THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Pediatric Hospice Waiver, Section 8.504
Rule Number:	MSB 14-02-26-A
Division / Contact / Phone:	LTSS / Candace Bailey / 303-866-3877

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 14-02-26-A, Revision to the Medical Assistance Rule Concerning Home and Community Based Services Pediatric Hospice Waiver, Section 8.504
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) 8.504, 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*

Replace current text beginning at §8.504 through the end of §8.504.8.A.2 with the new text provided. This revision is effective 06/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Pediatric Hospice Waiver, Section 8.504
Rule Number:	MSB 14-02-26-A
Division / Contact / Phone:	LTSS / Candace Bailey / 303-866-3877

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 for Children with Life Limiting Illness Waiver (HCBS-CLLI) 10 CCR 2505-10 8.504. The HCBS-CLLI (formally HCBS-PHW) was audited by the legislative audit committee. The audit found the waiver was not following the original intentions of the legislation. In order to comply with audit findings and recommendations the program rules need to be revised.

The current HCBS-CLLI rules do not clearly define the services or provider qualifications. CLLI services have been redefined and changed and provider qualifications have been updated in the waiver. Updated rules are needed to implement these changes.

The HCBS-CLLI (Children with Life Limiting Illness) program name was recently changed from HCBS-PHW (Pediatric Hospice Waiver) to HCBS-CLLI. The rule revision will also provide an opportunity to update the program name.

2. An emergency rule-making is imperatively necessary

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

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

Explain:

3. Federal authority for the Rule, if any:

42 U.S.C § 139n
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. (2013);
25.5-5-305 et.Seq. CRS (2012)

Initial Review	**04/11/2014**	Final Adoption	**05/09/2014**
Proposed Effective Date	**06/30/2014**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Home and Community Based Services Pediatric Hospice Waiver, Section 8.504
Rule Number:	MSB 14-02-26-A
Division / Contact / Phone:	LTSS / Candace Bailey / 303-866-3877

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 life limiting illnesses will be affected by the proposed rule. Clarifying the service definitions and updating the provider qualifications will provide these children better access to the services. As access and therefore utilization increases the Department will see an increase in waiver expenditures. The Department and Centers for Medicare and Medicaid (CMS) are responsible for the costs of the waiver. The Department expects the expenditures to increase to original forecasted amounts when the waiver was implemented in 2007.

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 are expected to receive more services that will better assist them and their families in this difficult time in their lives. The increase in services may result in an overall improvement in the quality of life for these children.

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.

   Waiver expenditures are expected to increase as a result of the implementation. This will be an increase in overall costs for the Department and CMS. The Department has appropriately forecasted and budgeted for the increase in cost.

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

   Currently the waiver is operated at a very low cost. This is due to the low utilization and access to services. Providing appropriate care and services to this fragile population will benefit not only the families involved in their care, but could result in fewer hospitalizations as well.

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.

8.504 HOME AND COMMUNITY BASED SERVICES ~~PEDIATRIC HOSPICE~~ for CHILDREN WITH LIFE LIMITING ILLNESSWAIVER [Eff. 12/30/2007]

8.504.1 DEFINITIONS

Assessment means a comprehensive ~~face-to-face evaluation using the ULTC 100.2 conducted by the case manager with the client, family and appropriate collaterals, with supporting diagnostic information from the individual's medical professional(s), to determine the applicant's level of functioning, service needs, available resources, and potential funding sources.~~and uniform process using the Uniform Long Term Care (ULTC) Instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, including Activities of Daily Living (ADL) 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.

Bereavement Counseling means counseling provided to the client and/or family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the client and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies~~. Bereavement counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.~~

Case Management means the a~~A~~ssessment of the client's needs, the development and implementation of the Service Plan, coordination and monitoring of service delivery, the evaluation of service effectiveness and periodic reassessment of the client's needs.

~~Client/Family/Caregiver Counseling~~Therapeutic Life Limiting Illness Support ~~means grief/loss or anticipatory grief counseling and bereavement counseling that assist the client, family or caregiver to decrease emotional suffering due to the client's health status, to decrease feelings of isolation or to cope with the client's life-limiting diagnosis. Support is intended to help the child and family in the disease process. Support is provided to the client to decrease emotional suffering due to health status and develop coping skills. Support is provided to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending death of a child. Support is provided to the client and/or family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Support will include but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, andand connecting the family with community resources such as funding or transportation.~~

Continued Stay Review (CSR) means a reassessment by the Single Entry Point case manager to determine the client's continued eligibility and functional level of care.

~~Continuous Nursing means line of sight, face-to-face skilled nursing that is more individualized and continuous, as opposed to visits or intermittent nursing care that is available under the State Plan home health benefit or is routinely provided in a hospital or nursing facility as described at 10 CCR 25050-10 Section 8.540.~~

Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital.

Curative Care means medical care or active treatment of a medical condition seeking to affect a cure.

Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the client to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

Intake/Screening/Referral means the SEP's initial contact with the ~~individual~~ applicant and shall include, but not be limited to, a determination of the need for a comprehensive client Assessment, referral to other waivers or services and long term care services.

Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probably before the child reaches adulthood at age 19.

Massage Therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.

~~Palliative/Supportive Care means hospice-like care provided to manage, control, and alleviate symptoms such as pain, nausea, discomfort and anxiety related to a life-limiting diagnosis that may be provided at the same time as curative treatments.~~Palliative/Supportive Care ~~Program means~~ is a specific program offered by a licensed health care facility or provider that is specifically focused on the provision of organized palliative care services. For the purposes of this waiver this includes a Hospice or Home Care Agency. Palliative care is specialized medical care for people with life limiting illnesses. This type of care is focused on providing clients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the client and the family. Palliative care is appropriate at any age (18 and under for this waiver) and at any stage in a life limiting illness and can be provided together with curative treatment. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of this waiver, Palliative Care includes Care Coordination and Pain and Symptom Management.

a. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a seamless system of care. Care Coordination shall not duplicate the administrative activities (specifically utilization management; i.e. review and authorization of service requests, level of care determinations, and waiver enrollment) provided by the case manager at the Single Entry Point.

b. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the client's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

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

~~Personal Care means services needed to meet a client's physical requirements and functional needs when such services are provided by a personal care attendant and do not require the supervision of a nurse or physician, such as assistance with activities of daily living.~~

~~Private Duty Nursing means continuous nursing different in nature and scope from the private duty nursing services in the State Plan, and does not include a requirement for the client to be technology-dependent.~~

Respite Care means services provided to an eligible client who is unable to care for himself/herself on a short term basis because of the absence or the need for relief of those persons normally providing care. Respite Care is provided in the client's residence and may be provided by different levels of providers depending upon the needs of the client.

Service 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~~s~~, and the expected outcome or purpose of such services.

Therapeutic Life Limiting Illness Support means grief/loss or anticipatory grief counseling that assist the client and family to decrease emotional suffering due to the client's health status, to decrease feelings of isolation or to cope with the client's life-limiting diagnosis. Support is intended to help the child and family in the disease process. Support is provided to the client to decrease emotional suffering due to health status and develop coping skills. Support is provided to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending death of a child. Support is provided to the client and/or family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Support will include but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the family with community resources such as funding or transportation.

Uniform Long Term Care ~~100.2 Form~~ (ULTC ~~100.2~~) Instrument means the ~~tool used to assess the functional needs of an applicant.~~Department prescribed form used to determine Functional Eligibility and medical verification for long term care services

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

8.504.2 BENEFITS

8.504.2.A. Home and Community Based Services under the ~~Pediatric Hospice~~Children with Life Limiting Illness Waiver (HCBS-~~PHW~~CLLI) benefits shall be provided within Cost Containment.

~~8.504.2.B. Benefits shall be available to eligible clients from the date of diagnosis of a life-limiting illness or condition.~~

8.504.2.~~C~~B. ~~Client/Family/Caregiver Counseling~~Therapeutic Life Limiting Illness Support shall be provided in individual or group setting.

1. ~~Client/Family/Caregiver Counseling~~Therapeutic Life Limiting Illness Support shall only be a benefit if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

2. ~~Client/Family/Caregiver Counseling~~Therapeutic Life Limiting Illness Support shall be limited to the client's assessed need up to a maximum of 98 hours per annual certification period.~~98 hours per every 365 days based on the date the client entered the program.annual certification as determined by the ULTC Assessment.~~

~~3. Family/Caregiver Counseling shall be available to family members for bereavement counseling for up to one year following the death of the client.~~

8.504.2.C. Bereavement Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

1. Bereavement Counseling shall be limited to the client's assessed need and is only billable one time.~~can be billed one time only.~~

2. . Bereavement counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

8.504.2.D. Expressive therapy ~~includes, but is not limited to, book writing, painting, music therapy and scrapbook making.~~shall be provided in an individual or group setting.

1. Expressive therapy shall be limited to the client's assessed need up to a maximum of 39 hours per annual certification period.~~is limited to 39 hours per every 365 days based on the date the client entered the program.annual certification as determined by the ULTC Assessment.~~

8.504.2.E. Massage Therapy shall be provided in an individual setting.

