS-BI services for one month will be discontinued from the program.

4. Institutional Status

a. Persons who are current residents of nursing facilities or hospitals are not eligible to receive HCBS-BI services.

b. An individual who is already an HCBS-BI recipient and who enters a hospital for treatment may not receive HCBS-BI service while in the hospital; and if the hospitalization continues for 30 days or longer, the URC/SEP case manager must terminate the client from the HCBS-BI program.

c. An individual who is already an HCBS-BI recipient aid who enters a nursing facility may not receive HCBS-BI service while in the nursing facility; and the URC/SEP case manager must terminate the client from the HCBS-BI program if Medicaid pays for all or part of the nursing facility care. However, a recipient of HCBS-BI services who enters a nursing facility for

respite care as a service under the HCBS-BI program shall not be required to obtain a nursing facility ULTC 100.2, but shall be continued as an HCBS-BI waiver participant and recipient of respite care in a nursing facility.

5. Cost Ceiling

Only persons who can be safely served within the cost ceiling, as defined in Section 8.515.19, are eligible for the HCBS-BI program. The equivalent cost of hospital care is calculated by the Department according to Section 8.515.19, DEPARTMENT CALCULATION OF COST CONTAINMENT AMOUNT.

8.515.16 START DATE FOR SERVICES

The period of eligibility for services will begin the day the Utilization Review Contractor certifies medical eligibility and will remain in effect as long as there is a current, valid certificate of medical necessity.

8.515.17 CLIENT PAYMENT OBLIGATION-POST ELIGIBILITY TREATMENT OF INCOME (PETI)

The case manager shall calculate the client PETI payment for 300% eligible HCBS-BI clients according to the following procedures:

A. For 300% eligible HCBS-B1 clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.

B. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so.

C. For clients who are temporary residents of a transitional living program, deductions of up to $400/month are allowed as client contributions toward deferring the room and board expense of transitional living which is not a covered benefit of the Medicaid program.

8.515.18 PRIOR AUTHORIZATION OF SERVICES

This section defines the process of prior authorization for service. For further information on responsibilities for submission of prior authorization for services, please refer to 8.515.30.1.

A. Upon receipt of the prior authorization request (PAR) as described at Section 8.515.30, I. PRIOR AUTHORIZATION REQUESTS, the Department or its agent shall review the PAR to determine whether it is in compliance with all applicable regulations, whether services requested are consistent with the client's documented medical condition and functional capacity, and whether services are reasonable in amount, frequency and duration. The Department or its agent shall:

1. Approve the PAR and forward signed copies of the Prior Authorization form to the case management agency or hospital discharge planner, when requirements are met;

2. Return the PAR to the case management agency, whenever the PAR is incomplete, illegible, unclear or incorrect; or if services requested are not adequately justified;

3. Disapprove the PAR when any of the requirements are not met. Services shall be disapproved that are duplicative of any other services that the client is receiving or services for which the client is receiving funds to purchase.

B. When the PAR is disapproved, in whole or in part, the Department or its agent shall notify the case management agency or hospital discharge planner, and the case management agency or hospital discharge planner shall notify the client of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et seq., RECIPIENT APPEALS AND HEARINGS. The denial of a Prior Authorization Request is an adverse action with respect to the client and may be appealed pursuant to Section 8.057 but cannot be appealed by the provider.

C. Approval of the PAR by the Department or its agent shall authorize providers of services under the case plan to receive payment for properly submitted claims. Payment is conditional upon the client financial eligibility for long term care medical assistance (Medicaid) on the dates of services.

8.515.19 DEPARTMENT CALCULATION OF COST-CONTAINMENT AMOUNT

The Department shall compute the equivalent average daily cost of hospital care for the person with a brain injury by averaging the reimbursement paid for the prior fiscal year for the eight (8) Diagnostic Related Groups pertinent to brain injury. The average expense of providing home and community based services, plus the average daily per capita expenditures for all other Medicaid services provided to these patients, must be equal to or less than the average cost of hospital level of care plus the average per capita expenditures of all other Medicaid services provided to these patients while residing in a hospital.

8.515.20 LIMITATIONS ON PAYMENT TO FAMILY

A. In no case shall any person be reimbursed to provide HCBS-BI services to his or her spouse.

B. Family members other than spouse or parent of a minor child may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS-BI program subject to the conditions below. For purposes of this section, family is defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

C. The family member must meet all requirements for employment by a certified personal care agency, and must be employed and supervised by the personal care agency.

D. The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

1. The total number of Medicaid personal care units for a family member, shall not exceed an average of 222 personal care units per six-month certification or the equivalent of 444 personal care units for a one-year certification for HCBS-BI. The relative personal care units shall be calculated by multiplying the number of days covered for the certification period by 1.2164 units, to determine the total amount of reimbursement to a family member, and dividing by the number of days covered by the care plan, to determine the average Medicaid cost per day. Family members must average at least 1.2164 hours of care per day (as indicated on the client's care plan) in order to receive the maximum reimbursement.

