THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Bariatric Surgery Services Section 8.300.C
Rule Number:	MSB 14-07-07-28-B
Division / Contact / Phone:	Medicaid Programs & Services / Ana Lucaci / 303-866-6163

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 14-07-07-28-B, Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Bariatric Surgery Services Section 8.300.C
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 8.300.C, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Delete all current text beginning at §8.300.3.C through the end of §8.300.3.C second unnumbered paragraph. Insert new text provided beginning at §8.300.3.C through the end of §8.300.3.C.5.g). This revision is effective 12/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Bariatric Surgery Services Section 8.300.C
Rule Number:	MSB 14-07-07-28-B
Division / Contact / Phone:	Medicaid Programs & Services / Ana Lucaci / 303-866-6163

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 Department is updating this rule to include content from the Bariatric Surgery Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit..

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:

   §1905(a)(1) of the Social Security Ac

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);

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Initial Review	**10/10/2014**	Final Adoption	**11/14/2014**
Proposed Effective Date	**12/30/2014**	Emergency Adoption	

DOCUMENT #01

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Rule Concerning the Bariatric Surgery Services Section 8.300.C
Rule Number:	MSB 14-07-07-28-B
Division / Contact / Phone:	Medicaid Programs & Services / Ana Lucaci / 303-866-6163

REGULATORY ANALYSIS

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

This rule will impact the providers of Bariatric Surgery 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.

Clearly defined and updated rules will improve client access to appropriate, high quality, cost-effective and evidence-based services while improving the health outcomes of Medicaid clients. Established criteria within rule will provide guidance to clients and providers regarding benefit coverage. For example, this rule will help ensure the appropriate clients are receiving this service at an appropriate age. The age limit is set for clients over the age of 16, with additional provisions regarding psychological maturity for clients that are under 18.

Through this rule, the providers are given specific criteria, steps and necessary documentation needed prior to requesting approval for client's procedure from the Department: weight, height and BMI of the client, co-morbid conditions, details regarding client's weight loss attempts, a recent psychiatric or psychological assessment, a description of the post-surgical follow-up program, a statement from the client agreeing the detailed commitment program after the surgery.

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

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

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

Clearly defined and updated rules increase client access to appropriate services and allow the Department to administer benefits in compliance with federal and state regulations, as well as clinical best practices and quality standards. Defining this benefit in rule will educate clients about their benefits and provide better guidance to service providers. The cost of inaction could

result in decreased access to services, poor quality of care, and/or lack of compliance with state and federal guidance.

All of the above translates into appropriate cost-effective care administered by the state.

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 methods or less intrusive methods for achieving the purpose of this rule. The department must appropriately define amount, scope and duration of this benefit in order to responsibly manage it.

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

N/A. The Department also documents its benefit coverage policies in written coverage standards. The benefit coverage policies must be written into rule to have the force of rule.

~~**8.300.3.C. Bariatric Surgery Benefit Coverage Standard Incorporated by Reference**~~

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

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

8.300.3.C. Bariatric Surgery

1. Eligible Clients

    a. All currently enrolled Medicaid clients over the age of sixteen when:

        i) The client has clinical obesity; and

        ii) It is Medically Necessary.

2. Eligible Providers

    a. Providers must enroll in Colorado Medicaid.

    b. Surgeons must be trained and credentialed in bariatric surgery procedures.

    c. Preoperative evaluations and treatment may be performed by:

        i) Primary care physician,

        ii) Nurse Practitioner,

        iii) Physician Assistant,

        iv) Registered dietician,

        v) Mental health providers available through the Client's Behavioral Health Organization.

3. Eligible Places of Service

    a. All surgeries shall be performed at a Hospital, as defined at 8.300.1.

        i) Facilities must have safety protocols in place specific to the care and treatment of bariatric clients.

    b. Pre- and Post- operative care may be performed at a physician's office, clinic, or other medically appropriate setting.

4. Covered Services and Limitations

a. Colorado Medicaid covers participating providers for one bariatric procedure per client lifetime unless a revision is appropriate based one of the identified complications.

i) Appropriate revision procedures are identified at section 8.300.3.C.4.d.

b. Covered primary procedures Include:

i) Roux-en-Y Gastric Bypass;

ii) Adjustable Gastric Banding;

iii) Biliopancreatic Diversion with or without Duodenal Switch;

iv) Vertical-Banded Gastroplasty;

v) Vertical Sleeve Gastroplasty.

c. Criteria for Primary Procedures

All Clients must meet the first four following criteria, clients under age 18 must meet criteria five:

i) The client is clinically obese with one of the following:

1) BMI of 40 or higher, or

2) BMI of 35-40 with objective measurements documenting one or more of the following co-morbid conditions:

a) Severe cardiac disease;

b) Type 2 diabetes mellitus;

c) Obstructive sleep apnea or other respiratory disease;

d) Pseudo-tumor cerebri;

e) Hypertension;

f) Hyperlipidemia;

g) Severe joint or disc disease that interferes with daily functioning;

h) Intertriginous soft-tissue infections, nonalcoholic steatohepatitis, stress urinary incontinence, recurrent or persistent venous stasis disease, or significant impairment in Activities of Daily Living (ADL).

ii) The BMI level qualifying the client for surgery (>40 or >35 with one of the above co-morbidities) must be of at least two years' duration. A client's BMI may fluctuate around the required levels during this period around the required levels, and will be reviewed on a case-by-case basis.

iii) The client must have made at least one clinically supervised attempt to lose weight lasting at least six consecutive months or longer within the past eighteen months of the prior authorization request, monitored by a registered dietician that is supervised by a physician, nurse practitioner, or physician's assistant.

iv) Medical and psychiatric contraindications to the surgical procedure must have been ruled out through:

1) A complete history and physical conducted by or in consultation with the requesting surgeon; and

2) A psychiatric or psychological assessment, conducted by a licensed mental health professional, no more than three months prior to the requested authorization. The assessment must address both potential psychiatric contraindications and client's ability to comply with the long-term postoperative care plan.

v) For clients under the age of eighteen, the following must be documented:

1) The exclusion or diagnosis of genetic or syndromic obesity, such as Prader-Willi Syndrome;

2) Whether female clients have attained Tanner stage IV breast development; and

3) Whether bone age studies estimate the attainment of 95% of projected adult height.