1. Massage Therapy shall only be used for the treatment of conditions or symptoms related to the client's illness.

2. Massage Therapy shall be limited to the client's assessed need up to a maximum of 24 hours per annual certification period~~is limited to 24 hours per annual certification as determined by the ULTC Assessment.~~

8.504.2.~~E~~F. Respite Care shall be provided in the home of an eligible client on a short term basis, not to exceed 30 days per ~~every 365 days based on the date the client entered the program.~~annual certification as determined by the ULTC Assessment. Respite Care shall not be ~~duplicated on~~provided at the same ~~date~~ time ~~of service~~ as state plan Home Health or Palliative/Supportive Care services.

1. Respite Care services include any of the following in any combination necessary according to the Service Plan.

a. Skilled nursing.

b. Home health aide

c. Personal Care

~~d. Private duty nursing~~

8.504.2.G.~~F~~ Palliative/Supportive Care shall not require a ~~six~~ nine month terminal prognosis for the ~~client.~~client and includes:

1. ~~Palliative/Supportive Care includes, but is not limited to:~~Pain and Symptom Management; and

2. Care Coordination

~~a. Skilled nursing~~

~~b. Home health aide~~

~~c. Physical therapy~~

~~d. Occupational therapy~~

~~e. Speech/language pathology~~

~~f. Alternative therapies~~

~~g. Dietary/nutritional counseling or therapy~~

8.504.2.~~H~~G. HCBS-~~PHW~~ CLLI clients are eligible for all other Medicaid state plan benefits, including ~~Curative Care~~Hospice and Home Health.

8.504.3 NON-BENEFIT

8.504.3.A. Case Management shall not be a benefit of the HCBS-~~PHW~~ CLLI but shall be provided as an administrative activity through the SEP.

8.504.4 CLIENT ELIGIBILITY

8.504.4.A. An eligible client shall:

1. Be determined financially eligible.

2. Be at risk of institutionalization into a hospital as determined by the SEP case manager using the ULTC ~~100.2~~Instrument and physician's statement.

3. Meet the target population criteria as follows:

   a. Have a life-limiting diagnosis, as certified in writing by a physician,.

   b. Have not yet reached 19 years of age.

4. A client shall receive at least one HCBS-~~PHW~~ CLLI waiver benefit per month to maintain enrollment in the waiver.

5. A client who has not received at least one HCBS-~~PHW~~ CLLI waiver benefit during a month shall be discontinued from the waiver.

6. Case Management shall not satisfy the requirement to receive at least one benefit per month on the HCBS-~~PHW~~ CLLI waiver.

8.504.5 WAIT LIST

8.504.5.A. The number of clients who may be served through the waiver at any one time during a year shall be limited ~~to 200~~by the federally approved CLLI waiver document.

8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-~~PHW~~ CLLI waiver, who cannot be served within the ~~200 client limit~~capacity limits of the federally approved waiver, shall be eligible for placement on a wait list maintained by the Department.

8.504.5.C. The SEP case manager shall ensure the applicant meets all criteria as set forth in Section 8.504.4.A.1-3 prior to notifying the Department to place the applicant on the wait list.

8.504.5.D. The SEP case manager shall ~~notify the Department by entering the ULTC 100.2 Form~~enter the client's Assessment and Professional Medical Information Page data in the Benefits Utilization System (BUS) and notify the Department by sending the client's enrollment information utilizing the Department's approved form, to the program administrator.

8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish the order of an applicant's place on the wait list.

8.504.5.F. Within five working days of notification from the Department that an opening for the HCBS-~~PHW~~ CLLI waiver is available the SEP case manager shall:

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

2. Update the existing ULTC ~~100.2~~Instrument Form data if the date is less than six months old.

3. Reassess for the target population criteria.

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

8.504.6 PROVIDER ELIGIBILITY

8.504.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-~~PHW~~ CLLI waiver and enter into an agreement with the Department ~~as set forth in~~and must comply with the requirements of 10 CCR 2505-10, Section 8.130.

8.504.6.B. Licensure and required certification for providers shall be in ~~accordance~~ good standing with their specific specialty practice act and with current state licensure status and regulations.

8.504.6.C. ~~Expressive Therapy or Client/Family/Caregiver Counseling~~Individuals providing Therapeutic Life Limiting Illness Support and Bereavement ~~Providers~~ Counseling shall enroll individually with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

8.504.6.D. ~~Client/Family/Caregiver Counseling~~Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling ~~Providers~~ shall be one of the following:

1. Licensed Clinical Social Worker (LCSW)

2. Licensed Professional Counselor (LPC)

3. Licensed Social Worker (LSW)

4. Licensed Independent Social Worker (LISW)

5. Licensed Psychologist; or

6. Non-denominational Spiritual Counselor, if employed by a qualified Medicaid home health or hospice agency.

8.504.6.E. Expressive therapy providers shall ~~meet any of the requirements for Client/Family/Caregiver Counseling providers and shall have at least one year of experience in the provision of Art, Music or Play therapy to pediatric/adolescent clients.~~enroll individually with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

1. Expressive Therapy services utilizing art or play therapy services shall be provided by individuals who~~m~~ meet the requirements for Therapeutic Life Limiting Illness Support providers and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent clients.

2. Expressive Therapy services utilizing music therapy shall be provided by individuals who~~m~~ hold a Bachelor's, Master's or Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists, and have at least one year of experience in the provision of music therapy to pediatric/adolescent clients.

8.504.6.F. Massage Therapy providers shall have an approved registration and be in good standing with the Colorado Office of Massage Therapy Registration.

~~8.504.6.F. Nurses, home health aides, personal care providers, physical therapists, occupational therapists, and speech/language pathologists shall:~~

~~1. be employed by a qualified Medicaid personal care, home health or hospice provider agency pursuant to the rules for those provider types; and~~

~~2. shall meet the required license or certification standards in accordance with their specific specialty practice act and current state licensure status and regulations.~~

8.504.6.G. Palliative/Supportive Care ~~Providers~~ services shall be provided by individuals whom are~~shall be~~ employed by or working under a formal ~~affiliation agreement~~contract with a qualified Medicaid hospice or home health agency.

8.504.6.H. Respite ~~Providers~~ services shall be provided by individuals whom are~~shall be~~ employed by a qualified Medicaid home health, hospice or personal care agency.

8.504.7 PROVIDER RESPONSIBILITIES

8.504.7. A. HCBS-CLLI 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).

8.504.7.B. CLLI 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 SEP 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 individual provider.

2. The location for the delivery of services.

3. Units of service.

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

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

6. 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 rendered service including screening of employees in accordance with Section 8.130.35.

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 8.504.7.B.

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

4. Ensure all care provided is coordinated with any other services the client is receiving.

a. Documentation of communication with the client's SEP case manager.

b. Documentation of communication/coordination with additional providers.

8.504.87 PRIOR AUTHORIZATION REQUESTS

8.504.87.A. The SEP case manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-PHW CLLI waiver.

8.504.87.B. All units of service requested shall be listed on the Service Plan form.

8.504.87.C. The first date for which services can be authorized shall be the later of any of the followingis the latest date of the following:

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

2. The assigned start date on the certification page of the ULTC 100.2Instrument Form.

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

8.504.87.D. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the UTLC 100.2 FormInstrument.

8.504.87.E. The SEP case manager shall submit a revised PAR if a change in the Service Plan results in a change in services.

8.504.87.F. The revised Service Plan shall list the service being changed and state the reason for the change. Services on the Revised Service Plan, plus all services on the original Service Plan, shall be entered on the revised PAR.

8.504.87.G. Revisions to the Service Plan requested by providers after the end date on a PAR shall be disapproved.

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

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

8.504.98 REIMBURSEMENT

8.504.98.A. Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee scheduled as determined by the Department.

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 14-02-25-F, Revision to the Medical Assistance Home and Community-Based Services Rule Concerning Persons with Spinal Cord Injury (HCBS-SCI). Rule 10 C.C.R. 2505-10, Sections 8.517.5, 8.517.6.
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) 8.517.5, 8.517.6., 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*

Replace all current text beginning at §8.517. through the end of §8.517.10.D.6.d with the new text provided (from §8.517 through the end of §8.517.11.D.6.d.) This revision is effective 06/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community-Based Services Rule Concerning Persons with Spinal Cord Injury (HCBS-SCI). Rule 10 C.C.R. 2505-10, Sections 8.517.5, 8.517.6.
Rule Number:	MSB 14-02-25-F
Division / Contact / Phone:	Long Term Services & Supports/Emily Moncrief/(303)866-5070

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 Home and Community-Based Services for persons with Spinal Cord Injury (HCBS-SCI) waiver pilot program reached its 67 client capacity limit in November of 2013. Currently there is a waiting list with resources opening onto the program on July 1st, 2014. The current rule only offers broad guidance regarding the waiting list. This amended rule will meet the need for more specific guidance regarding the criteria and processes for managing the waiting list

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. Section 1915 (c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review	**04/11/2014**	Final Adoption	**05/09/2014**
Proposed Effective Date	**06/30/2014**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community-Based Services Rule Concerning Persons with Spinal Cord Injury (HCBS-SCI). Rule 10 C.C.R. 2505-10, Sections 8.517.5, 8.517.6.
Rule Number:	MSB 14-02-25-F
Division / Contact / Phone:	Long Term Services & Supports/Emily Moncrief/(303)866-5070

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 benefit individuals interested in being placed on the waiver, now that it has reached its client capacity limits. The number of these individuals will fluctuate over the remainder of the pilot program, presently there is a list of approximately six individuals on the waiting list for the waiver.