2. When HCBS funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance can not be used to reimburse the family.

8.515.21 CLIENT RIGHTS

The hospital discharge planner shall inform persons eligible for HCBS-B1 of their right to choose between HCBS-BI services and continued hospital care.

The hospital discharge planner or Single Entry Point case manager shall offer persons eligible for HCBS-BI services the free choice of any and all available and qualified providers of appropriate services.

Persons eligible for HCBS-BI shall be entitled to all appeal rights as listed at Section 8.057, et. seq., RECIPIENTS APPEALS AND HEARINGS.

A. The Utilization Review Contractor shall inform the person of appeal rights when the adverse actions concern the level of care or the determination of client target group.

B. The income maintenance technician shall inform the person of appeal rights when the adverse actions concern financial eligibility and shall also notify the hospital discharge planner or single entry point case manager of the adverse action.

C. The case manager shall inform the client of appeal rights for all other adverse actions concerning HCBS-BI eligibility in accordance with Departmental regulations.

The case manager shall assure that persons eligible for HCBS-BI services receive the protection of client rights at Section 8.023.18, CLIENT RIGHTS, LONG TERM CARE SINGLE ENTRY POINT SYSTEM.

8.515.30 HCBS-BI CASE MANAGEMENT FUNCTIONS

A. HCBS-BI PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

Single Entry Point agencies must comply with single entry point rules governing case management functions at Section 8.393, et. seq., SINGLE ENTRY POINT SYSTEM, and must, in addition, comply with all specific requirements in the rest of the section on HCBS-BI case management functions.

B. INTAKE/SCREENING/REFERRAL

1. Assessment will be completed by hospital discharge planners and an initial plan of care will be developed prior to the client's release to the community based care.

2. The start date will be the date at which the Utilization Review Contractor approves the assessment and the client is discharged to community based care as defined in 8.515.16. If the applicant is unable to sign due to the medical condition of the applicant, any mark the applicant is capable of making will be accepted in lieu of a signature.

3. Consent to treatment shall be obtained from the client. If the applicant is unable to sign due to their medical condition, any mark that the applicant is capable of making will be accepted in lieu of a signature. If the applicant is not capable of making a mark or if the client is felt to be cognitively compromised to the extent that right to consent should be delegated to a family member, the signature of a family member or other person legally authorized to represent the applicant will be accepted.

4. Hospital staff will verify the individual's current financial eligibility status and initiate a call to the Brain Injury Program Coordinator. This verification shall include whether or not the applicant is in a category of assistance that includes financial eligibility for long term care and shall be confirmed in writing by a DSS-1 form from the county eligibility technician.

5. If financial eligibility is to be determined, the hospital staff will initiate contact with the county department of social services of the client's county of residence for Medicaid application.

C. ASSESSMENT

The discharge planner shall complete the following activities for a comprehensive client assessment:

1. Obtain all required information from the client's physician and inpatient treatment team and/or medical records.

2. Determine the client's functional capacity during a face-to-face interview, preferably with the observation of the client in functional settings outside the hospital environment when possible.

3. Determine the ability and appropriateness of the client's caregiver, family, and other collateral sources, to provide assistance in activities of daily living.

4. Determine the client's service needs, including the client's need for services not provided under HCBS-BI.

5. Review service options based on the client's needs, the potential funding sources, and the availability of resources.

6. Explore the client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with Departmental rules.

7. View and document the current Personal Care Boarding Home license or verify with the Department of Public Health and Environment, if the client lives, or plans to live, in a congregate facility as defined at Section 8.485.50, GENERAL DEFINITIONS, in order to assure compliance with Section 8.485.20, KEYS AMENDMENT COMPLIANCE.

8. Determine and document client preferences in program selection.

9. The case manager shall assure that:

a. The ULTC-100.2 assessment and plan of care is completed within two days of the hospital being notified that an applicant may be functionally eligible for the Brain Injury Waiver Program.

b. The Long Term Care Professional Medical Information section of the ULTC. 100.2 is completed by the individual's attending physician' office. A completed form shall include the provider's name and address, and the name and title of the person providing the information.

c. A completed copy of the ULTC 100.2 is submitted to the State Brain Injury Program Administrator and to the County Department of Human Services eligibility technician to notify them of admission into the HCBS-BI program.

D. HCBS-BIDENIALS

HCBS-BI services cannot be paid for if a person is determined, at any point in the assessment process, to be ineligible for the following reasons:

1. Financial Eligibility

The income maintenance technician shall notify the applicant of denial for reasons of financial eligibility, and shall inform the applicant of appeal rights in accordance with the Colorado Department of Human Services Staff Manual Volume 3, INCOME MAINTENANCE. The case manager shall not attend the appeal hearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the State.

2. Level of Care and Target Group Denials

a. The URC/SEP agency shall notify the applicant of denial for reasons related to determination of level of care and target group eligibility, and shall inform the applicant of appeals rights in accordance with Section 8.8.057.

b. The URC/SEP case manager shall attend the appeal hearing to defend any denial action.

