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Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Hospice Services Benefit Coverage Standard Incorporation by Reference, Section 8.550.4.C
Rule Number:	MSB 13-03-12-H
Division / Contact / Phone:	Medicaid Programs & Services / Kimberly Smith / 3038664538

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 13-03-12-H, Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Hospice Services Benefit Coverage Standard Incorporation by Reference, Section 8.550.4.C
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 8.550.4.C, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Replace current text at §8.550.4.C with the new text provided and renumber the current text at §8.550.4.C to §8.550.4.D. All text indicated in blue is for reference and clarification only. This change is effective 10/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Hospice Services Benefit Coverage Standard Incorporation by Reference, Section 8.550.4.C
Rule Number:	MSB 13-03-12-H
Division / Contact / Phone:	Medicaid Programs & Services / Kimberly Smith / 3038664538

STATEMENT OF BASIS AND PURPOSE

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

The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Hospice Services into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations.

The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers.

Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.

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:

Initial Review	**08/09/2013**	Final Adoption	**09/13/2013**
Proposed Effective Date	**10/30/2013**	Emergency Adoption	

DOCUMENT #01

42 CFR § 431.10

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2012);
§ 24-4-103, C.R.S. (2012); § 25.5-5-102(2), C.R.S. (2012); 10 C.C.R. 2505-10 §§ 8.010, 8.550.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning Hospice Services Benefit Coverage Standard Incorporation by Reference, Section 8.550.4.C
Rule Number:	MSB 13-03-12-H
Division / Contact / Phone:	Medicaid Programs & Services / Kimberly Smith / 3038664538

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.

   This rule will impact the providers of Hospice services as defined in the Hospice Services Benefit Coverage Standard.

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

   By clearly defining clinical criteria in the Hospice Services Benefit Coverage Standard and then incorporating it by reference into rule, the Department hopes to achieve its goal to reduce inappropriate utilization and variations in care. Additionally, having clearly defined clinical criteria will allow the Department to have defensible policies when defending appeals. We hope that clearly defined and enforceable criteria will reduce the number of Department decisions overturned in appeals, and the general appeal volume.

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

   This rule does not have any costs to the Department or any other agency as a result of its implementation and enforcement.

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

   Enforceable policy statements will help the Department recover improper payments for inappropriate services rendered, uphold decisions based upon evidence-based criteria, and reduce the volume of appeals. By being able to enforce evidence-based criteria, this rule may generate cost-savings as inappropriate utilization and appeal volumes are reduced.

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

   Incorporation by reference is the least burdensome method for achieving the purpose of codifying the Department's benefit policy statements.

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

   The Department considered the traditional approach of defining the amount, duration, and scope of covered services within their Administrative Code. This approach involves the most detail found in the Administrative Code, requires that providers refer to rule text for information on the Department's covered services, and contributes to lengthy rules. In favor of simplicity, a more streamlined rule making process, and ease of accessibility the Department chose to employ the incorporation by reference method.

8.550.4.C Hospice Services Benefit Coverage Standard

All eligible providers of hospice services enrolled in the Colorado Medicaid program shall be in compliance with the Colorado Medicaid Hospice Services Benefit Coverage Standard (approved May 30, 2012), which is hereby incorporated by reference. The incorporation of the Hospice Services Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.550.4.D~~C~~. Services not covered as part of the hospice benefit include, but are not limited to:

1. Services provided before or after the Hospice Election period.
2. Services of the client's attending or consulting physician that are unrelated to the terminal condition which are not waived under the Hospice benefit.
3. Services or medications received for the treatment of an illness or injury not related to the client's terminal condition.
4. Services which are not otherwise included in the Hospice benefit, such as electronic monitoring, non-medical transportation, and home modification under a Home and Community-Based Services (HCBS) program.
5. Personal care and homemaker services beyond the scope provided under Hospice which are contiguous with a home health aide visit.