   This rule will also benefit the two Single Entry Point (SEP) agencies who provide case management for the clients on the HCBS-SCI waiver by providing guidance.

   The 67 individuals who are already on the waiver will not be effected by the rule change.

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

   The impact of the rule on individuals interested in being placed on the waiting list will be positive. This rule will increase individual's engagement in the process by providing clarity and documentation regarding their status in relation to the waiting list. This rule will also benefit these individuals by providing transparency and formalizing the equitable processes administering the waiting list.

   This rule will also impact the two Single Entry Point (SEP) agencies who provide case management for the clients on the HCBS-SCI waiver. This rule will benefit the SEP agencies by providing a uniformed process for all clients.

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

   The proposed rule amendment is not anticipated to have any impact on the budget of the Department or of any other agency.

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

   The current rule allows for interpretation regarding how to administer the waiting list. If this rule is not amended, this area of the waiver will not offer the same levels of direction and

accountability that exists for the HCBS-SCI waiver pilot program. The cost of this inaction could result in challenges and questions in regards to the Departments interpretations of the rule. There is no benefit from inaction.

The benefit of amending the rule will be transparency and the ability to reference in rule the criteria for eligibility and processes for managing the waiting list. This action will formalize the processes of notification and documentation giving individuals interested in the waiting list. This action will benefit individuals by providing a clear understanding regarding their eligibility, rights of appeal, reasoning for their possible position on the list, and the ability to see what their position is on the waiting list. There is no financial cost to taking this action.

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

   This is the least costly and intrusive method of updating the waiting list procedure.

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.

   It was determined that alternative methods would not achieve the same levels of accountability for the Department and for the SEP agencies. If the waiting list process was outlined and given as direction to the SEP agencies and not placed in rule it would lower the ability of the Department to ensure that assessments and timeframes were met. If this process was utilized by the Department and not in rule there would lower the ability for the clients and the SEP agencies to hold the Department accountable for a transparent uniformed process.

8.517 HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY

8.517.1 DEFINITIONS OF SERVICES PROVIDED

Adult Day Services means services as defined at Section 8.491.

Alternative Therapies means services as defined at Section 8.517.~~10~~11.

Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.

Electronic Monitoring means services as defined at Section 8.488.

Home Modification means services as defined at Section 8.493.

Homemaker Services means services as defined at Section 8.490.

In-Home Support Services means services as defined at Section 8.552.

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

Personal Care Services means services as defined at Section 8.489.

Respite Care means services as defined at Section 8.492.

8.517.2 GENERAL DEFINITIONS

Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about beneficial physiologic and /or psychological changes.

Alternative Therapies Care Plan means the plan developed prior to the delivery of Alternative Therapies in accordance with Section 8.517.11~~10~~.D.

Alternative Therapies Center means a location certified annually by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11~~10~~.C.

Chiropractic Care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems.

Denver Metro Area means the counties of Adams, Arapahoe, Denver, Douglas, and Jefferson.

Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

Individual Cost Containment Amount means the average costs of institutional services for the nursing facility level of care as determined annually by the Department.

Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.

Spinal Cord Injury means an injury to the spinal cord and includes the International Classification of Diseases, 9th Edition, Clinical Modification (ICD-9-CM) codes 952 through 954.9.

Supervising Physician means an individual that is employed or contracted by a certified Alternative Therapies Center to supervise the provision of Alternative Therapies and meets the qualifications required by Section 8.517.11~~10~~.C.1.f.

8.517.3 LEGAL BASIS

The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) program is created upon authorization of a waiver of the state-wideness requirement contained in Section 1902(a)(1) of the Social Security Act (42 U.S.C. § 1396a); and 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). Upon approval by the United States Department of Health and Human Services, this waiver is granted under Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n). 42 U.S.C. § § 1396a and 1396n are incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. 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. This regulation is adopted pursuant to the authority in Section 25.5-1-301, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Section 24-4-101 et seq., C.R.S. and the Colorado Medical Assistance Act, Sections 25.5-6-1301 et seq., C.R.S.

8.517.4 SCOPE AND PURPOSE

8.517.4.A. The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) program provides assistance to individuals with spinal cord injuries in the Denver Metro Area that require long term supports and services in order to remain in a community setting.

8.517.4.B. The HCBS-SCI program provides an opportunity to study the effectiveness of Alternative Therapies and the impact the provision of this service may have on the utilization of other HCBS-SCI program and/or acute care services.

8.517.4.C. An independent evaluation shall be conducted in the third year of program operation to determine the effectiveness of the Alternative Therapies.

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) services shall be offered only to persons who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a diagnosis of Spinal Cord Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) and in the Uniform Long Term Care 100.2 (ULTC 100.2) assessment tool.

3. Individuals shall have been determined to have a significant functional impairment as evidenced by a comprehensive functional assessment using the ULTC 100.2 assessment tool that results in at least the minimum scores required per Section 8.401.1.15.

4. Individuals shall reside in the Denver Metro Area as evidenced by residence in one of the following counties:

a. Adams;

b. Arapahoe;

c. Denver;

d. Douglas; or

e. Jefferson

8.517.5.B FINANCIAL ELIGIBILITY

Individuals must meet the financial eligibility requirements specified at Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.517.5.C LEVEL OF CARE CRITERIA

Individuals shall require long term support services at a level comparable to services typically provided in a nursing facility.

8.517.5.D NEED FOR HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY (HCBS-SCI) SERVICES

1. Only clients that currently receive Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) services, or that have agreed to accept HCBS-SCI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-SCI program.

   a. Case management is not an HCBS-SCI service and shall not be used to satisfy this requirement.

   b. The desire or need for any Medicaid services other than HCBS-SCI services, as listed at Section 8.517.1, shall not satisfy this eligibility requirement.

2. Clients that have not received HCBS-SCI services for a period greater than 30 consecutive days shall be discontinued from the waiver. ~~program.~~

8.517.5.E EXCLUSIONS

1. Clients who are residents of nursing facilities or hospitals are not eligible to receive Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) services.

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

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

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

8.517.5.F COST CONTAINMENT AND SERVICE ADEQUACY

1. The client shall not be eligible for the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) 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-SCI 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-SCI waiver ~~program~~ at reassessment if the case manager determines the client's needs are more extensive than HCBS-SCI program services are able to support and/or that the client's health and safety cannot be assured in a community setting.

3. The client may be eligible for the HCBS-SCI program at reassessment if the case manager determines that HCBS-SCI 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.

8.517.6 ~~8.517.5.G~~ WAITING LIST

1. The number of clients who may be served through the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver during a fiscal year shall be limited by the federally approved waiver.

2. Individuals ~~Persons~~ determined eligible for the HCBS-SCI ~~-~~ waiver who ~~services that~~ cannot be served within the federally approved waiver capacity limits ~~of the HCBS-SCI waiver~~ shall be eligible for placement on a waiting list.

3.~~a.~~ The waiting list shall be maintained by the Department.

4. The Case Manager shall ensure the individual meets all eligibility criteria as set forth at Section 8.517.5 prior to notifying the Department to place the individual on the waiting list.

5. ~~b.~~ The date the Case Manager determines an individual has met all ~~used to establish the person's placement on the waiting list shall be the date on which all other~~ eligibility requirements as set forth at Section 8.517.5 ~~were determined and the Department Administrator was notified.~~ is the date the Department will use for the individual's placement on the waiting list.

6. When an eligible individual is placed on the waiting list for the HCBS- SCI Waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

7. ~~c.~~ As openings become available within the capacity limits of the federally approved waiver, individuals ~~persons~~ shall be considered for HCBS-SCI services in the order of the individual's placement on the ~~based on the date of~~ waiting list ~~placement.~~

8. When an opening for the HCBS-SCI Waiver becomes available the Department will provide written notice to the Case Management Agency.

9. Within ten business days of notification from the Department that an opening for the HCBS-SCI waiver is available the Case Management Agency shall:

a. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

b. Update the existing functional level of care assessment in the official client record if less than six months has elapsed since the date of the previous assessment.

c. Reassess for eligibility criteria as set forth at 8.517.5.

d. Notify the Department of the individual's eligibility status.

8.517.7 ~~8.517.6~~ START DATE FOR SERVICES

8.517.7~~6~~.A. The start date of eligibility for Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) services shall not precede the date that all of the requirements at Section 8.517.5, have been met. The first date for which HCBS-SCI 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 level of care and targeting criteria are certified.