4) Mental health evaluations for clients age 17 must address issues specific to these clients' maturity as it relates to compliance with postoperative instructions.

d. Revision Procedures

i) Colorado Medicaid covers Revisions of a surgery for clinical obesity if it is used to correct complications such as slippage of an adjustable gastric band, intestinal obstruction, or stricture, following a primary procedure.

ii) Indications for surgical revision:

1) Weight loss to 20% below the ideal body weight;

2) Esophagitis, unresponsive to nonsurgical treatment;

3) Hemorrhage or hematoma complicating a procedure;

4) Excessive bilious vomiting following gastrointestinal surgery;

5) Complications of the intestinal anastamosis and bypass;

6) Stomal dilation, documented by endoscopy;

7) Documented slippage of the adjustable gastric band;

8) Pouch dilation documented by upper gastrointestinal examination or endoscopy producing weight gain of 20% of more, provided that:

a) The primary procedure was successful in inducing weight loss prior to the pouch dilation; and

b) The client has been compliant with a prescribed nutrition and exercise program following the procedure (weight and BMI prior to surgery, at lowest stable point, and at current time must be submitted along with surgeon's statement to document compliance with diet and exercise);

9) Other and unspecified post-surgical non-absorption complications.

e. Non-Covered Services:

i) For Clients with clinically diagnosed COPD (Chronic Obstructive Pulmonary Disease), including Chronic Bronchitis or Emphysema.

ii) Repeat procedures not associated with surgical complications.

iii) Cosmetic Follow-up: Weight loss following surgery for clinical obesity can result in skin and fat folds in locations such as the medial upper arms, lower abdominal area, and medial thighs. Surgical removal of this skin and fat for solely cosmetic purposes is not a covered benefit.

iv) During pregnancy.

5. Prior Authorization Requirements

All bariatric surgical procedures require prior authorization, which must include:

a) The Client's height, weight, BMI with duration.

b) A list and description of each co-morbid condition, with attention to any contraindication which might affect the surgery including all objective measurements.

c) A detailed account of the Client's clinically supervised weight loss attempt(s), including duration, medical records of attempts, identification of the supervising clinician, and evidence of successful completion and compliance.

d) A current psychiatric or psychological assessment regarding contraindications for bariatric surgery, as described in 8.300.3.C.4.c(iv)(2).

e) A statement written or agreed to by the client, detailing for the interdisciplinary team the client's:

i) Commitment to lose weight;

ii) Expectations of the surgical outcome;

iii) Willingness to make permanent life-style changes;

iv) Be willing to participate in the long-term postoperative care plan offered by the surgery program, including education and support, diet therapy, behavior modification, and activity/exercise components; and

v) If female, client's statement that she is not pregnant or breast-feeding and does not plan to become pregnant within two years of surgery.

f) A description of the post-surgical follow-up program.

g) For clients under the age of eighteen, documentation of the physical criteria requirements at 8.300.3.C.4.c(v).

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Division Rule Concerning Dialysis Treatment Centers Section 8.310
Rule Number:	MSB 14-07-28-C
Division / Contact / Phone:	HPBO / Ana Lucaci / x6163

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 14-07-28-C, Revision to the Medical Assistance Health Program Services and Supports Division Rule Concerning Dialysis Treatment Centers Section 8.310
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) 8.310, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Delete all current text beginning at §8.310 through the end of §8.310.1 second unnumbered paragraph. Insert new text provided beginning at §8.310 through the end of §8.310.3.C.1. This revision is effective 12/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Division Rule Concerning Dialysis Treatment Centers Section 8.310
Rule Number:	MSB 14-07-28-C
Division / Contact / Phone:	HPBO / Ana Lucaci / x6163

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 Department is updating this rule to include content from the Dialysis Services Benefit Coverage Standard. Specifically, the rule will define the amount, scope and duration of the benefit.

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. § 1396d(a)(8)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   § 25.5-5-301, C.R.S.

Initial Review	**10/10/2014**	Final Adoption	**11/14/2014**
Proposed Effective Date	**12/30/2014**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Health Program Services and Supports Division Rule Concerning Dialysis Treatment Centers Section 8.310
Rule Number:	MSB 14-07-28-C
Division / Contact / Phone:	HPBO / Ana Lucaci / x6163

REGULATORY ANALYSIS

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

This rule will impact clients and providers of Dialysis 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.

Clearly defined and updated rules will improve client access to appropriate, high quality, cost-effective and evidence-based services while improving the health outcomes of Medicaid clients. Established criteria within rule will provide guidance to clients and providers regarding benefit coverage.

For example, this rule will help ensure that appropriately diagnosed clients are receiving the allowed services, such as hemodialysis or peritoneal dialysis in a dialysis treatment center. The rule also clarifies responsibilities that dialysis centers carry when clients are performing in-center self-dialysis and home-dialysis: provide appropriate course of training by qualified personnel, necessary supplies, and equipment for dialysis services. In the case of home-dialysis, the dialysis center is also responsible for the delivery, installation, and maintenance of the equipment.

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

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

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

Clearly defined and updated rules increase client access to appropriate services and allow the Department to administer benefits in compliance with federal and state regulations, as well as clinical best practices and quality standards. Defining this benefit in rule will educate clients about their benefits and provide better guidance to service providers. The cost of inaction could result in decreased access to services, poor quality of care, and/or lack of compliance with state and federal guidance.

All of the above translates into cost savings for the state.

In FY [13-14] estimated benefit utilization and associated costs (estimated due to lack of Quarter 4 data) were as follows:

1. [1,408] people accessed this benefit;
2. Total expenditures were [$10,150,667.95]; and
3. Per capita expenditure averaged [$7,209.28]

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 methods or less intrusive methods for achieving the purpose of this rule. The department must appropriately define amount, scope and duration of this benefit in order to responsibly manage it.

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

N/A. The Department also documents its benefit coverage policies in written coverage standards. The benefit coverage policies must be written into rule to have the force of law.