8.550.5 ELIGIBILITY

THIS PAGE 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 13-03-12-K, Revision to the Medical Assistance Physician Services Rule Concerning Speech -- Language and Hearing Services Benefit Coverage Standard Incorporation by Reference, Section 8.200.3.D.2
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 8.200.3.C, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). <Select One>

PUBLICATION INSTRUCTIONS*

Insert new text at §8.200.3.D.2 immediately following current text at §8.200.3.C.1 plus two unnumbered paragraphs. New text consists of §8.200.3.D.2 plus two unnumbered paragraphs. All text indicated in blue are for reference and clarification only and should not be changed. This change is effective 10/30/2013.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Physician Services Rule Concerning Speech -- Language and Hearing Services Benefit Coverage Standard Incorporation by Reference, Section 8.200.3.D.2
Rule Number:	MSB 13-03-12-K
Division / Contact / Phone:	Medicaid Programs & Services / Kimberly Smith / 3038664538

STATEMENT OF BASIS AND PURPOSE

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

The purpose of this rule is to incorporate by reference the Benefit Coverage Standard for Speech -- Language and Hearing Services into the Medical Assistance Health Program Rule. Incorporating the standard by reference gives the standard the full force of law as though the actual standard were published in the Colorado Code of Regulations.

The underlying standard was created through the Benefits Collaborative project. The goal of the project is to ensure appropriate benefit utilization while maintaining statewide equity and consistency in the delivery of services. This is accomplished by clearly defining sufficiency, amount, duration and scope of the benefits. Clearly-defined coverage standards will provide assurance for persons receiving benefits that services meet established criteria and will provide better guidance for service providers.

Additionally the standards will assure that public funds are more responsibly allocated and will reduce the administrative burden on the Department. To achieve that goal, this project has placed a high emphasis on using evidence-based criteria, which is more reliable, in defining coverage standards for available benefits. Well-defined criteria will reduce confusion and unnecessary adversarial situations among those receiving benefits, service providers and the Department. Lastly, clearly-defined benefits will simplify the appeal process for all participants.

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:

Initial Review	**08/09/2013**	Final Adoption	**09/13/2013**
Proposed Effective Date	**10/30/2013**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

42 CFR § 431.10

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2012);
§ 24-4-103, C.R.S. (2012); § 25.5-5-102(2), C.R.S. (2012); 10 C.C.R. 2505-10 § 8.010.

Initial Review	**08/09/2013**	Final Adoption	**09/13/2013**
Proposed Effective Date	**10/30/2013**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Physician Services Rule Concerning Speech -- Language and Hearing Services Benefit Coverage Standard Incorporation by Reference, Section 8.200.3.D.2
Rule Number:	MSB 13-03-12-K
Division / Contact / Phone:	Medicaid Programs & Services / Kimberly Smith / 3038664538

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.

   This rule will impact the providers of speech -- language and hearing services as defined in the Speech -- Language and Hearing Services Benefit Coverage Standard.

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

   By clearly defining clinical criteria in the Speech -- Language and Hearing Services Benefit Coverage Standard and then incorporating it by reference into rule, the Department hopes to achieve its goal to reduce inappropriate utilization and variations in care. Additionally, having clearly defined clinical criteria will allow the Department to have defensible policies when defending appeals. We hope that clearly defined and enforceable criteria will reduce the number of Department decisions overturned in appeals, and the general appeal volume.

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

   This rule does not have any costs to the Department or any other agency as a result of its implementation and enforcement.

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

   Enforceable policy statements will help the Department recover improper payments for inappropriate services rendered, uphold decisions based upon evidence-based criteria, and reduce the volume of appeals. By being able to enforce evidence-based criteria, this rule may generate cost-savings as inappropriate utilization and appeal volumes are reduced.

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

   Incorporation by reference is the least burdensome method for achieving the purpose of codifying the Department's benefit policy statements.

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

   The Department considered the traditional approach of defining the amount, duration, and scope of covered services within their Administrative Code. This approach involves the most detail found in the Administrative Code, requires that providers refer to rule text for information on the Department's covered services, and contributes to lengthy rules. In favor of simplicity, a more streamlined rule making process, and ease of accessibility the Department chose to employ the incorporation by reference method.