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 the hospital or nursing facility.

8.517.8~~7~~ CASE MANAGEMENT FUNCTIONS

8.517.8~~7~~.A. The requirements at Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) program.

8.517.9~~8~~ PRIOR AUTHORIZATION OF SERVICES

8.517.9~~8~~.A. All Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) services must be prior authorized by the Department or its agent.

8.517.9~~8~~.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.517.9~~8~~.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 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.

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

8.517.98.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-SCI 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-SCI services is also conditional upon:

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

b. The provider's certification status; and

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

8.517.98.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 necessary to meet the client's needs.

8.517.98.G. Services requested on the PAR shall be supported by information on the Long Term Care Service Plan, the ULTC-100.2, and written documentation from the income maintenance technician of the client's current monthly income.

8.517.98.H. The PAR start date shall not precede the start date of HCBS-SCI eligibility in accordance with Section 8.517.76.

8.517.9.I. The PAR end date shall exceed the end date of the HCBS-SCI eligibility certification period.

8.517.109 PROVIDER AGENCIES

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

8.517.1110 ALTERNATIVE THERAPIES

Alternative Therapies are limited to Acupuncture, Chiropractic Care, and Massage Therapy as defined at Section 8.517.2.

8.517.1110.A. Inclusions

1. Acupuncture used for the treatment of conditions or symptoms related to the client's spinal cord injury.

2. Chiropractic Care used for the treatment of conditions or symptoms related to the client's spinal cord injury.

3. Massage Therapy used for the treatment of conditions or symptoms related to the client's spinal cord injury.

8.517.1110.B. Exclusions / Limitations

1. Alternative Therapies shall be provided only for the treatment of conditions or symptoms related to the client's spinal cord injury.

2. Alternative therapies shall be limited to the client's assessed need for services as determined by the Supervising Physician and documented in the Alternative Therapies Care Plan.

3. Alternative Therapies shall be provided in an outpatient setting.

4. Alternative Therapies shall be provided only by agencies certified by the Department of Health Care Policy and Financing to have met the certification standards listed at Section 8.517.11~~10~~.C.

5. Clients receiving Alternative Therapies shall participate in an independent evaluation to determine the effectiveness of this service.

6. The utilization of Alternative Therapies may typically begin at a higher frequency and is expected to decrease as the client progresses. Authorization and payment for the Alternative Therapies service is limited as follows:

   a. During the first 90 days of the initial Alternative Therapies Care Plan, the schedule of services recommended by the Supervising Physician shall not exceed 15 visits for any one modality or 30 visits for any combination of modalities.

   b. After the first 90 days of the initial Alternative Therapies Care Plan and in all subsequent Alternative Therapies Care Plans, the schedule of services recommended by the Supervising Physician shall not exceed 12 visits for any one modality or 24 visits for any combination of modalities per 90 day period.

8.517.11~~10~~.C. Certification Standards

1. Organization and Staffing

   a. Alternative Therapy Centers shall employ or contract with an adequate number of qualified professionals necessary for the provision of Alternative Therapies in accordance with this regulation.

   b. Alternative Therapies must be provided by licensed, certified, and/or registered individuals operating within the applicable scope of practice and under the direction of a Supervising Physician.

   c. Acupuncturists shall be licensed by the Department of Regulatory Agencies, Division of Registrations as required by the Acupuncturists Practice Act (12-29.5-101, C.R.S.) and have at least five years experience practicing Acupuncture at a rate of at least 750 hours per year.

   d. Chiropractors shall be licensed by the State Board of Chiropractic Examiners as required by the Chiropractors Practice Act (12-33-101, C.R.S.) and have at least five years experience practicing Chiropractic Care at a rate of at least 750 hours per year.

   e. Massage Therapists shall be registered by the Department of Regulatory Agencies, Division of Registrations as required by the Massage Therapy Practice Act (12-35.3-101, C.R.S.) and have at least five years experience practicing Massage Therapy at a rate of at least 750 hours per year.

f. Supervising Physicians shall be licensed to practice medicine in the State of Colorado as required by 12-36-107 et seq., C.R.S. Supervising Physicians must also be board certified in Physical Medicine and Rehabilitation, Internal Medicine, Neurology, and/or Family Practice and have at least five years experience incorporating Alternative Therapies as part of an overall care plan.

2. Environmental Standards

a. Alternative Therapy Centers shall develop a plan for infection control that is adequate to avoid the sources of and prevent the transmission of infections and communicable diseases. The facility shall also develop a system for identifying, reporting, investigating and controlling infections and communicable diseases of patients and personnel. Sterilization procedures shall be developed and implemented in necessary service areas.

b. Policies shall be developed and procedures implemented for the effective control of insects, rodents, and other pests.

c. All wastes shall be disposed in compliance with local, state and federal laws.

d. A preventive maintenance program to ensure that all essential mechanical, electrical and patient care equipment is maintained in safe and sanitary operating condition shall be provided. Emergency Systems, and all essential equipment and supplies shall be inspected and maintained on a frequent or as needed basis.

e. Housekeeping services to ensure that the premises are clean and orderly at all times shall be provided and maintained. Appropriate janitorial storage shall be maintained.

f. Alternative Therapy Centers shall be constructed and maintained to ensure access and safety.

g. Alternative Therapy Centers shall demonstrate compliance with the building and fire safety requirements of local governments and other state agencies.

3. Failure to comply with the requirements of this regulation may result in the suspension or recovery of payment for services provided and/or the revocation of the Alternative Therapy Center provider certification.

8.517.11~~10~~.D ALTERNATIVE THERAPIES CARE PLAN

1. The Supervising Physician shall:

a. Guide the development of the Alternative Therapies Care Plan in coordination with the client and/or client's representative and the Alternative Therapies practitioners as applicable;

b. Recommend the appropriate modality, amount, scope, and duration of the Alternative Therapies within the established limits;

c. Order only services and/or modalities that are necessary and appropriate; and

d. Supervise the Alternative Therapies practitioners and the services provided.

2. The Supervising Physician shall reassess the Alternative Therapies Care Plan at least every three months or more frequently as necessary. The reassessment may include a visit with the client.

3. When recommending the use of Alternative Therapies for the treatment of a condition or symptom related to the client's spinal cord injury, the Supervising Physician should use evidence from published medical literature that demonstrates the effectiveness of Alternative Therapies for the treatment of the condition or symptom.

    a. Where no evidence exists, the medical judgment of the Supervising Physician and the input of the Alternative Therapies practitioners should guide recommendations.

4. The Supervising Physician may require consultation or referral to other specialists prior to finalization of the Alternative Therapies Care Plan.

5. The Alternative Therapies Care plan shall be developed using any Department prescribed forms or templates.

6. The Alternative Therapies Care Plan shall include at least the following:

    a. A summary of the client's medical history;

    b. An assessment of the client's current medical conditions/needs determined by a comprehensive history and physical exam.

    c. The amount, scope, and duration of each recommended Alternative Therapies modality and the expected outcomes.

    d. The recommended schedule of services.

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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 14-02-25-A, Revision to the Medical Assistance Home and Community Based Services Brain Injury Waiver Rule Concerning the Transitional Living Program, Section 8.516.30
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.516.30, 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*

Replace current text at §8.516.30.A. paragraphs 2 &.3; §8.516.30.B. paragraphs 1. & .4.; §8.516.30.C. paragraph 5.; §8.516.30.E through §8.516.30.E.9.; §8.516.30.I through the end of the third unnumbered paragraph. All text indicated in blue is for context only and should not be changed. This revision is effective 06/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services Brain Injury Waiver Rule Concerning the Transitional Living Program, Section 8.516.30
Rule Number:	MSB 14-02-25-A
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin / 303.866.2549

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 revision to the rules under the Home and Community Based Services Brain Injury waiver enables providers to offer a more robust array of services by altering definitions and time limits on therapeutic treatment for clients. These proposed revisions also alter the definition of medically stable in order to expand therapeutic services to clients.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. §1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   C.R.S. 25.5-6-704

Initial Review	**04/11/2014**	Final Adoption	**05/09/2014**
Proposed Effective Date	**06/30/2014**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services Brain Injury Waiver Rule Concerning the Transitional Living Program, Section 8.516.30
Rule Number:	MSB 14-02-25-A
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin / 303.866.2549

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.

   HCBS-BI waiver recipients receiving Transitional Living Program services will be given a more comprehensive array of services under this change. The proposed changes also delete the narrow definition of medically stable as a requirement for persons to receive these services.

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

   HCBS-BI waiver recipients will be impacted in a positive way through a clearer definition of Transitional Living services.

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

   The revisions to this waiver identify the reimbursement rate for Transitional Living services as an acuity-based service to ensure that clients who need the services the most receive them first.

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

   The proposed rule changes expand the array of therapeutic services available to HCBS-BI clients in a Transitional Living setting. Clients will also benefit from an expanded definition of a medically stable person receiving Transitional Living services.