3. Continued Stay Review Denials

a. For a client who has been receiving services under the HCBS-BI Waiver program, the URC/SEP case manager shall notify the client pursuant to Section 8.057.

b. The URC/SEP case manager shall attend the hearing to defend the denial action of continued program eligibility.

4. Cost-effectiveness

Depending upon the timing of the denial of further services due to cost-effectiveness criteria, the SEP case manager shall notify the applicant of denial, on a State-prescribed form, when it is determined that the applicant does not meet the eligibility requirement at 8.515.19 for COST-EFFECTIVENESS and shall inform the applicant of appeal tights in accordance with Section 8.057 RECIPIENT APPEALS AND HEARINGS. The case manager shall also attend the appeal hearing to defend this denial action. If the applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the applicant, and the competency of the applicant to choose to live in an unsafe situation. If the case manager determines that the applicant will be unsafe with the amount of services available, and that the applicant is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-BI eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the client's physician attesting to the client's mental competency status, and all other available information which will support the determination that the client is unsafe and incompetent to make a decision to live in an unsafe situation; and which will satisfy the burden of proof required of the case manager making the decision. Denials and appeals for reasons of cost effectiveness, or safety related to cost-effectiveness, are independent of any action that may be taken by the Utilization Review Contractor in regard to level of care and target group determination.

5. Institutional Status

The case manager shall notify the applicant of denial, on a Departmentally prescribed form, when the case manager determines that the applicant does not meet the eligibility requirement at Section A.4, 8.515.15, INSTITUTIONAL STATUS, and shall inform the applicant of appeal rights in accordance with

Section 8.057 et., seq., RECIPIENT APPEALS AND HEARINGS. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the Utilization Review Contractor in regard to level of care and target group determination.

E. CARE PLANNING

The hospital discharge planner shall initiate development of the care plan after completing the client assessment and shall complete the care plan (including all required paperwork) prior to discharge. Care Planning shall include, but not be limited to, the following tasks:

1. Identification and documentation of care plan goals and client choices;

2. Identification and documentation of all services needed, including type of service, specific functions to be performed, frequency and amount of service, type of provider, funding source, and services needed but not available.

3. Documentation of the client's choice of HCBS-BI services or continued hospitalization including a signed statement of choice from the client or authorized representative;

4. Documentation that the client was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;

5. The formalization of the care plan agreement of a Long Term Care Plan, including appropriate signatures. If the applicant is unable to sign due to a medical or cognitive condition, any mark that the applicant is capable of making will be accepted in lieu of a signature. If the applicant is not capable of making a mark, the signature of a family member or other person authorized to represent the applicant is acceptable.

6. The arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the client regarding service provision.

7. The inclusion of a process, developed in coordination with the eligible client and the client’s family or guardian, by which the client may receive necessary care if the client’s family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The client and the client’s family or guardian shall be duly informed of these alternative care provisions at the time the plan of care is initiated.

8. Referral to community resources as needed and development of resources for individual clients if a resource is not available within the client's community.

9. Referral to state brain injury program coordinator for an explanation of complaint procedures to the client.

When developing the care plan, the discharge planner shall make every effort to ensure that there is no duplication between those services requested under HCBS and services from any other funding source. This includes, but is not limited to, services provided or paid for through Home Health, Home Care Allowance, Veteran's Aid and Attendance, or Assisted Living Residence.

F. CALCULATION OF CLIENT. PAYMENT (PETI)

This section explains responsibilities for calculation of PETI; for further information on the process of calculation and allowances, please refer to Section 8.515.17.

The case manager shall calculate the PETI client payment for 300% eligible HCBS-BI clients according to the following procedure:

For 300% eligible HCBS-BI clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required.

For 300% eligible HCBS-BI clients who are residing temporarily in Transitional Living Centers, the case manager shall complete. a State-prescribed form which calculates the client payment according to specifications delineated for Alternate Care Facility clients according to Section 8.486.60 et. seq., CALCULATION OF CLIENT PAYMENT (PETI).

G. PRUDENT PURCHASE AND SERVICE FUNDING PRIORITIES.

1. The discharge planner or case manager shall attempt to meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

2. Diligent effort will be made to assist the client in making informed choices by:

a. Presenting/outlining available service providers/options and providing a brief description of that service category in written format;

b. Assisting the family and client in weighing various factors in the selection of provider; and

c. Maintaining current and accurate knowledge of various community resources.

3. When services are available to the client at no cost from family, friends, volunteers or others, these services shall be utilized before the purchase of services, providing these services adequately meet the needs of the client and do not constitute an undue hardship on the family through the exhaustion of financial or emotional resources.

4. When public dollars must be used to purchase services, the discharge planner or case manager shall encourage the client to make the most efficient use of the services available by selection of the lowest cost provider of service where quality of service is comparable.