8.200.3.C Services and goods generally excluded from coverage are identified in 10 C.C.R. 2505-10, Section 8.011.11.

8.200.3.D Physician Services Benefit Coverage Standards

1. Podiatry Services Benefit Coverage Standard

All eligible providers of podiatry services enrolled in the Colorado Medicaid program shall be in compliance with the Colorado Medicaid Podiatry Services Benefit Coverage Standard (approved May 1, 2012), which is hereby incorporated by reference. The incorporation of the Podiatry Services Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

2. Speech – Language and Hearing Services Benefit Coverage Standard

All eligible providers of speech language and hearing services enrolled in the Colorado Medicaid program shall be in compliance with the Colorado Medicaid Speech – Language and Hearing Services Benefit Coverage Standard (approved June 17, 2012), which is hereby incorporated by reference. The incorporation of the Speech – Language and Hearing Services Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

The Benefit Coverage Standard is available from Colorado Medicaid's Benefits Collaborative Web site at Colorado.gov/hcpf. Click "Boards & Committees," and click "Benefits Collaborative," and click "Approved Benefit Coverage Standards." Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

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THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Children with Autism Waiver, Sections 8.519.1, 8.519.5 and 8.519.7
Rule Number:	MSB 13-04-26-B
Division / Contact / Phone:	Long Term Services and Supports, Waiver Operations Unit / Candace Bailey / 3877

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 13-04-26-B, Revision to the Medical Assistance Rule Concerning Home and Community Based Services Children with Autism Waiver, Section 8.519.5 and 8.519.7
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.519.5, 8.519.7, 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 §8.519.1 Definitions, insert two new unnumbered paragraphs with the definitions that begin "Plan of Correction (POC) . . ." and "Prior Authorization Request (PAR). . . "immediately following unnumbered paragraph with the definition that begins "Lone Staff means . . ."
Insert new unnumbered paragraph with the definition that begins "Standardized, Norm-Referenced Assessment means . . ." immediately following unnumbered paragraph with the definition that begins "Senior Therapist means . . ."
Delete current unnumbered paragraphs with definitions that begin "Plan of Correction (POC) . . ." and "Prior Authorization Request (PAR). . . "
At §8.519.5 Wait List, replace current text at §8.519.5.D through 8.519.5.E with new text provided and insert new text at 8.519.5.E. 1 and 2.
At §8.519.7 Provider Responsibilities, insert new text at §8.519.9.7.B.3.v.5 and renumber the current following paragraphs 5 – 7 to 6 – 8. Insert new text at §8.519.9.7.B.4 through §8.519.9.7.B.4.b.
All text indicated in blue is for reference and clarification only and should not be changed. This change is effective 10/30/2013.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Children with Autism Waiver, Sections 8.519.1, 8.519.5 and 8.519.7
Rule Number:	MSB 13-04-26-B
Division / Contact / Phone:	Long Term Services and Supports, Waiver Operations Unit / Candace Bailey / 3877

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule amends the regulations for the Home and Community Based Services Children with Autism Waiver (HCBS-CWA) Definitions 10 CCR 2505-10 8.519.1, Waitlist 10 CCR 2505-10 8.519.5, and Provider Responsibilities 10 CCR 2505-10 8.519.7. The proposed changes will bring the Department and the waiver into compliance with state statue 25-5-6-804, et. Seq. CRS (2012). The proposed rule will allow the Department to prioritize the waitlist based on an objective norm-referenced assessment of the child's adaptive functioning. The proposed rule will also amend provider responsibilities to include the provider will conduct or obtain an objective norm-referenced assessment when the child enters the waiver and every six months the child is on the waiver, as well as upon exit of the waiver. This will allow the provider a chance to compare the assessments and make appropriate adjustments to the plan of care as needed. The providers must also provide the assessment results to the parent or guardian and case manager. The definition section was updated to include a definition of Standardized, norm-referenced assessment.