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

   There are no less costly or less intrusive methods for achieving the expansion of Transitional Living services.

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

   The proposed rule change is the best alternative for clarifying TL services under the HCBS-BI waiver.

8.516.30 TRANSITIONAL LIVING

A. DEFINITIONS

1. Transitional living means programs, which occur outside of the client's residence, designed to improve the client's ability to live in the community by provision of 24 hour services, support and supervision.

2. Program services include but are not limited to assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication management, communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household. ~~Programs are normally limited in duration to six months.~~

3. Extraordinary therapy needs mean, for purposes of this program, a client who requires more than three hours per day of any combination of therapeutic disciplines. This includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

B. INCLUSIONS

1. All services must be documented in an approved plan of care and be prior authorized by the ~~State Brain Injury Program Coordinator or designated agent~~ Department of Health Care Policy and Financing (the Department).

2. Clients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs.

3. Clients must require available paraprofessional nursing assistance on a 24 hour basis due to dependence in activities of daily living, locomotion, or cognition.

4. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a client requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for the Transitional Living Program service~~high intensity therapy~~ for a client must be documented and authorized individually ~~through~~ by the ~~Brain Injury Program~~ Department~~Coordinator~~. ~~"Extraordinary therapy needs" for purposes of this program, are defined by a client who needs more than three hours per week of any one therapeutic discipline: ie. physical therapy, occupational therapy, or speech therapy.~~

C. EXCLUSIONS

1. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges.

2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.

3. Room and board charges are not a billable component of transitional living services.

4. Items of personal need or comfort shall be paid out of money set aside from client's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program.

5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by ~~the State Brain Injury Program Coordinator~~the Department.

D. CERTIFICATION STANDARDS

Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-1-107, et, seq.,

1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs.

2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in SECTIONS following titled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS.

3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards.

4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis.

5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

~~2. The person must be medically stable as defined by having the need for less than one hour per eight hour shift of skilled nursing intervention and being able to actively participate in intensive therapy during the day.~~

~~3~~2. Clients, families, medical proxies, ~~;~~ or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

~~4~~3. Understanding that clients of transitional living programs frequently experience behavior which may be a danger to themselves or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.

~~5~~4. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve clients for whom they lack adequate resources to ensure safety of program participants and staff.

~~6~~5. Upon entry into the program, discharge planning shall begin with the client and family. Transitional living programs shall work with the client and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services.

~~7~~6. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

~~8~~7. During daytime hours, the ratio of staff to clients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.

~~9~~8. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the ~~Brain Injury Program Coordinator.~~Department.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service related profession plus three years experience providing direct services to individuals with brain injury. A bachelor's degree with five years experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.

2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the client. These staff members will have successfully completed a training program of at least 40 hours duration.

3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.

4. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from impatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two week period following admission.

3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.

5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

6. All transitional services must utilize licensed psychologists with~~n~~ two years of experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.

7. Programs shall have a process verified in writing by which a client is made aware of the process for filing a grievance. Complaints by the client or family shall be handled via telephone or direct contact with the client or family.

8. Customer satisfaction surveys will be regularly performed and reviewed.

9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.

10. Client safety in the community will be assessed: safety status and recommendations will be documented.

11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.

2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the acuity-based per diem reimbursement rate ~~negotiated with~~established by the Department of Health Care Policy and Financing and will not bill the client in excess of his/her SSI payment or $400 per month, whichever is less for room and board charges.

All transitional living services shall be prior authorized through submission to the ~~Brain Injury Program Coordinator.~~ Department. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond six months duration~~,~~ must be reauthorized with ~~attached~~ treatment plan justification and shall be submitted~~, if appropriate,~~ through the reconsideration process established ~~with~~ by the ~~Departmental fiscal agent.~~.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community based Services for Person with Brain Injury Rule Concerning Counseling, Section 8.516.50
Rule Number:	MSB 14-02-25-B
Division / Contact / Phone:	Long Term Services & Supports Division/Colin Laughlin / 303.866.2549

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 14-02-25-B, Revision to the Medical Assistance Home and Community based Services for Person with Brain Injury Rule Concerning Counseling, Section 8.516.50
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) 8.516.50, 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*

Replace current text at §8.516.50.B paragraphs 5., 6., and 7. with current text provided; delete current text at §8.516.50.C. paragraph 2.; replace current text at §8.516.50.D paragraph 1.; and replace current text at §8.516.50.E with new text provided. All text indicated in blue is for clarification only and should not be changed. This revision is effective 06/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community based Services for Person with Brain Injury Rule Concerning Counseling, Section 8.516.50
Rule Number:	MSB 14-02-25-B
Division / Contact / Phone:	Long Term Services & Supports Division/Colin Laughlin / 303.866.2549

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 revision to the rules for the Home and Community Based Services Counseling services within the Brain Injury waiver enables families to receive counseling and training services without the waiver recipient in the room. This revision expands family services.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. §1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   C.R.S. 25.5-6-704

Initial Review	**04/11/2014**	Final Adoption	**05/09/2014**
Proposed Effective Date	**06/30/2014**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community based Services for Person with Brain Injury Rule Concerning Counseling, Section 8.516.50
Rule Number:	MSB 14-02-25-B
Division / Contact / Phone:	Long Term Services & Supports Division/Colin Laughlin / 303.866.2549

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.

   Families of clients in the HCBS-BI waiver will benefit from more flexibility in the counseling service.

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

   Family counseling/training will remain uninterrupted. Families will continue receiving the same services under the HCBS-BI waiver.

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.

   Because counseling is already a service provided under the HCBS-BI waiver, no additional costs are anticipated.

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

   Currently, the HCBS-BI waiver only allows families to receive the counseling/training service offered by the waiver in the presence of the HCBS-BI waiver client. Because this service is already offered to families under this waiver, it does not coincide with additional cost.

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

   There is no less costly or less intrusive method for achieving the flexibility for families as offered under the proposed rule change.

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

   There are no alternative methods for providing families and the HCBS-BI waiver client with more discretion concerning the presence of the client in family training/counseling sessions.

8.516.50 COUNSELING

A. DEFINITIONS

Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries.

B. INCLUSIONS

1. Counseling is available to the program participant's family in conjunction with the client if they: a) have a significant role in supporting the client or b) live with or provide care to the client. "Family" includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the waiver participant.

2. Services may be provided in the waiver participant's residence, in community settings, or in the provider's office.

3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.

4. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department of Health Care Policy and Financing as directed by certification standards listed below.

5. Family training/counseling must be carried out for the direct benefit of the client of the HCBS-BI program.

~~5~~6. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as may be necessary to safely maintain the individual at home.

~~6.~~7. ~~-~~Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

1. Family training is not available to individuals who are employed to care for the recipient.

~~2. Family training/counseling must be carried out in the presence of and for the direct benefit of the client of the HCBS-BI program.~~

D. CERTIFICATION STANDARDS

1. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to ~~stale~~state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker. Certified Rehabilitation Counselor. Licensed Professional Counselor, or Licensed Clinical Psychologist.

2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years experience in providing counseling to individuals with brain injury and their families.

3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling, ~~(if the individual is present)~~ Individual Counseling, and Group Counseling.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Respite Care, Section 8.516.70
Rule Number:	MSB 14-02-25-C
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin / 303.866.2549

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 14-02-25-C, Revision to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Respite Care, Section 8.516.70
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.516.70, 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*

Replace current text at the 11th unnumbered paragraph under §8.515.2 with new text provided. All text indicated in blue is for clarity only and should not be changed. Insert new text at §8.516.70. The new text should be inserted immediately following current text at §8.516.60.E and immediately preceding text at §8.517. This revision is effective 06/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Respite Care, Section 8.516.70
Rule Number:	MSB 14-02-25-C
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin / 303.866.2549

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 revision to the rules for the Home and Community Based Services Respite Care service within the Brain Injury waiver requires changes to clarify limits and better define processes for clients and case managers to request additional units of the service.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. §1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   C.R.S. 25.5-6-704

Initial Review	**04/11/2014**	Final Adoption	**05/09/2014**
Proposed Effective Date	**06/30/2014**	Emergency Adoption	

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Respite Care, Section 8.516.70
Rule Number:	MSB 14-02-25-C
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin / 303.866.2549

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.

   Clients in the HCBS-BI waiver will benefit from the proposed specification of respite care because this section will allow for up to 30 days (or 720 hours) of respite care in each certification period. The proposed change is not projected to result in added cost to HCBS-BI clients.

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

   HCBS-BI clients respite benefits will remain uninterrupted, and therefore this change will not have a qualitative or quantitative impact on clients.

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.

   Because respite care for HCBS-BI clients currently is defined under the EBD waiver definition, there is no anticipated added cost for agencies resulting from this change.

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

   The Department of Health Care, Policy, and Financing is actively working to clarify the delivery of services under its 1915(c) waivers to ensure all waivers have clearly labeled services for clients. Specifying respite services into HCBS-BI is one step in ensuring appropriate labeling of service delivery options in this particular waiver.