H. COST CONTAINMENT

The hospital discharge planner shall determine whether the person can be served at or under the cost ceiling for hospital based service for an individual recipient by using a departmentally prescribed form to:

1. Determine the maximum authorized costs for all HCBS-BI services for the period of tune-covered by the case plan, and compute the average cost per day by dividing the number of days in the case plan period; and

2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount.

I. SUBMISSION OF PRIOR AUTHORIZATION REQUESTS

This section describes responsibilities for submission of prior authorization within the functions of case management; for further information regarding the processing of prior authorization requests, please refer to Section 8.515.18.

1. Discharge planners and case managers shall submit Prior Authorization Requests for transitional living, nonmedical transportation, environmental modifications, and assistive equipment only.

2. Every PAR shall include the Care Plan and the Prior Approval Request. For prior authorization of transitional living services, a tentative treatment plan and evaluation from the probable provider shall be submitted with the PAR. All units of service requested on the Prior Approval Request must be listed on the Care Plan. If a range of units is estimated on the care plan, the number of units at the higher end of the range may be requested on the Prior Approval Request.

3. If a PAR includes a request for environmental modification services, the PAR shall also include all documentation listed at Section 8.516.00, ENVIRONMENTAL MODIFICATION.

4. The start date of the prior authorization request form shall never precede the start date of eligibility for HCBS-BI services according to Section 8.515.16.

5. The PAR shall not cover a period of time longer than the length of stay assigned by the Utilization Review Contractor.

6. If a PAR is returned for corrections, the corrected PAR must be returned to the Department or its agent within two days after the discharge planner received the notification letter of correction.

J. COORDINATION, MONITORING, AND EVALUATION OF SERVICES

1. The case manager shall monitor the services that are being provided, the appropriateness and effectiveness of services provided, the amount of care, the timeliness of service delivery, the client's satisfaction, the safety of the client, and shall take corrective actions as needed. Monitoring contacts must occur and be documented at least once every month, or more frequently as determined by the client's needs and single entry point agency policy.

2. The case manager shall contact each client on a face-to-face basis at least once every three months, or more frequently as determined by the client's needs and single entry point agency policy during the initial year of program participation.

3. On-going case management shall include, but not be limited to, the following tasks:

a. Review of the client's case plan and service agreements.

b. Contact with the client concerning whether services are being delivered according to the plan; and the client's satisfaction with services provided.

c. Contact with service providers to verify that services are being delivered according to the plan; and concerning service coordination, effectiveness and appropriateness, as well as to inquire into and/or remedy any complaints raised by the client, family members, caregivers or others who are involved in the immediate support of the recipient.

d. Contact with caregivers, family members, or significant others in the recipient's immediate support system in the event any issues or complaints have been presented through the process of monitoring and sampling the recipients satisfaction with care provided through the HCBS-BI program

e. Conflict resolution and or crisis intervention, as needed.

f. Informal assessment of changes in client functioning, service effectiveness, service appropriateness, and service cost effectiveness.

g. Notification of appropriate enforcement agencies, as needed.

h. Referral to community resources, and arrangement for non-HCBS-BI services as needed.

4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. REVISIONS ADDED TO THE CASE PLAN

a. Whenever a change in the care plan results in an increase or change in the services to be provided, the case manager shall provide a revised care plan listing the services being revised and the reason for revision. A Revised cost containment sheet must be submitted reflecting resultant changes/Calculations

b. If additional services include any one of the previously listed services requiring prior authorization, the case manager must submit a prior authorization request according to Section 8.515.30.

K. REASSESSMENT

1. The case manager shall complete a reassessment of each HCBS-BI client before the end of the length of stay assigned by the Utilization Review Contractor at the last level of care determination. The case manager shall initiate a reassessment more frequently when warranted by significant changes that may affect HCBS-BI eligibility. In addition, a reassessment shall be completed every six months for the first year, and annually thereafter.

2. The case manager shall complete the reassessment, utilizing the ULTC 100.2 Assessment form.

3. Reassessment shall include, but not be limited to, the following activities:

a. Verify continuing Medicaid eligibility, including verification of an aid category mat includes eligibility for long term care benefits.

b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;

c. Evaluate continuing need for the HCBS-BI program, and clearly document reasons for continuing HCBS-BI, transfer to the HCBS-EBD, HCA or other program, or terminate the client's eligibility according to Section 8.515.30, M.

d. Reassess the client's functional status, according to the procedures in Section 8.515.30, C, ASSESSMENT.

e. Review the care plan, including verification of whether services have been delivered according to the case plan, and write a new case plan, according to procedures at Section 8.515.30, E, CARE PLANNING.

f. Refer the client to community resources as needed; and

g. Submit the complete and correct ULTC 100.2 Assessment to the Utilization Review Contractor for a continued stay review, in accordance with the guidelines at ASSESSMENT.

L. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

Single entry point agencies shall comply with the procedures as detailed in 8.39332, A, et. seq., INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES for transferring clients to another county or single entry point district

M. DISCONTINUATION OF SERVICES

1. Clients shall be discontinued from the HCBS-BI program whenever they no longer meet one or more of the eligibility requirements in section 8.515.15 ELIGIBLE PERSONS. Clients shall also be discontinued from the program if they die , move out of state or voluntarily withdraw from the program; or if the client's physician fails to sign a required assessment form

2. Clients who are discontinued from HCBS-BI because they no longer immediately of the termination and their appeal rights as follows:

a. Financial Eligibility

Procedures at Section 8.393.28 HCBS-EBD DENIALS shall be followed for discontinuation for this reason.

b. Level of Care and Target Group

Procedures at Section 8393.28, HCBS-EBD DENIALS shall be followed for discontinuation for this reason.

c. Receiving HCBS-BI Services

Procedures at Section 8.393.28 HCBS-EBD DENIALS shall be followed for discontinuation for this reason.

d. Institutional Status

Procedures at Section 8.393.28 HCBS-EBD DENIALS shall Procedures at Section 8.393.28 HCBS-EBD DENIALS shall the Department shall assume responsibility for than the single entry point agency case manager.

e. Cost Effectiveness

Procedures at Section 8.393.28 HCBS-EBD DENIALS shall be followed for discontinuations for this reason, except that the Department shall assume responsibility for communicating the decision via an advisement letter rather than the single entry point agency case manager.

N. COMMUNICATION

Communication requirements of case management functions within single entry point agencies will comply with all provisions of 8.393.28.

O. CASE RECORDING DOCUMENTATION

Documentation standards and requirements for the HCBS-BI program must comply with Section 8.393.26, et seq., of this Staff Manual.

8.515.40 HCBS-BI Provider Agencies

A. GENERAL CERTIFICATION STANDARDS

1. Provider agencies shall conform to all State established standards for the specific services they provide under this program, shall abide by all the terms of the provider agreement with the State, and shall comply with all federal and state statutory requirements. A provider 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.

2. Provider agencies shall have written policies and procedures for recruiting, selecting, retaining, training, and terminating employees.

3. Provider agencies shall have written policies governing access to duplication and dissemination of information from the recipient's records in accordance with state statutes on CONFIDENTIALITY OF INFORMATION at 26-1-114, C.R.S. as amended. Provider agencies shall have written policies and procedures for providing employees with client information needed to provide the services assigned, within the agency policies for protection of confidentiality.

4. Provider agencies shall maintain liability insurance in at least such minimum amounts as set annually by the Department, and shall have written policies and procedures regarding emergency procedures.

5. Provider agencies shall provide written human rights and post same in a readily visible area. Residents of Supportive Living Care facilities who believe their rights have been denied may request the assistance of the facility; contact the case manager, local ombudsman, or the resident's legal representative. Any case, which cannot be resolved through these routes, may be referred to the Department for a final determination.

6. Provider agencies shall have written individualized treatment plans for each client with goals and objectives based on the clients needs. Progress toward goals shall be monitored and reported in objective measurable terms on a weekly basis. If a client is receiving services in a transitional living center, formal progress reports should be submitted on a bimonthly basis to the case manager. For other service providers, formal progress reports shall be submitted to the

referring case manager on a semi-annual or an annual basis. The interdisciplinary team or professional, the client, and the family, when appropriate will mutually develop treatment goals.

7. Specific treatment modalities outlined in the treatment plans shall be systematically implemented with techniques that are consistent, functionally based, and active throughout the treatment period. Methods shall be appropriate to the goals, and treatment plans shall be reviewed and modified as appropriate. Goals of treatment shall reference outcomes in the degree of personal and living independence, work productivity, and psychological, social, and physical adjustment.

8. Initial assessment and progress shall be communicated to the client, the family and the referral source regularly in a manner that can be easily understood. The client and his/her family shall be offered a copy of the treatment plan and the client's signature shall be obtained on the care plan.

9. Provider agencies shall have written policies and procedures regarding the handling and reporting of critical incidents, including accidents, suspicion of abuse, neglect or exploitation, and criminal activity.

10. Provider agencies shall maintain a log of all complaints and critical incidents, which shall include documentation of the resolution of the problem.

11. Provider agencies shall maintain records on each client. The specific record for each client must include at least the following information:

a. Name, address, phone number and other identifying information about the client.

b. Name, address and phone number of the discharge planner, case manager and case management agency.

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

d. Special health needs or conditions of the recipient.

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

f. Documentation of the services provided, including where, when, to whom and by whom the service was provided, and the exact nature of the specific tasks performed as well as the amount or units of service.

g. Documentation of supervision of care.

h. All information regarding a client must be kept together for easy access and review by supervisors, program monitors and auditors.

i. If a resident receives compensation from the facility it shall be done in accordance with 10-CCR 2505-10 §8.495.82.

12. Provider agencies shall maintain a personnel record for each employee. The employee record must contain a copy of the employee's job description, documentation of employee training, education, certification or licensure and work experience which qualifies them to provide the requisite service to people with brain injury, and documentation of supervision and performance evaluation.