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 C.F.R. Section 441-300-441.310

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   25.5-6-804 et.seq. CRS (2012)

Initial Review	**08/09/2013**	Final Adoption	**09/13/2013**
Proposed Effective Date	**10/30/2013**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Children with Autism Waiver, Sections 8.519.1, 8.519.5 and 8.519.7
Rule Number:	MSB 13-04-26-B
Division / Contact / Phone:	Long Term Services and Supports, Waiver Operations Unit / Candace Bailey / 3877

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.

   Children with Autism will be affected by the proposed rule. Those children with more severe needs and greater disability will benefit from this rule change as they will be prioritized on the waitlist and may not wait as long for waiver services. As these children may be able to be offered waiver services sooner, they may also be able to receive services longer and ultimately show greater improvement in adaptive behaviors. There will be no increased cost as this waiver is capped at 75 participants with a limit of $25,000 in services per participant per year.

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 affected children may be able to receive waiver services sooner and therefore longer. This may result in overall greater improvement for the child.

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 anticipated costs to making this amendment to the rule as participation is capped at 75 clients and each client has a service limit. These caps and limits are not changing.

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

   There would be no fiscal impact with inaction. The Department would however be out of compliance with state statue.

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.

8.519 HOME AND COMMUNITY BASED SERVICES FOR CHILDREN WITH AUTISM WAIVER

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8.519.1 DEFINITIONS

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

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

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

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

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

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

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

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

Department means the Department of Health Care Policy and Finacing.

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

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

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

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

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

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

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

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

Standardized, Norm-Referenced Assessment means the most current version of an assessment tool that measures a child's adaptive functioning, including but not limited to self-help skills, expressive and receptive communication, and adaptive and maladaptive behaviors. Examples of appropriate assessment tools include but are not limited to: the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), Scales of Independent Behavior, Revised (SIB-R), and Adaptive Behavior Assessment System, Second Edition (ABAS-II).

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

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

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

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

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

8.519.5 WAIT LIST

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

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

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

8.519.5.D. The Case Manager shall ~~notify the Department by entering~~enter the client's Assessment and Professional Medical Information Page data in the BUS and notify the Department by sending the client's enrollment information, utilizing the Department's approved form, to the Program Administrator~~.~~

8.519.5.E. The score received from a standardized, norm-referenced assessment~~The date and time of the ULTC Instrument, as entered in the BUS~~, shall be used to establish the order of an applicant's place on the wait list after November 1, ~~,~~2013.

1. The case manager will confirm that the assessment score submitted by a client is from a standardized norm-referenced assessment tool.

2. If two clients have the same score, the date and time of the completed ULTC Instrument, as entered in the BUS, shall be used to establish the clients' order on the wait list.

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

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

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

3. Reassess for the target population criteria.

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

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8.519.7 PROVIDER RESPONSIBLITIES

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

1. Recruiting, selecting, retaining and terminating employees.

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

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

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

8.519.7.B. CWA Providers shall:

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

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

3. Ensure that adequate records are maintained.

   a. Client records shall contain:

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

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

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

      iv. Special health needs or conditions of the client.

      v. Documentation of the specific services provided which includes:

         1. Name of the individual provider.

         2. The location for the delivery of services.

         3. Units of service.

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

5. All Standardized norm-referenced assessments completed or obtained

6~~5~~. Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.

7~~6~~. Documentation regarding supervision of benefits.

8~~7~~. Financial records for all claims, including documentation of services as set forth at 10 C.C. R. 2505-10, Section 8.040.02.

b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide behavioral therapies.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

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

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

4. Conduct or obtain a recent norm-referenced assessment (no more than 30 days old) of each client upon entering the program, every six months while on the program, and upon exit of the program.

a. The provider shall provide a copy of the assessment results of each completed assessment to the case manager and the parents or guardian of the child.

b. The provider shall review the results of each assessment completed for a child and make necessary adjustments to the child's intervention plan accordingly.

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