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

   This method is not costly or intrusive, and is intended to clarify existing policy for providers and clients across the state.

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 clarification of services as put forth by the proposed rule change.

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.

Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510

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~~ 8.516.70.

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 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.

~~8.492~~8.516.70 RESPITE CARE

~~11.~~ A. DEFINITIONS

~~11.~~1. Respite care means services provided to an eligible client on a short-term basis because of the absence or need for relief of those persons normally providing the care.

~~.1~~2. Respite care provider means a Class I nursing facility, an alternative care facility or an employee of a certified personal care agency which meets the certification standards for respite care specified below.

~~8.492.20~~B. INCLUSIONS

~~.21~~1. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite client, as ordered by the physician.

~~.222. An alternative care facility shall provide all the alternative care facility services as listed at Section 8.495, ALTERNATIVE CARE FACILITIES, which are required by the individual respite client.~~

~~8.492.30~~C. RESTRICTIONS

1. An individual client shall be authorized for no more than a cumulative total of thirty (30) days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home or in a nursing facility.

A. A mix of delivery options is allowable as long as the aggregate amount of services is below thirty (30) days, or 720 hours, of respite care.

1. In home respite is limited to no more than eight (8) hours a day.

2. Nursing facility respite billed on a per diem.

~~.31 An individual client shall be authorized for no more than thirty (30 days of respite care in each calendar year.~~

~~.32 Alternative care facilities shall not admit individuals for respite care who are not appropriate for alternative care facility placement, as specified at Section 8.495, ALTERNATIVE CARE FACILITIES.~~

~~.33~~ 2. Only those portions of the facility that are Medicaid certified for nursing facility ~~or alternative care facility~~ services may be utilized for respite clients.

~~8.492.40~~D. CERTIFICATION STANDARDS AND PROCEDURES

~~.41~~1. Respite care standards and procedures for nursing facilities are as follows:

A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

B. The nursing facility does not have to maintain or hold open separately designated beds for respite clients, but may accept respite clients on a bed available basis.

C. For each HCBS-~~EBD~~BI respite client, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the client. The chart must identify the client as a respite client. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

D. An admission to a nursing facility under HCBS-~~EBD~~BI respite does not require a new ULTC-100.2, a PASARR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or labwork as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

E. The nursing facility shall have written policies and procedures available to staff regarding respite care clients. Such policies could include copies of these respite rules, the facility's policy regarding ~~self-administration~~self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care clients.

F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite client's entry into the facility.

~~.422. Respite care standards and procedures for alternative care facilities are as follows:~~

~~A. The nursing facility alternative care facility shall have a valid contract with the Department as a Medicaid certified HCBS-EBD nursing alternative care facility provider. Such contract shall constitute automatic certification for HCBS-EBD respite care.~~

~~B. For each respite care client, the nursing facility alternative care facility shall follow normal procedures for care planning and documentation of services rendered.~~

~~.43~~3. Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

~~8.492.50~~E. REIMBURSEMENT

~~.51~~1. Respite care reimbursement to nursing facilities shall be as follows:

A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-~~EBD~~BI claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

~~.52~~2. Respite care reimbursement to alternative care facilities shall be as follows:

A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-~~EBD~~BI claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

~~.53~~3. Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

~~.54~~4. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI services shall not be reimbursed during the respite stay.

~~.55~~5. ~~Effective 2/1/99, t~~There shall be no reimbursement provided under this section for respite care in uncertified congregate facilities.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Substance Abuse Counseling, Section 8.516.60
Rule Number:	MSB 14-02-25-D
Division / Contact / Phone:	Long Term Supports & Services/Colin Laughlin / 303.866.2549

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 14-02-25-D, Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Substance Abuse Counseling, Section 8.516.60
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.516.60, 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*

Replace current text in the unnumbered paragraph immediately following §516.60.A with the new text provided. Replace current text at §8.516.60.D.3 with the new text provided. All text indicated in blue is for clarification only and should not be changed. This revision is effective 06/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Substance Abuse Counseling, Section 8.516.60
Rule Number:	MSB 14-02-25-D
Division / Contact / Phone:	Long Term Supports & Services/Colin Laughlin / 303.866.2549

STATEMENT OF BASIS AND PURPOSE

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

   The rule change expands the provider pool for substance abuse services as specified under the HCBS-BI waiver by changing the level of certification required for the Certified Addictions Counselor. The proposed rule change also revises typographical errors from previous versions.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. 1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   C.R.S. 25.5-6-704

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Proposed Effective Date	**06/30/2014**	Emergency Adoption	

DOCUMENT #07

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Substance Abuse Counseling, Section 8.516.60
Rule Number:	MSB 14-02-25-D
Division / Contact / Phone:	Long Term Supports & Services/Colin Laughlin / 303.866.2549

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.

   Persons who receive substance abuse counseling services under the HCBS-BI waiver will be impacted by this change. Because the change increases the number of potential providers for this service, HCBS-BI waiver clients will benefit. There is no anticipated additional cost to either provider or clients resulting from this change because the substance abuse services are already in place.

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

   Positive qualitative impacts are expected for clients who receive substance abuse services under the HCBS-BI waiver as a result of the expanding provider pool. Ideally, clients will have more service options with this change.

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 foreseen additional costs to the Department or to any other agency because the number of clients who receive substance abuse counseling services under the HCBS-BI waiver is not expected to increase. The enrollment cap for this waiver remains the same.

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

   Clients under the HCBS-BI waiver are expected to benefit from increased provider options. There are also no anticipated costs to providers.

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

   There are no less costly or less intrusive methods for achieving the expansion of the provider pool for substance abuse services.

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 alternative methods for these services were considered.

8.516.60 SUBSTANCE ABUSE COUNSELING

A. DEFINITION

Substance abuse programs are individually designed interventions to redu~~-a~~ce or eliminate the use of alcohol and/or drugs by the water participant which~~,-~~ i~~f~~f not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

B. INCLUSIONS

1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program

2. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver participant, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons if directly involved in the support system of the client, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager.

3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall b~~h~~e submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

Inpatient treatment is not a covered benefit.

D. CERTIFICATION STANDARDS

1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing.

2. Programs must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury.

3. Counselors should be certified at the Certified ~~Alcohol~~ Addiction Counselor II~~I~~ level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any individual with a brain injury or their family members. A recommended training curriculum will include a three day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Concerning Eligible Persons, Section 8.515.5
Rule Number:	MSB 14-02-25-E
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin / 303.866.2549

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 14-02-25-E, Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Concerning Eligible Persons, Section 8.515.5
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.515.5, 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*

Replace current text beginning at §8.515.5.A.1 through §8.515.5.A.1.f with new text provided (through §8.515.5.A.1.d.) Replace current text at §8.515.5.A.2.b with new text provided and delete current text at §8.151.5.A.2.c. Delete current text at §8.151.5.B.2.a and replace current text at §8.515.5.B.2.b with new text provided. All text indicated in blue is for clarification only and should not be changed. This revision is effective 06/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Concerning Eligible Persons, Section 8.515.5
Rule Number:	MSB 14-02-25-E
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin / 303.866.2549

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).

   Revisions to the Eligible Persons section within the Home and Community Based Services Brain Injury Waiver rule expands eligibility by eliminating barriers to enrollment such as age restrictions of when the injury occurred and requirements for a prognosis showing continued functional improvement.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. §1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   C.R.S. 25.5-6-704

Initial Review	**04/11/2014**	Final Adoption	**05/09/2014**
Proposed Effective Date	**06/30/2014**	Emergency Adoption	

DOCUMENT #08

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revisions to the Medical Assistance Home and Community Based Services for Persons with Brain Injury Rule Concerning Eligible Persons, Section 8.515.5
Rule Number:	MSB 14-02-25-E
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin / 303.866.2549

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.

   Clients in the HCBS-BI waiver will benefit from lowered restrictions to enrollment in the HCBS-BI waiver. Clients who have the injury under the age of 16 will now be eligible upon their turning 16 for the waiver. There is no current waitlist and enough capacity remains to be unconcerned about any potential wait times increasing.

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

   Individuals who have suffered a brain injury under the age of 16 will now have access to the HCBS-BI waiver under the proposed changes at the point they turn 16.

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.

   Because the enrollment cap for the HCBS-BI waiver remains unchanged, there is no anticipated cost for any agency resulting from these revisions.

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

   The Department of Health Care Policy and Financing believes not changing the rule will disallow individuals from receiving appropriate care in the brain injury waiver based solely on when the injury occurred as opposed to need.

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

   This method is not costly or intrusive for affected clients or agencies overseeing the proposed changes.

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 of achieving this change to the HCBS BI waiver Eligible Persons rule found at 8.515.5.

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~~a. The individual shall have been:

      i. ~~referred~~ 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; or

      ~~i.~~ii. ~~The individual shall have been d~~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; and

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

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

   ~~f~~ d. 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~~a. Individuals enrolled in the ~~nursing facility level of care~~Brain Injury waiver shall be aged 16 years and older and shall have sustained the brain injury ~~between the ages of 16 and 64 years~~prior to the age of 65.