13. Personnel records for each employee or volunteer must include name, age, sex, home address and phone number, and results of TB testing for any employee or volunteer providing direct care to Supported Living or Transitional Living residents or involved in meal preparation or food handling.

14. A provider agency may become separately certified to provide more than one type of HCBS-BI service if all requirements are met for each certification. Administration of the different services provided shall be clearly separate for auditing purposes. The provider agency must also understand and be able to articulate its different functions and roles as a provider of each service, as well as all the rules that separately govern each of the types of services, in order to avoid confusion on the part of the clients and others.

15. Provider agencies shall send billing and other staff to the provider automated medical payment training offered by the fiscal agent, at least once each year.

16. An agency as defined in 8.515.14 A. GENERAL DEFINITIONS seeking certification as an HCBS-BI provider, shall submit a request to the Department of Health Care Policy and Financing or its agent.

17. Upon receipt of the request the Department or its agent shall forward certification information and relevant departmental application forms to the requesting agency.

18. Upon receipt of the completed application from the requesting agency, the Department of Health Care Policy and Financing or its agent shall review the information and complete an on-site review of the agency, based on the departmental regulations for the service for which certification has been requested.

19. If a provider holds a current Commission on the Accreditation of Rehabilitation Facilities (CARF) accreditation for a specific program, the Department or its agent may consider that to satisfy a portion of the certification requirements as a Supported Living program provider. CARF re-accreditation shall occur annually or as required by CARF.

20. care or assisted living facilities and life safety, fire and building codes. All inclusions at 8.495.20 apply to Supported Living providers. Refer to Alternative Care

Facilities regulations at 10 CCR 2505-10 §8.495.54-.57 and 8.495.72.L, 8.495.116 & .117, 8.495.130, .140, .180 and .191.

21. Following completion of the on-site review the Department or its agent shall notify the provider agency applicant of its recommendation by forwarding the results of the on site survey and its recommendation of approval, denial, or provisional approval of certification and if appropriate, request a corrective action plan to satisfy the requirements of a provisional approval

22. Determination of certification approval, provisional approval or denial shall be made by the Department within thirty days of receipt of the completed application from the agency or from the completion of the survey.

B. APPROVAL OF CERTIFICATION

If certification is approved, the agency shall initiate an agreement with the state's fiscal agent to implement the automated medical payment system (AMPS) and execute a provider agreement with the Department of Health Care Policy and Financing.

C. If a Supportive Living provider holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for a specific program, the Department may deem certification for that program. CARF re-accreditation shall occur yearly.

D. PROVISIONAL APPROVAL OF CERTIFICATION

If agencies do not meet all Department established certification standards, but the deficiencies do not constitute a threat to client's health and safety, such agencies may be provisionally certified for a period not to exceed sixty days at the discretion of the Department.

If provisional approval has been granted, the Department or its agent shall assure that corrective action has been taken according to the approved plan, and shall conduct an on-site review, if necessary, within the designated time period.

E. DENIAL OF CERTIFICATION

If the agency is unable to complete an adequate corrective action plan within the prescribed time, certification shall be denied.

F. RECERTIFICATION PROCESS

Initial certification shall be for a period of one year. No later than thirty days prior to the end of the current certification, the department shall notify the provider agency of the certification decision, which may be certification, provisional certification, or denial of certification. The Department or its agent shall follow the same procedures as those followed for certification, as described at 8.487.20 GENERAL CERTIFICATION.

G. TERMINATION OR NON-RENEWAL OF PROVIDER AGREEMENTS

The Department shall initiate termination or non-renewal of a provider agreement if an agency 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 Department shall follow procedures at 8.130, PROVIDER AGREEMENTS.

H. EMERGENCY TERMINATION OF PROVIDER AGREEMENTS

Emergency termination of any provider agreement shall be in accordance with procedures at 8.050 PROVIDER APPEALS AND HEARINGS.

I. TRANSFER OF OWNERSHIP

The provider shall notify the department or its agent within five working days of any change of ownership. Upon transfer of ownership of the provider agency or facility, the new provider must initiate a new agreement with the Department.

J. PROVIDER RIGHTS

The Department shall notify provider agencies in writing of any adverse action taken by the State against the agency, and shall inform the agency of its appeal rights in accordance with the procedures described in Section 8.050.

K. PROVIDER REIMBURSEMENT

1. Payment to certified HCBS-BI providers for services provided to eligible clients shall be made when claims are submitted in accordance with the following procedures.

a. Claims shall be submitted to the fiscal agent on Department prescribed formats through the automated medical payment system if available.

b. Claims shall be submitted in complete and correct format.

c. Payment shall not exceed departmental limits as described under the reimbursement sections for each HCBS-BI service.

d. Payment shall be made only for the service or services for which the agency is certified;

e. Payment shall be made only for the types and amounts of services that are authorized.

f. Payment shall be made only for services provided by persons employed by the agency at the time the services were provided.

g. For services of transitional living, behavioral programming, nonmedical transportation, assistive and special equipment, and environmental modifications, prior authorization is required, and reimbursement will be made only if the prior authorization process has been followed.