~~**8.310 DIALYSIS TREATMENT CENTERS**~~

~~**8.310.1 Dialysis Treatment Center Benefit Coverage Standard Incorporated by Reference**~~

~~All Dialysis Treatment Centers enrolled in the Colorado Medicaid program shall be in compliance with the Colorado Medicaid Dialysis Treatment Center Benefit Coverage Standard (approved May 1, 2012) which is hereby incorporated by reference. The incorporation of the Dialysis Treatment Center Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.~~

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

8.310 DIALYSIS TREATMENT CENTERS

8.310.1 Definitions

Acute Kidney Injury (AKI) is the sudden loss of kidney function, the ability of the kidneys to remove waste and excess fluid. AKI is typically a condition in which kidney function can be expected to recover after a short period of time with treatment (i.e. pharmaceuticals or dialysis). However, AKI can progress to a complete recovery of kidney function, development of Chronic Kidney Disease (CKD) or End Stage Renal Disease (ESRD).

Chronic Kidney Disease (CKD) is the slow loss of kidney function over time until the kidneys reach ESRD.

Dialysis is the process of cleaning the blood when the kidneys have failed and are no longer filtering the blood to remove waste and excess fluid. Kidney failure can stem from AKI or CKD. Dialysis includes both peritoneal dialysis and hemodialysis.

End Stage Renal Disease (ESRD) is defined as irreversible and permanent damage to the kidneys that requires either a regular course of dialysis treatment or kidney transplantation to maintain life.

Provider means a Dialysis Treatment Center that is hospital-affiliated or independent of a licensed hospital, and licensed by the Colorado Department of Public Health and Environment to provide outpatient dialysis services or training for home or self-dialysis.

Home Dialysis Training is a program that trains Clients to perform dialysis in the client's home with little or no professional assistance, and trains other individuals to assist clients in performing home dialysis.

Self-Dialysis Training is a program that trains Clients to perform self-dialysis in the treatment facility with little or no professional assistance, and trains other individuals to assist Clients in performing self-dialysis.

8.310.2. Eligibility

8.310.2.A. Client Eligibility

1. Any Colorado Medicaid Client diagnosed with CKD, AKI or ESRD, which requires dialysis treatments to restore kidney function or maintain life shall be eligible.

8.310.2.B. Provider Eligibility

1. To provide services, a Dialysis Treatment Center must be:

    a. Enrolled in the Colorado Medical Assistance Program;

    b. Certified by the Centers for Medicare and Medicaid Services (CMS) to participate in the Medicare program as a dialysis treatment center;

    c. Certified by the Colorado Department of Public Health and Environment

8.310.2.C. Prior Authorization

1. Prior Authorization is not required for services listed at Section 8.310.3.B.

8.310.3. General Services

8.310.3.A. Provider Requirements

1. The Provider must utilize the most cost efficient method of dialysis treatment appropriate for each client, as assessed through an evaluation for peritoneal dialysis based upon an individual medical diagnosis and condition.

2. The Provider Facility must develop and implement a written, individualized comprehensive plan of care for each patient, which must include:

    a. The services necessary to address the patient’s needs;

    b. The comprehensive assessment and changes in the patient’s condition;

    c. Measurable and expected outcomes, and estimated timetables to achieve these outcomes;

d. The outcomes specified in the patient plan of care must be consistent with current evidence-based professionally-accepted clinical practice standards; and

e. The plan of care must represent the selection of a suitable treatment modality (e.g., dialysis or transplantation) and dialysis setting (e.g., home, self-care) for each patient (42 CFR 405, 410, 413, 414, 488 and 494).

8.310.3.B. Covered Dialysis Services

The following are covered services under the Colorado Medicaid Dialysis Center Program:

1. In-Center Dialysis

a. Dialysis treatments completed by facility staff, and all necessary equipment and supplies.

b. In-Center dialysis is a benefit when the client meets one of the following conditions:

i) The client requires dialysis treatments prior to completing home dialysis training;

ii) Training to perform self-treatment in the home environment is contraindicated;

iii) The client is otherwise not a proper candidate for self-treatment in a home environment;

iv) The home environment of the eligible client contraindicates self-treatment; or

v) The eligible client is awaiting a kidney transplant.

c. Self-dialysis may be performed within the facility with limited professional assistance, if the client has completed an appropriate course of training.

i) The benefit includes training of the client by qualified personnel.

2. Home Dialysis

a. To be eligible for home dialysis a client or client's caregiver must receive appropriate training to perform dialysis at home.

b. The benefit includes training by qualified personnel, necessary supplies, and equipment for dialysis services.

c. The Benefit includes delivery, installation, and maintenance of equipment for home dialysis

3. The following are included in the Dialysis Center reimbursement and should not be billed separately:

a. Costs associated with home dialysis other than necessary delivery, equipment, installation, maintenance, supplies, or training.

b. Blood and blood products.

c. Additional staff time or personnel costs.

d. Routine Laboratory Services

i) All laboratory services considered routine for dialysis treatment, and performed by a dialysis treatment facility, are included as part of the dialysis treatment reimbursement.

ii) A Provider performing routine laboratory services must be a certified clinical laboratory.

e. Routine Pharmaceuticals for Dialysis Treatment

i) All pharmaceuticals considered routine for dialysis treatment, and dispensed by a dialysis treatment facility, are included as part of the dialysis treatment reimbursement.

ii) Pharmaceuticals not dispensed by the dialysis provider are billed by and reimbursed to the dispensing pharmacy.

8.310.3.C. Non-Covered Services

The following are non-covered services under the Colorado Medicaid Dialysis Center benefit:

1. Personal care items such as slippers or toothbrushes.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Managed Care Contracts Division Rule Concerning Billing Procedures for Certified Health Agencies, Section 8.564
Rule Number:	MSB 14-05-06-A
Division / Contact / Phone:	Health Programs / Richard Delaney / 303 866-3436

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 14-05-06-A, Revision to the Medical Assistance Managed Care Contracts Division Rule Concerning Billing Procedures for Certified Health Agencies, Section 8.564
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) 8.564.B, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace current text at §8.564.B with the new text provided. All text indicated in blue is for clarity only and should not be changed. This revision is effective 12/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Managed Care Contracts Division Rule Concerning Billing Procedures for Certified Health Agencies, Section 8.564
Rule Number:	MSB 14-05-06-A
Division / Contact / Phone:	Health Programs / Richard Delaney / 303 866-3436

STATEMENT OF BASIS AND PURPOSE

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

   This rule is amending the reference to a specific claim form that will no longer be accepted by the Department of Health Care Policy and Financing. The existing form is the Colorado 1500, the new form will be the CMS 1500. The CMS 1500 is the standard form for claim submission.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

Initial Review	**10/10/2014**	Final Adoption	**11/14/2014**
Proposed Effective Date	**12/30/2014**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Managed Care Contracts Division Rule Concerning Billing Procedures for Certified Health Agencies, Section 8.564
Rule Number:	MSB 14-05-06-A
Division / Contact / Phone:	Health Programs / Richard Delaney / 303 866-3436

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 change will not affect services or members, the change is specific to the billing requirements for Certified Health Agencies that use paper forms.