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.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Section Rule Concerning Application To Participate In The Medical Assistance Pharmacy Program Repeal of Form Med - 11E
Rule Number:	MSB 14-02-28-A
Division / Contact / Phone:	Pharmacy / Eskedar Makonnen /303-866-4079

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 14-02-28-A, Revision to the Medical Assistance Pharmacy Section Rule Concerning Application To Participate In The Medical Assistance Pharmacy Program Repeal of Form Med - 11E
3. This action is an adoption of: a repeal of existing rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Form- Med- 11E, 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*

Repeal all text beginning at 10 CCR 2505-10, MED 11E through the end of the section. This repeal is effective 06/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Pharmacy Section Rule Concerning Application To Participate In The Medical Assistance Pharmacy Program Repeal of Form Med - 11E

Revision to the Medical Assistance Pharmacy Section Rule Concerning Application To Participate In The Medical Assistance Pharmacy Program Repeal of Form Med - 11E

Rule Number: MSB 14-02-28-A

Division / Contact / Phone: Pharmacy / Eskedar Makonnen /303-866-4079

Title of Rule:

Rule Number: MSB 14-02-28-A

Division / Contact / Phone: Pharmacy / Eskedar Makonnen /303-866-4079

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).

   FORM MED-11E, attached to the Medical Assistance rule, is a pharmacy provider enrollment application form from c. 1984. The form is no longer used to enroll pharmacy providers. The department has a standard enrollment application form that is accessible through its website for all providers. Repealing the MED -11E form will eliminate unnecessary confusion for providers and staff.

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:

   N/A

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review **04/11/2014** Final Adoption **05/09/2014**

Proposed Effective Date **06/30/2014** Emergency Adoption

DOCUMENT #09

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Pharmacy Section Rule Concerning Application To Participate In The Medical Assistance Pharmacy Program Repeal of Form Med - 11E
Rule Number:	MSB 14-02-28-A
Division / Contact / Phone:	Pharmacy / Eskedar Makonnen /303-866-4079

REGULATORY ANALYSIS

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

   The Proposed rule change will result in no change to how providers currently enroll to participate in the medical assistance pharmacy program. Accordingly, they are no classes of persons affected by this rule change.

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

   Not applicable; there are no affected classes of persons.

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

   The proposed rule chance will result in no change of operation; therefore, there will be no new costs to the Department or state.

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

   The proposed rule change imposes no new costs. Repealing a form that has no longer been in use will be a good housekeeping practice.

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

   Not applicable; the rule change has no cost.

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.

   Not applicable; the way to achieve the purpose of the proposed rule is by repealing the form.

~~DEPARTMENT OF HEALTH CARE POLICY AND FINANCING~~

~~Medical Services Board~~

~~MEDICAL ASSISTANCE - FORM MED-11E~~

~~10 CCR 2505-10 _MED-11E~~

~~[Editor's Notes follow the text of the rules at the end of this CCR Document.]~~

FORM MED 11E Repealed, effective June 30, 2014.

~~FORM MED-11E~~

~~_____~~
~~_____~~

~~Pharmacy Name~~

~~_____~~
~~_____~~

~~Address~~

~~Provider # _____~~

~~Phone _____~~

~~MED-11E (Rev. 6/84)~~

~~COLORADO STATE DEPARTMENT OF SOCIAL SERVICES DIVISION OF MEDICAL ASSISTANCE~~

~~APPLICATION TO PARTICIPATE IN THE MEDICAL ASSISTANCE PHARMACY PROGRAM~~

~~_____, a duly licensed Pharmacy, (Name of Pharmacy) hereinafter referred to as the Applicant, hereby makes application to participate In the Medical Assistance Program administered by the State Department of Social Services, hereinafter referred to as the Department, to the benefit of recipients of the medical benefits thereof. The applicant desires to participate in said program as a vendor of medical services, benefits, and/or goods within the scope of authority as is vested by the aforesaid license as a Pharmacy issued by the _____(Regulatory Agency) of the State of _____ on _____.(Date Issued)~~

~~If approved as a participating provider, the applicant agrees:~~

~~1. To perform its pharmaceutical duties and obligations in conformances with provisions of Title XIX of the Social Security Act. all other relevant Federal laws and regulations, the Colorado Social Services Code 26-1-101, et. seq., C.R.S. 1973, as amended, and especially the Colorado Medical Assistance Act, 26-4-101 et seq., C.R.S. 1973, as amended, and all pertinent rules and regulations of the Colorado Department of Social Services, as all of the foregoing are in effect at the date of the approval of the provider's application to participate, or as they may later be amended.~~

~~2. To submit billings for authorized services and/or goods in accordance with the form, manner, and amounts provided by the aforementioned statutes and rules and regulations, and provide such services and goods on the basis of being compensated therefore in accordance with said rules and regulations. It is further agreed that in the event the applicant should receive payment for~~

medical services, benefits, and/or goods in an amount in excess of that permitted by said law and rules and regulations, such excessive payments may be deducted from future payments on behalf of recipients otherwise payable to said applicant and/or recovery of such payments may be made otherwise at the option and discretion of the Department in accordance with its rules and regulations pertaining to recoveries or other legal means.

3. Not to submit bills, or otherwise attempt to collect from the recipients, relatives of recipients or others for medical services, benefits. and/or goods which are provided recipients by said Applicant under said medical program and which benefits, services, and/or goods are paid for by the Department. Said applicant further agrees to accept the payment under the said medical program as payment in full from the Department. This statement in no way relieves the applicant of responsibility as defined by law or rule or regulation to obtain payment from legally responsible persons, as is required by said law or rule or regulations.

4. To provide the Department with at least 30 days prior notice in the event of termination of participation in said medical program. (Termination of participation in the Medicaid Program, unless otherwise agreed to in writing by the Department, shall arise from voluntary or involuntary cessation of business; election to no longer participate; transfer of title and property to another party, corporation or partnership; any foreclosure, bankruptcy or receivership action.) However, this provision shall not apply in the case where an amendment to the rules of the Department is determined to be unacceptable to the eligible provider and for said reason he elects to discontinue participation 1n the program. In such event, the eligible provider shall forthwith notify the Department in writing of its intent to discontinue and the eligible provider and the Department shall forthwith negotiate the termination date. In no event shall said date be longer than 60 days from the effective date of the rule amendment.

5. To provide acceptable assurance to the Department of compliance with all Federal and State laws concerning discrimination and unfair employment practices, Including but not limited to Title VII of the Civil Rights Act of 1964. ss 504 of the Rehabilitation Act of 1973. and ss 24-34-301. C.R.S. 1973. as amended.

6. To give full cooperation to the Department and its duly authorized agents, in the administration of said medical program, and to maintain all records necessary to disclose the extent of services furnished to recipients as may be provided for in the said rules and regulations. The applicant further agrees to furnish representatives of the Department or its duly authorized agents, the Department of Health and Human Services or the Medicaid Fraud Control Unit, with all information regarding reimbursement claimed by the provider for furnishing services.

7. To abide by all processing or reimbursement requirements mandated by the Department of Social Services, either directly or through the Fiscal Agent. Fiscal Agent means an entity that processes or reimburses vendor claims for the Department.

8. That approval of this application by the Department authorizes the applicant to participate in the Medicaid program. However, neither this application nor its approval in any way alters, amends, or abrogates the legal responsibility of the applicant to execute a subcontract if it later agrees to provide medical services for Medicaid recipients through a Health Maintenance Organization or similar program.

9. That reimbursement by the Department to the applicant shall be made in accordance with the aforementioned Departmental rules and regulations as applied to the pharmacy claim form submitted by the provider.

10. Any violations of the above conditions may result in withdrawal of approval of this agreement to participate.

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WHEREAS, the state has established a Colorado Medical Assistance Program, hereinafter referred to as the "program", by which to participate in Title XIX of the Social Security Act, hereinafter referred to as "Medicaid", through the Department; and

WHEREAS, Contractor is licensed to operate a health care facility and is certified to operate a(n) (skilled) (intermediate) care facility through the Colorado Department of Health, pursuant to Medicaid and Medicare statutes and regulations, and desires to participate in the program and provide nursing services and care to eligible recipients; and

WHEREAS, Contractor has demonstrated a quantitative and qualitative need for Contractor's services to its geographic region. consistent with comprehensive health planning goals and data, for the duration of this contract; and

WHEREAS, as of the date of the execution of this contract, Contractor meets all other qualifications for participation in the program.

NOW THEREFORE, it is hereby agreed that

1. Contractor agrees to perform its duties and obligations hereunder in conformance with the provisions of Title XIX of the Social Security Act, other relevant federal law, all pertinent federal regulations promulgated pursuant to federal law, the Colorado Social Services Code, C.R.S. 1973. 26-i-101, et seq ., including the Colorado Medical Assistance Act, C.R.S. 1973, 26-4-101, et seq ., other relevant State law, the Colorado State Plan for medical assistance under Title XII, and all pertinent regulations of the Colorado Department of Social Services, as all the foregoing are in effect as of the date of the execution of this contract, or as they may later be amended.