2. Provider agencies shall maintain adequate financial records for all claims, including documentation of services as specified at Section 8.040.02, RULES GOVERNING SUBMISSION OF CLAIMS, Section 8.130, PROVIDER AGREEMENTS, and Section 8.487.10 GENERAL CERTIFICATION STANDARDS.

3. Supportive Living services shall be a per diem reimbursement negotiated with the Department that follows a tiered rate methodology. The methodology shall be based on the provider's mix of client functional acuity scores and the services received. Supportive Living providers shall submit functional acuity scores to the Department twice per year on December 1 and June 1. The providers shall utilize the Department approved functional acuity tool for each HCBS-BI client.

8.515.60 PERSONAL CARE SERVICES

A. DEFINITION

Personal care services means services which are furnished to an eligible client in the client's home to meet the client's physical maintenance and support needs, when those services are not skilled personal care as described in the exclusions section below, do not require the supervision of a nurse, and do not require physician's orders. Assistance may include eating, bathing, dressing, personal hygiene, and activities of daily living.

1. Personal care provider means a provider agency as defined at Section 8.485.50(Q), GENERAL DEFINITIONS, which has met all the certification standards for personal care provider listed below.

2. Personal care staff means those employees of the personal care provider agency who perform the personal care tasks.

3. Skilled personal care means skilled care which may only be provided by a certified home health aide, as further defined at Section 8.520, HOME HEALTH SERVICES.

4. Unskilled personal care means personal care which is not skilled personal care, as defined above.

B. INCLUSIONS

All inclusions listed in Section 8.489 apply.

C. EXCLUSIONS AND RESTRICTIONS

All exclusions and restrictions listed in Section 8.489 apply.

D. CERTIFICATION STANDARDS

All certification standards for personal care services listed in Section 8.489 apply to the HCBS-BI waiver program providers.

E. REIMBURSEMENT

1. Payment for personal care services shall be the lower of the billed charges or the maximum rate of reimbursement. Total daily charges for personal care can not exceed the sum of ten hours of care. Reimbursement shall be per unit of one hour.

2. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as personal care services. The time billed for travel shall be listed separately from, but documented on the same form as, the

time for service provision on each visit Travel time must be summed for the week and then rounded to the nearest hour for billing purposes. If the travel time to and from a client's residence is 15 minutes one way-30 minutes round trip, then the travel time for one week shall be 210 minutes (rounded up to 4 hours) for the week.

3. When personal care services are used to provide respite for unpaid primary care givers, the exact services rendered must be specified in the documentation.

4. When an employee of a personal care agency provides services to a client who is a relative, the personal care agency shall bill under a special procedure code, in hourly units, using rates and hours which shall not exceed a maximum of 222 units per 6 month certification, when averaged out over the number of days in the 6 month plan period or 444 units per 12 month certification.

5. If a visit by a Home Health Aide employed by a Home Health Agency includes unskilled personal care, as defined in this section, only the Home Health Aide visit shall be billed.

8.515.90 RESPITE CARE

A. DEFINITIONS

Respite Care means an organized program whose purpose is to sustain the family or other primary caregiver of persons with brain injury by providing those individuals with time-limited and temporary relief from the ongoing responsibility of care. Services may be provided on a scheduled basis or in response to a crisis or emergency.

Respite care providers are trained personnel in a variety of settings including skilled nursing facilities, hospitals, drop in resource centers, and certified respite providers or any other facility which meets the certification standards for respite care specified below.

B. INCLUSION

Families will be eligible for unlimited days of respite care per year.

C. EXCLUSION

If the waiver participant is in a transitional living residence, Supported Living Care facility or out-of-home placement, no respite care services will be provided while the waiver recipient is in the transitional living program.

D. POLICIES

1. The information provided at referral and the medical, social, psychological and other information available should vary according to the circumstances for which respite is being sought, including the extent of the crisis or emergency present in the referral and the duration and scope of the Respite Program.

2. The design and schedule of the respite services is variable and should be based upon the needs and convenience of both the person with brain injury and his/her family or primary caregiver, whenever possible.

3. The program should minimize the disruption in the continuity of living patterns which may be created by the respite services.

E. CERTIFICATION STANDARDS

1. The nursing facility must have a valid contract with the Department as a Medicaid certified nursing facility. Such contract shall constitute an automatic certification for HCBS-BI respite care. A respite care provider billing number shall be issued to all certified nursing faculties.

OR

Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services must meet the same

competency standards as all other providers and be employed by the certified provider agency.

2. The respite program shall have or be part of a risk protection program that includes appropriate insurance, screening of personnel, ongoing training of personnel to enhance skills, and supervision.