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

   No impact is expected. The change is to forms that are standard in the industry.

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

   There are no costs directly related to this rule change.

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

   Not applicable.

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

   The change of billing forms is appropriate to make claiming easier for providers. If there is any cost, it will be a reduction in costs by the providers by being able to use the industry standard form.

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 changes are a response to stakeholder suggestions that the Department use the industry standard claim form.

8.564 BILLING PROCEDURES

A. Certified health agencies providing clinic services must bill the Medical Assistance Program directly using the designated billing method and the prescribed procedure codes recognized by the Colorado State Department of Social Services. The amount of the provider's usual and customary charges to the general public will be billed if applicable.

B. Obstetrical services and adjunctive services, except for EPSDT medical screenings, must be billed directly as described in 10 C.C.R. 2505-10, Section 8.040.2~~on the Colorado 1500 Claim Form~~.

C. EPSDT medical screening services must be billed directly on the EPSDT Screening/Claim Form.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Client and Clinical Care Durable Medical Equipment Rule Concerning Complex Rehabilitation Technology, Section 8.590
Rule Number:	MSB 14-07-28-D
Division / Contact / Phone:	Client & Clinical Care/Pharmacy Unit/Eskedar Makonnen/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 14-07-28-D, Revision to the Medical Assistance Client and Clinical Care Durable Medical Equipment Rule Concerning Complex Rehabilitation Technology, Section 8.590
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.590, 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*

Insert after the second unnumbered paragraph at §8.590.1 that begins with "Cochlear Implant or . . ." the new text provided in unnumbered paragraphs beginning with "Complex Rehabilitation Technology means . . ."; subparagraphs a., b., c.; unnumbered paragraph beginning with "Complex Rehabilitation Technology Professional means . . ."; and unnumbered paragraph beginning with Complex Rehabilitation Technology Supplier means . . .". Insert new unnumbered paragraph that begins "Financial Relationship means . . ." immediately after current unnumbered paragraph that begins "Durable Medical Equipment (DME) means…" and immediately before the unnumbered paragraph that begins "Facilitative Device means…". Insert new unnumbered paragraph that begins "Immediate Family Member means . . ." immediately after current unnumbered paragraph that begins "Hearing Aid means…" and immediately before the unnumbered paragraph that begins "Medical Necessity, for purposes …". Insert new unnumbered paragraph that begins "Qualified Health Care Professional means

*to be completed by MSB Board Coordinator

. . .” immediately after current unnumbered paragraph that begins “Prosthetic or Orthotic Device means…” and immediately before the unnumbered paragraph that begins “Related Owner means…”.

Add new text provided at §8.590.2.G.17. Add new text provided beginning at §8.590.5.D and ending with §8.580.5.D.5. Add new text provided beginning at §8.590.7.L and ending with §8.590.7.L.3.

All text provided in blue is for clarity only and should not be changed. This revision is effective 12/30/2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Client and Clinical Care Durable Medical Equipment Rule Concerning Complex Rehabilitation Technology, Section 8.590
Rule Number:	MSB 14-07-28-D
Division / Contact / Phone:	Client & Clinical Care/Pharmacy Unit/Eskedar Makonnen/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).

   HB 14-1211 requires the Department of Health Care Policy and Financing (Department) to recognize Complex Rehabilitation Technology (CRT) as a unique category of services under Medicaid. The Department must adopt CRT supplier standards and restrict the provision of CRT to only suppliers meeting the standards; and ensure clients receiving CRT are evaluated or assessed as needed by both a qualified healthcare professional and a qualified CRT professional. The proposed rule will make changes to Section 8.590 to reflect these new benefit standards for CRT.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

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

Initial Review	**10/10/2014**	Final Adoption	**11/14/2014**
Proposed Effective Date	**12/30/2014**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Client and Clinical Care Durable Medical Equipment Rule Concerning Complex Rehabilitation Technology, Section 8.590
Rule Number:	MSB 14-07-28-D
Division / Contact / Phone:	Client & Clinical Care/Pharmacy Unit/Eskedar Makonnen/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 benefits clients who qualify for CRT by ensuring the Department continues to protect access to CRT for individual clients with unique medical, physical and functional needs. Current practices allow for any DME supplier to provide CRT. The rule restricts the provision of CRT to only qualified CRT suppliers who meet certain standards. While that may exclude some DME suppliers, it will ensure CRT suppliers maintain a level of quality so that clients receive the appropriate CRT that meets their unique medical, physical and functional needs.

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 established CRT supplier standards ensures clients getting CRT will receive the appropriate design and configuration by limiting the provision of CRT to qualified suppliers. Clients will also receive specialty evaluation or assessment by a health care professional and a CRT professional. This can cut time and cost that would have otherwise resulted from improperly fitted CRT. Providers who wish to be CRT suppliers would have to take the necessary steps to comply with all the CRT supplier standards to ensure they are delivering access to quality services for all CRT 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.

   HB 14- 1211 appropriated the Department $51,133 comprised of $16,533 from the general fund and $34,600 from federal for Fiscal Year 2014-15 to implement the CRT bill. The Department does not anticipate the cost of implementing the bill will exceed the appropriated amount.

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

   The proposed rule change ensures the Department is compliant with state law. Failure to implement the proposed rule change would cause the Department to be noncompliant with state law.

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 methods or less intrusive methods, the rule change is to comply with HB 14-1211.

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.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.590.1 DEFINITIONS

Abuse, for purposes of this rule only, means the intentional destruction of or damage to equipment that results in the need for repair or replacement.