2. This contract shall be for a term of commencing _____, and continuing to and including _____, unless earlier terminated by the Department under any of the following circumstances and for any of the following reasons:

(a) The Colorado Department of Health/United States Department of Health and Human Services has issued a conditional or short-term certification to contractor, dated _____, 19_____, which specified the discovery of certain enumerated deficiencies in Contractor's facility. Unless said deficiencies are corrected on or before the _____ day of _____, 19_____, this agreement will automatically expire on said date.

(b) In the event that Contractor should lose its license or certification from the Department of Health, this contract shall terminate as of the date delicensure or decertification occurs.

(c) In the event that Contractor should lose its certification to participate in the Title XVIII Program, the Department shall take such action concerning Title XIX certification as is consistent with law and regulation.

(d) In the event that Contractor fails to comply with any of toe previsions of this contract or statutes, rules, or regulations described herein at paragraph 1, this contract shall be terminated for "good cause" as defined in Staff Manual, VIII, Provider Appeals and Hearings Section.

3. Records and Information

(a) Contractor agrees to keep such records as are necessary to disclose the extent of the services provided to individuals receiving Colorado medical assistance. Such records

shall include, but not be limited to, dietary services, nurse staffing, drug use, and financial records relating thereto.

(b) Contractor agrees to keep all records, plans and programs required by law and Department rules and regulations.

(c) Contractor agrees to keep all records pertaining to personal needs accounts, including but not limited to bank statements and bank books.

(d) Contractor agrees to keep all records of patient income received by Contractor and amounts due the Contractor on behalf of said patients.

(e) Contractor agrees to keep all personal needs and medical records and supporting documents at the nursing home facility operated by Contractor.

(f) Contractor agrees to make available, at all reasonable times during the contract period and five (5) years thereafter, all records and documents' pursuant to this agreement for inspection, audit, or reproduction by any authorized representative of the Department or appropriate federal agencies.

(g) Contractor shall provide the Department with the same complete and current ownership information required by and provided to the Department of Health pursuant to that Department's licensure regulations.

4. Contractor agrees to allow the Department of Health and Human Services, the Department and its designated and duly authorized representatives, including the Colorado Department of Health and the Medicaid Fraud Control Unit access to the health care facility at any time reasonable under the circumstances for purposes of conducting surveys, inspections, or audits as permitted or required by state and federal statutes and regulations and to allow medical review of the care received or being received by any recipient/patient who is or has been in the care and/or custody of the Contractor.

5. Contractor agrees to comply with the requirements of Title VI of the Civil lights Act of 1964.

6. Payment Rate

(a) Contractor shall be reimbursed by the Department in such amounts as stay from time to time be set by the Colorado Department of Social Services pursuant to the Medicaid statute, the Colorado Medical Assistance Act, and the rules and regulations promulgated thereunder.

(b) Contractor agrees to accurately report to the Department on Form MED-13 (Financial and Statistical Report for Nursing Homes) all patient related expenses and all sources of income. The contractor shall, in addition to Its own signature, secure the signature of every accountant who in any way assists in the construction or completion of every Department Form NED-13 submitted to the Department.

(c) All billings for reimbursement shall be submitted in a form. Banner, and amount provided for by Department rules and shall contain such information as may he required by the Department.

(d) Contractor agrees to accurately report to the Department all money received on behalf of each patient. Contractor further agrees that no charges other than those made under the term of this contract and in accordance with law and Department rules shall be made to patients, their relatives, estates or any other person for Medicaid reimbursable services.

(e) All warrants endorsed by and presented to a bank by Contractor shall constitute payment in full, except when endorsed under good faith protest pursuant to Title IV, C.R.S. 1973.

(f) Contractor agrees to allow the Department or its designated representatives access to all information necessary to determine Contractor's reimbursement rate.

(g) In the event that under or over-payments were administratively made in error by the State to the Contractor, the parties agree that adjustment shall be made pursuant to procedures established by the Department.

(h) No advance payments shall be made by the Department pursuant to this contract. "Advance payments" are those made prior to the actual rendition of services by the Contractor.

7. Reapplication

In the event that Contractor intends to apply for a new contract upon the termination of this contract. Contractor agrees to reapply for said new contract by completing and submitting its application upon an approved contract form (MED-11A) not less than sixty (60) days prior to the termination date of this agreement to the Department of Social Services, Division of Medical Assistance. The Division of Medical Assistance may. on its own initiative, provide blank reapplication forms to the Contractor prior to the termination date of this contract, provided that, failure to so provide shall not constitute the state's waiver of or an estoppel to the Contractor's responsibilities under this paragraph.

8. Notice of Change of Ownership or Premature Termination of Contract

After the effective date of this contract, contractor shall notify this Department in writing of any change of ownership, as defined by Department regulations, not less than thirty (30) days prior to the effective date of that change. Contractor shall also provide the Department with sixty (60) days prior written notice of the date of termination of this contract in the event that date precedes the termination date described in paragraph 2 herein.

9. Declaration of Responsibility

The Contractor agrees to furnish a current Declaration to the Department which shall list the specific individual(s) who is (are) authorized to execute agreements on behalf of the Contractor. The Declaration, attached are incorporated as Exhibit A to this contract, shall be signed and attested by an authorized corporate officer, a general partner, or the sole proprietor, as appropriate.

10. Surety Bond

Where applicable pursuant to law, the Contractor agrees to purchase and maintain a surety bond in the amount of ten thousand dollars ($10,000) to protect its patients' personal needs trust funds. A current copy of such bond shall be provided to the Department and must be on file prior to contrast effective date.

(a) Contractor agrees to replace any shortages determined by audit of the personal needs trust fund by the Department.

(b) Contractor agrees to keep records of each patient's personal Deeds trust fund for a period of three (3) years from the date of the patient's discharge from the facility or until such records have been audited by the Department, whichever occurs last.

(c) Contractor agrees, in the event of cancellation of the current surety bond, to give the Department written notice within five (5) days of such cancellation. Contractor further agrees to undertake a new bonding agreement within ten (10) days of such cancellation.

(d) All bonding requirements set forth in this paragraph shall remain in effect until written release is made by the Department, pursuant to paragraph 15 of this contract.

11. Subcontracts

No subcontract for management or operation services shall be made by the Contractor with any other party for furnishing any work or services under this contract without the prior written consent and approval of the Department. This prior written consent shall be granted within thirty (30) days of the Department's receipt of written request unless for good cause shown.

12. Prohibition of Assignment

Neither the benefits nor the burdens of this contract may be assigned by the Contractor, either in whole or in part. The contract is void and automatically cancelled by the Department upon change of ownership of the health care facility or in the parties to the operational lease of a health care facility.

13. Insolvency

The contract is voidable and subject to immediate cancellation by the Department upon the Contractor's insolvency, including the filing of proceedings in bankruptcy.

14. Transfer of Patient Property

In the event of the termination or nonrenewal of this contract, all records, funds, and personal property of each patient-recipient, including personal needs trust monies, shall be transferred with the recipient to his/her new facility in a manner consistent with Department regulations. Any records not so transferred shall, at the written option of the State, either be transferred to the State or retained by the Contractor until written release by the State. All bonding shall remain in effect until written release is made by the State.

15. Integration

This agreement is intended as the complete integration of all understandings between the parties. No prior or contemporaneous addition, deletion, or other amendment hereto shall have any force or effect whatsoever, unless embodied herein in writing. No subsequent novation, renewal, addition, deletion, or other amendment hereto shall have any force or effect unless embodied in a written contract executed and approved pursuant to the State Fiscal Rules.

16. Parties Relationship

The parties of this Contract intend that the relationship between the completed by this Contract is that of independent contractor. No agent, employee, or servant of Contractor shall be or shall be deemed to be an employee, agent, or servant of Social Services. Contractor will be solely and entirely responsible for its acts and the acts of its agents, employees, servants and subcontractors during the performance of this contract.

17. Indemnification

Contractor shall indemnify Social Services against all liability and loss, and against all claims and actions based upon or arising out of damage or injury, including death, to persons or property caused by or sustained in connection with the contractors performance of this Contract or by

conditions created thereby, or based upon any violation of any statute, ordinance, or resolution are the defense of any such claims or actions.

18. Payment

Payment pursuant to this Contract will be made as earned, in whole or in part, from available State funds for the purchase of nursing care services. It is agreed that the maximum amount of State funds available for the fiscal year is in the amount appropriated. The liability of the state, at any time, for such payments shall be limited to the unencumbered amount remaining of such funds.

19. Contingent Funding

This contract is subject to and contingent upon the continuing availability of Federal funds for the purposes hereof.

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Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 3/4/07, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the History link that appears above the text in 10 CCR 2505-10. To view versions effective on or after 3/4/07, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]