3. If 24-hour respite services are provided by the organization at its own location, the living quarters should be homelike, age appropriate, and culturally sensitive and in compliance with all Assisted Living Residence regulations.

F. REIMBURSEMENT

1. Respite care reimbursement to nursing facilities shall be according to procedures identified in 8.492.50.

2. Nursing facilities shall agree to accept Medicaid reimbursement as full and final payment for respite services and are not allowed to solicit personal needs allowance monies from the client or his/her family.

3. Individual respite, providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

8.516.00 ENVIRONMENTAL MODIFICATION

A. DEFINITIONS

1. Environmental modification means specific adaptations or installations in an eligible client's home setting which:

a. Are necessary to ensure the health, welfare, and safety of the individual;

b. Enable the individual to function with greater independence in the home;

c. Are required because of the individual's illness, impairment or disability, as documented on the screening assessment and care plan form; and

d. Prevent institutionalization of the individual.

2. Environmental modification provider means a provider agency as defined at Section 8.515.14 0 GENERAL DEFINITIONS which has met all the certification standards for environmental modification services listed in Section 8.493.40 et seq. CERTIFICATION SERVICES FOR HOME MODIFICATIONS SERVICES.

B. INCLUSIONS

Such adaptations may include:

- the installation of ramps

- installation of grab-bars

- widening of doorways

- modification of bathroom facilities

- installation of specialized electric and plumbing systems which are necessary to accommodate the medical equipment and supplies necessary for the welfare of the recipient.

C. EXCLUSIONS AND RESTRICTIONS

1. Adaptations or improvements to the home which are not of direct medical or remedial benefit to the HCBS-BI program client, such as carpeting, roof repair, central air conditioning, furnace replacement, etc. shall not be approved.

2. If the home modification is estimated to cost $500 or more, the following procedures shall be followed:

a. An occupational therapist shall assess the client's needs and the effectiveness of the requested home modification and submit a written recommendation. In geographical areas where an occupational therapist is not available, the services of a physical therapist may be substituted. A report specifying how the home modifications would contribute to the person's ability to remain in or to return to his/her home, and how the modification would increase the individual's independence and decrease the need for other services such as personal care, must be completed by the therapist on a Department prescribed form and submitted with a PAR to the Brain injury Program Coordinator.

b. In conjunction with the occupational therapist, the case manager shall first consider less costly alternative methods of addressing the client's needs and shall send documentation of the activity with the Prior Authorization Review.

c. The case manager shall first consider alternative funding sources such as. but not limited to. Worker's Compensation Insurance, private automobile insurance. Medicare, vocational rehabilitation funds and funds raised or provided by volunteer organizations; and shall send documentation of this activity with the PAR.

d. The case manager shall follow a bid process as specified in 8.493.30, D.

e. The Department or its agent may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the request for environmental modification.

f. The Department reserves the right to deny requests for environmental modification that are not reasonable in cost, when compared to usual and customary charges.

g. There shall be a lifetime cap of $10,000 per household on any HCBS Medicaid funds approved for environmental modification services.

D. CERTIFICATION STANDARDS FOR ENVIRONMENTAL MODIFICATIONS

1. Environmental Modification providers shall conform to all general certification standards and procedures at 8.487. HCBS-EBD Provider agencies.

2. Environmental modification providers shall be licensed in the city or county in which they propose to provide environmental modification services.

3. All environmental modifications shall be provided in accordance with the Uniform Building Code as adopted by the State of Colorado and all local building codes.

4. All environmental modifications shall be inspected and approved by a qualified individual such as:

- A local county building inspector or

- A licensed engineer, architect, contractor or any other person as agreed upon by the State.

- In addition, copies of building permits and inspection reports shall be submitted to the case management agency, and all problems noted on inspections shall be corrected before the provider submits a claim for the environmental modification.

E. REIMBURSEMENT METHOD FOR ENVIRONMENTAL MODIFICATION SERVICES

Payment of environmental modification services shall be the lower of the billed charges or the prior authorized amount. The unit of reimbursement shall be one unit per service rendered. The date of service is considered to be the day of completion of me modification

8.516.20 NON-MEDICAL TRANSPORTATION

A. DEFINITIONS

1. Non-medical transportation services means services as defined in 8.494.10.

2. Non-medical transportation provider means providers as defined in 8.494.10.

B. INCLUSIONS

Non-medical transportation services shall include, hut not be limited to transportation between the client's home and non-medical services or resources such as adult day care, shopping, therapeutic swimming, dentist appointments, counseling sessions, and other services as required by the care plan to prevent institutionalization.

C. EXCLUSIONS

1. Non medical transportation services shall not he used to substitute for medical transportation which is subject to reimbursement under Section 8.680 through 8.691. OTHER HEALTH SERVICES-TRANSPORTATION.

2. Non medical transportation services shall only he used after the case manager has determined that free transportation is not available to the client.

D. CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES

Transportation providers shall conform to all standards listed in 8.494.40 CERTIFICATION STANDARDS FOR TRANSPORTATION SERVICES.