Cochlear Implant or cochlear prosthesis means an electrode or electrodes surgically implanted in the cochlea which are attached to an induction coil buried under the skin near the ear, and the associated unit which is worn on the body.

Complex Rehabilitation Technology means individually configured manual Wheelchair systems, power Wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designated options and accessories, which qualify as Durable Medical Equipment that:

a. Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living, including employment, identified as medically necessary to promote mobility in the home and community or prevent hospitalization or institutionalization of the client;

b. Are primarily used to serve a medical purpose and generally not useful in the absence of illness or injury; and

c. Require certain services provided by a qualified Complex Rehabilitation Technology Supplier to ensure appropriate design, configuration, and use pf such items, including patient evaluation or assessment of the client by a Qualified Health Care Professional, and that are consistent with the client's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

Complex Rehabilitation Technology Professional means an individual who is certified by the Rehabilitation Engineering and Assistive Technology Society of North America or other nationally recognized accrediting organizations as an assistive technology professional.

Complex Rehabilitation Technology Supplier means a provider who meets all the requirements of Section 8.590.5.D.

Disposable Medical Supplies (Supplies) means supplies prescribed by a physician that are specifically related to the active treatment or therapy for an illness or physical condition. Supplies are non-durable, disposable, consumable and/or expendable.

Durable Medical Equipment (DME) means medically necessary equipment prescribed by a physician that can withstand repeated use, serves a medical purpose, and is appropriate for use outside of a medical facility.

Financial Relationship means any ownership interest, investment interest or compensation arrangement between a Qualified Health Care Professional and a Complex Rehabilitation Technology Supplier, or their officers, directors, employees or Immediate Family Members. An ownership or investment interest may be reflected in equity, debt, or other instruments and includes, but is not limited to, mortgages, deeds of trust, notes or other obligations secured by either entity.

Facilitative Device means DME with a retail price equal to or greater than one hundred dollars that is exclusively designed and manufactured for a client with disabilities to improve, maintain or restore self-sufficiency or quality of life through facilitative technology. Facilitative Devices do not include Wheelchairs.

Hearing Aid means a wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories thereto, including ear molds but excluding batteries and cords.

Immediate Family Member means any spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, sibling or stepsibling, in-laws, grandparents and grandchildren.

Medical Necessity, for purposes of rule 8.590, means DME, Supplies and Prosthetic or Orthotic Devices that are necessary in the treatment, prevention or alleviation of an illness, injury, condition or disability.

Misuse means failure to maintain and/or the intentional utilization of DME, Supplies and Prosthetic or Orthotic Device in a manner not prescribed, recommended or appropriate that results in the need for repairs or replacement. Misuse also means DME, Supply or Prosthetic Device use by someone other than the client for whom it was prescribed.

Prosthetic or Orthotic Device means replacement, corrective or supportive devices that artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

Qualified Health Care Professional means a licensed physical therapist, a licensed occupational therapist, or other licensed health care professional who performs specialty evaluations within his/her scope of practice and who has no Financial Relationship with a Complex Rehabilitation Technology Supplier.

Related Owner means an individual with 5% or more ownership interest in a business and one entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business.

Related Party means a provider who is associated or affiliated with, or has control of, or is controlled by the organization furnishing the DME, Supplies and Prosthetic or Orthotic Device. An owner related individual shall be considered an individual who is a member of an owner's immediate family, including a spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, sibling or stepsibling, in-laws, grandparents and grandchildren.

Wheelchair means any wheelchair or scooter that is motor driven or manually operated for the purposes of mobility assistance, purchased by the Department or donated to the client.

Wrongful Disposition means the mismanagement of DME, Supplies and Prosthetic or Orthotic Devices by a client by selling or giving away the item reimbursed by the Department.

8.590.2 BENEFITS

8.590.2.A. DME, Supplies and Prosthetic or Orthotic Devices are a benefit when Medically Necessary. To determine Medical Necessity the equipment, supplies, and Prosthetic or Orthotic Device shall:

1. Be prescribed by a physician and when applicable, be recommended by an appropriately licensed practitioner.

2. Be a reasonable, appropriate and effective method for meeting the client's medical need.

3. Have an expected use that is in accordance with current medical standards or practices.

4. Be cost effective, which means that less costly and medically appropriate alternatives do not exist or do not meet treatment requirements.

5. Provide for a safe environment.

6. Not be experimental or investigational, but generally accepted by the medical community as standard practice.

7. Not have as its primary purpose the enhancement of a client's personal comfort or to provide convenience for the client or caretaker.

8.590.2.B. DME, Supplies and Prosthetic or Orthotic Devices shall not be provided to clients residing in a hospital, nursing facility or other facility receiving daily Medicaid reimbursement except under the following circumstances:

1. DME, Supplies and Prosthetic or Orthotic Devices may be provided to clients residing in a hospital, nursing facility or other facility receiving daily Medicaid reimbursement if the client is within fourteen days of discharge and when prior authorization and/or training are needed to assist the client with equipment usage and the equipment is needed immediately upon discharge from the facility.

2. Repairs and modifications to client owned DME, Prosthetic or Orthotic Devices not required as part of the per diem reimbursement shall be provided to clients residing in a hospital, nursing facility or other facility receiving daily Medicaid reimbursement.

3. Prosthetic or Orthotic Devices may be provided to clients residing in a hospital, nursing facility or other facility receiving daily Medicaid reimbursement if Prosthetic or Orthotic benefits are not included in the facilities' per diem rate.

8.590.2.C. DME, Supplies and Prosthetic or Orthotic Devices shall not be duplicative or serve the same purpose as items already utilized by the client unless it is medically required for emergency or backup support. Backup equipment shall be limited to one.

8.590.2.D. All items purchased by the Department shall become the property of the client unless the client and provider are notified otherwise by the Department at the time of purchase.

8.590.2.E. Rental equipment shall be provided if the Department determines it to be cost effective and Medically Necessary.

8.590.2.F. Supplies shall be for a specific purpose, not incidental or general purpose usage.

8.590.2.G. The following DME and Supplies are benefits for clients regardless of age:

1. Ambulation devices and accessories including but not limited to canes, crutches or walkers.

2. Bath and bedroom safety equipment.

3. Bath and bedroom equipment and accessories including, but not limited to, specialized beds and mattress overlays.

4. Manual or power Wheelchairs and accessories.

5. Diabetic monitoring equipment and related disposable supplies.

6. Elastic supports/stockings.

7. Blood pressure, apnea, blood oxygen, Pacemaker and uterine monitoring equipment and supplies.

8. Oxygen and oxygen equipment in the client's home, a nursing facility or other institution. The institutional oxygen benefit is fully described in 10 C.C.R. 2505-10, Section 8.580.

9. Transcutaneous and/or neuromuscular electrical nerve stimulators (TENS/NMES) and related supplies.

10. Trapeze, traction and fracture frames.

11. Lymphedema pumps and compressors.

12. Specialized use rehabilitation equipment.

13. Oral and enteral formulas and supplies.

14. Parenteral equipment and supplies.

15. Environmental controls for a client living unattended if the controls are needed to assure medical safety.

16. Facilitative Devices.

    a. Telephone communication devices for the hearing impaired and other facilitative listening devices, except hearing aids, and cochlear implants.

    b. Computer equipment and reading devices with voice input or output, optical scanners, talking software, Braille printers and other devices that provide access to text.

    c. Computer equipment with voice output, artificial larynges, voice amplification devices and other alternative and augmentative communication devices.

    d. Voice recognition computer equipment software and hardware and other forms of computers for persons with disabilities.

    e. Any other device that enables a person with a disability to communicate, see, hear or maneuver including artificial limbs and orthopedic footwear.

17. Complex Rehabilitation Technology.

8.590.2.H. The following DME are benefits to clients under the age of 21:

1. Hearing aids and accessories.

2. Phonic ear.

3. Therapy balls for use in physical or occupational therapy treatment.

4. Selective therapeutic toys.

5. Computers and computer software when utilization is intended to meet medical rather than educational needs.

6. Vision correction unrelated to eye surgery.

8.590.2.I. The following Prosthetic or Orthotic Devices are benefits for clients regardless of age:

1. Artificial limbs.

2. Facial Prosthetics.

3. Ankle-foot/knee-ankle-foot orthotics.

4. Recumbent ankle positioning splints.

5. Thoracic-lumbar-sacral orthoses.

6. Lumbar-sacral orthoses.

7. Rigid and semi-rigid braces.

8. Therapeutic shoes.

9. Orthopedic footwear, including shoes, related modifications, inserts and heel/sole replacements.

10. Specialized eating utensils and other medically necessary activities of daily living aids.

11. Augmentative communication devices and communication boards.

8.590.2.J. Repairs and replacement parts are covered under the following conditions:

1. The item was purchased by Medicaid; or

2. The item is owned by the client, client's family or guardian; and

3. The item is used exclusively by the client; and

4. The item's need for repair was not caused by client misuse, abuse or neglect; and

5. The item is no longer under the manufacturer warranty.

8.590.2.K. Repairs, replacement, and maintenance shall be based on the manufacturer's recommendations and shall be performed by a qualified rehabilitation professional. Repairs, replacement and maintenance shall be allowed on the client's primary equipment and/or one piece of backup equipment. Multiple backup equipment will not be repaired, replaced or maintained.

8.590.2.L. If repairs are frequent and repair costs approach the purchase price of new equipment, the provider shall make a request for the purchase of new equipment. The prior authorization request shall include supporting documentation explaining the need for the replacement equipment and the cost estimates for repairs on both the old equipment and the new equipment purchase.

8.590.2.M. Supplies are a covered benefit when related to the following:

1. Surgical, wound or burn care.

2. Syringes or needles.

3. Bowel or bladder care.

4. Antiseptics or solutions.

5. Gastric feeding sets and supplies.

6. Tracheostomy and endotracheal care supplies.

7. Diabetic monitoring.

8.590.2.N. Quantities of supplies shall not exceed one month's supply unless they are only available in larger quantities as packaged by the manufacturer.

8.590.2.O. Medicaid clients for whom Wheelchairs, Wheelchair component parts and other specialized equipment were authorized and ordered prior to enrollment in a Managed Care Organization, but delivered after the Managed Care Organization enrollment shall be the responsibility of the Department. All other DME and disposable supplies for clients enrolled in a Managed Care Organization shall be the responsibility of the Managed Care Organization.

8.590.2.P. Items used for the following are not a benefit to a client of any age:

1. Routine personal hygiene.

2. Education.

3. Exercise.

4. Participation in sports.

5. Client or caretaker convenience.

6. Cosmetic purposes.

7. Personal comfort.

8.590.2.Q. For clients age 21 and over, the following items are not a benefit:

1. Hearing aids and accessories.

2. Phonic ears.

3. Therapeutic toys.

4. Vision correction unrelated to eye surgery.

8.590.2.R. Rental Policy.

1. The Department may set a financial cap on certain rental items. The monetary price for those items shall be determined by the Department and noted in the Medicaid bulletin.

The provider is responsible for all maintenance and repairs as described at 8.590.4.P-Q, until the cap is reached.

2. Upon reaching the capped amount, the equipment shall be considered purchased and shall become the property of the client. The provider shall give the client and/or caregiver all applicable information regarding the equipment as described at 8.590.4.C.4. The equipment shall not be under warranty after the rental period ends.

3. The rental period may be interrupted, for a maximum of sixty consecutive days.

4. If the rental period is interrupted for a period greater than sixty consecutive days, the rental period must begin again. The interruption must be justified, documented by a physician, and maintained in the provider file.

5. If the client changes providers, the current rental cap remains in force.

8.590.2.S DME and Supply Benefit Coverage Standards Incorporated by Reference

All eligible providers of Durable Medical Equipment and Disposable Medical Supplies enrolled in the Colorado Medicaid program shall be in compliance with the following Colorado Medicaid Benefit Coverage Standards, which are hereby incorporated by reference:

1. Alternative and Augmentative Communication Devices (AACD) (approved June 28, 2013). The incorporation of the AACD Benefit Coverage Standard excludes later amendments to, or editions of, the referenced material.

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

8.590.3 PRIOR AUTHORIZATION

8.590.3.A. Selected DME, Supplies, and Prosthetic or Orthotic Devices require prior authorization before they will be provided. All items requiring prior authorization are listed in the Medicaid bulletin.

8.590.3.B. Prior authorization shall not be required for Medicare Crossover claims.

8.590.3.C. Prior authorization shall be required for clients who have other primary insurance besides Medicare.

8.590.3.D. Prior authorization requests shall include the following information:

1. A full description of the item(s).

2. The requested number of items.

3. A full description of all attachments, accessories and/or modifications needed to the basic item(s).

4. The effective date and estimated length of time the item(s) will be needed.

5. The diagnosis, prognosis, previous and current treatments and any other clinical information necessary to establish Medical Necessity for the client.

6. Any specific physical limitations the client may have that are relevant to the prior authorization consideration.

7. The client's prescribing physician's, primary care physician's and provider's name and identification numbers.

8. The serial numbers for all Wheelchair repairs.

9. The ordering physician's signature. The physician can either sign the authorization or attach a written prescription or letter of medical necessity to the authorization.

8.590.3.E. Diagnostic and clinical information shall be completed prior to the physician's signature. The provider shall not complete or add information to the prior authorization after the physician has signed the request.

8.590.3.F. Requests for prior authorization shall be submitted in a timely fashion. Requests submitted with a begin date in excess of three months prior to the date of submission shall include additional, updated documentation indicating the continued Medical Necessity of the request. Retroactive approval beyond three months without such documentation shall be considered only in cases of client retroactive program eligibility.

8.590.3.G. Approval of a prior authorization does not guarantee payment or constitute a waiver of any claims processing requirements including eligibility and timely filing.

8.590.4 PROVIDER RESPONSIBILITIES

Providers shall issue express warranties for Wheelchairs and Facilitative Devices and shall assure that any refund resulting from the return of a Wheelchair or other Facilitative Device is returned to the Department in compliance with Sections 6-1-401 to 6-1-412, C.R.S. (2005) and Sections 6-1-501 to 6-1-511, C.R.S. (2005). Sections 6-1-401 to 6-1-412 and 6-1-501 to 6-1-511, C.R.S. (2005) are incorporated herein by reference. No amendments or later editions are incorporated. The Acute Care Benefits Section Manager, Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of the statute, or the materials may be examined at any publications depository library.

8.590.4.A. The Provider shall implement a system that supports client autonomy and describes how equipment will be serviced and maintained, routine follow-up and response procedures to prevent any interruption of services to the clients. This system shall include provisions describing how service and repairs may occur at the client's location when appropriate.

8.590.4.B. The Provider shall implement and maintain a process for honoring all warranties expressed and implied under applicable State laws.

8.590.4.C. Providers of custom Wheelchairs, seating products and any other DME shall be able to appropriately assess and provide adequate repairs, adjustment and service by qualified rehabilitation professionals for all products they distribute.

8.590.4.D. Providers shall maintain the following for all items provided to a client:

1. Physician prescriptions.

2. Approved prior authorization requests.

3. Additional documentation received from physicians or other licensed practitioners.

4. Documentation that the client and/or caregiver have been provided with the following:

   a. Manufacturer's instructions.

   b. Warranty information.

   c. Registration documents.

   d. Service manual.

   e. Operating guides.

5. Documentation on all reimbursed equipment, which shall include:

   a. Manufacturer's name and address.

   b. Date acquired.

   c. Acquisition cost.

   d. Model number.

   e. Serial number.

   f. Accessories, attachments or special features included in the item.

6. Providers shall verify that equipment requiring repairs belongs to the presenting client.

8.590.4.E. Providers shall retain all documentation for a period of six years.

8.590.4.F. Providers shall provide a copy of all documentation to a client or his/her representative, if requested.

8.590.4.G. Providers shall be responsible for delivery of and instructing the client on the proper use of the ordered/authorized equipment or supplies appropriate for the stated purpose consistent with the requirements, goals and desired outcomes at the time of the prescription and delivery.

8.590.4.H. The provider shall be responsible for client evaluation, wheelchair measurements and fittings, client education, adjustments, modifications and delivery set-up installation of equipment in the home. If modifications require the provider to fabricate customized equipment or orthotics to meet client needs, the provider shall justify the necessity and the cost of additional materials of the modifications. Modifications shall not alter the integrity, safety or warranty of the equipment.

8.590.4.I. The provider shall pick-up inappropriate or incorrect items within five business days of being notified. The provider shall not bill the Department for items known to be inappropriate or incorrect and awaiting pick-up. The provider shall submit a credit adjustment to the Department within twenty business days following the pick-up date if a claim was submitted prior to notification an item was inappropriate or incorrect.

8.590.4.J. Providers shall confirm continued need for disposable supplies with the client or caretaker prior to supply shipment.

8.590.4.K. All purchased equipment shall be new at the time of delivery to the client unless an agreement was reached in advance with the client and Department.

8.590.4.L. Providers shall provide DME, Supplies, Prosthetic or Orthotic Devices, repairs and all other services in the same manner they provide these services to non-Medicaid clients.

8.590.4.M. Providers shall ensure the equipment provided will be warranted in accordance with the manufacturer's warranty. The provider shall not bill Medicaid or the client for equipment, parts, repairs, or other services covered by the warranty.

8.590.4.N. The following requirements shall apply to warranted items:

1. The provider shall be able to provide adequate repairs, adjustments and services by appropriately trained technicians for all products they distribute.

2. The provider shall complete services or repairs in a timely manner and advise the client on the estimated completion time.

3. The provider shall arrange for appropriate alternative, like equipment in the absence of client owned backup equipment. The provider shall provide the alternative equipment at no cost. If the backup equipment is not available as loan equipment, the provider shall arrange for a temporary equipment rental through the Department.

4. The provider shall exclude from warranty provisions, replacement or repairs to equipment that are no longer able to meet client needs due to changes in anatomical and/or medical condition that occurred after purchase.

5. The provider may refuse warranty services on items for which there have been documented patterns of specific client abuse, misuse or neglect. The provider shall notify the Department in all documented cases of abuse, misuse or neglect within ten business days of learning of the incident of abuse.

8.590.4.O. Previously used or donated DME may be provided to the client if agreed upon by the client and the Department Departmental approval will be coordinated by the Acute Care Benefits Section.

8.590.4.P. The Provider shall assure the item provided meets the following conditions:

1. The item is fully serviced and reconditioned.

2. The item is functionally sound and in good operating condition.

3. The item will be repaired and have parts replaced in a manner equivalent to an item that is new. The item will have parts available for future repairs in a manner equivalent to the manufacturer's warranty on a like item which is new.

4. The provider will make all adjustments and modifications needed by the client during the first year of use, except for changes and adjustments required due to growth or other anatomical changes or for repairs not covered by the manufacturer's warranty on a like new item.

8.590.4.Q. The provider shall receive and perform service and repairs in the same manner they provide services for non-Medicaid clients for rental equipment.

8.590.4.R. The provider shall assure the following for rental equipment:

1. Appropriate service to the item.

2. Complete services or repairs in a timely manner with an estimate of the approximate time required.

3. Appropriate alternative equipment during repairs.

4. Provision and replacement of all expendable items, including but not limited to hoses, fuses, and batteries.

8.590.5 PROVIDER REQUIREMENTS

8.590.5.A. Providers are required to have one or more physical location(s), within the State of Colorado, or within fifty (50) miles of any Colorado border.

8.590.5.B. The above providers must also have:

1. A street address; and

2. A local business telephone number;

3. An inventory; and

4. Sufficient staff to service or repair products.

8.590.5.C. Providers who do not meet the requirements of 8.590.5.A may apply to become a Medical provider if the DME or disposable medical supplies are medically necessary and cannot otherwise be purchased from a provider who meets the requirements of 8.590.5.A.

1. Applications from providers who do not meet the requirements of 8.590.5.A must be submitted to the DME Program Coordinator for approval.

2. Applications submitted pursuant to this section will be reviewed for approval on a case-by-case basis for those specialty items only.

8.590.5.D. To qualify as a Complex Rehabilitation Technology Supplier, a provider must meet the following requirements:

1. Be accredited by a recognized accrediting organization as a supplier of Complex Rehabilitation Technology;

2. Meet the supplier and quality standards established for Durable Medical Equipment suppliers under the Medicare or Medical Assistance Program;

3. Employ at least one Complex Rehabilitation Technology Professional at each physical location to:

a. Analyze the needs and capacities of a client for a Complex Rehabilitation Technology item in consultation with the evaluating clinical professionals;

b. Assess and determine the appropriate Complex Rehabilitation Technology for a client, with such involvement to include seeing the client either in person or by any other real-time means within a reasonable time frame during the determination process; and

c. Provide the client with technology-related training in the proper use and maintenance of the selected Complex Rehabilitation Technology items.

4. Maintain a reasonable supply of parts, adequate physical facilities, qualified and adequate service or repair technicians to provide clients with prompt service and repair of all Complex Rehabilitation Technology it sells or supplies; and

5. Provide the client with written information at the time of sale on how to access service and repair.

8.590.6 CLIENT RESPONSIBILITIES

8.590.6.A. Clients or client caregivers shall be responsible for the prudent care and use of DME, Supplies, and Prosthetic or Orthotic Devices. Repairs, servicing or replacement of items are not a benefit if there is documented evidence of client Abuse, Misuse, Neglect or Wrongful Disposition.

8.590.6.B. Clients shall be responsible for the cost of any additional items or enhancements to equipment not deemed Medically Necessary. The client shall sign an agreement with the provider that states:

1. The cost of the items.

2. That the client was not coerced into purchasing the items.

3. That the client is fully responsible for the cost, servicing and repairs to the items after the warranty period is completed.

8.590.6.C. The client shall contact the point of purchase for service and repairs to covered items under warranty. Clients may contact a participating provider of their choice for service and repairs to covered items not under warranty or for an item under warranty if the original point of purchase is no longer a participating provider.

8.590.6.D. The client shall become the owner of any equipment purchased by the Department and remains subject to Medicaid DME rules unless otherwise notified by the Department at the time of purchase.

8.590.6.E. The client shall be responsible for obtaining a police report for items being replaced due to theft, fire damage or accident. The police report shall be attached to the prior authorization requesting replacement of the item.

8.590.6.F. The client shall be responsible for reporting to the manufacturer, dealer or alternative warranty service provider instances where a Wheelchair or Facilitative Device does not conform to the applicable express warranty.

8.590.6.G. The client or caregiver shall be responsible for routine maintenance on all equipment purchased or rented by the Department. Routine maintenance is the servicing described in the manufacturer's operating manual as being performed by the user to properly maintain the equipment. Non-performance of routine maintenance shall be considered Neglect. Routine maintenance includes, but is not limited to:

1. Cleaning and lubricating moving parts.

2. Adding water to batteries.

3. Checking tire pressure.

4. Other prescribed Manufacturer procedures.

8.590.6.H. The client utilizing rental equipment shall be responsible for notifying the provider of any change of address. The client shall be responsible for any rental fee accrued during the time the equipment's location is unknown to the provider.

8.590.6.I. The client shall not remove rental equipment from Colorado.

8.590.7 REIMBURSEMENT

8.590.7.A. Invoices received from Related Owners or Related Parties shall not be accepted. Only invoices received from unrelated manufacturers or wholesale distributors shall be recognized as allowable invoices.

8.590.7.B. The provider shall not bill the Department for authorized accessory items included by the manufacturer as part of a standard package for an item.

8.590.7.C. The provider shall credit the cost of any accessory or part removed from a standard package to the Department.

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

8.590.7.E. The refund amount due the Department on a returned Wheelchair or Facilitative Device shall be agreed upon by the dealer or manufacture; wherever the item was returned, and the Department.

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

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

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

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

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

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

8.590.7.G. Reimbursement for used equipment shall include:

1. A written, signed and dated agreement from the client accepting the equipment.

2. Billing the Department, the lesser of 60% of the maximum allowable reimbursement indicated in the most recent Medicaid Bulletin or 60% of the provider's usual submitted charges.

8.590.7.H. Reimbursement for purchased or rented equipment shall include, but is not limited to:

1. All elements of the manufacturer's warranties or express warranties.

2. All adjustments and modification needed by the client to make the item useful and functional.

3. Delivery, set-up and installation of equipment in the home, and if appropriate to a specific room in the home.

4. Training and instruction to the client or caregiver in the safe, sanitary, effective and appropriate use of the item and necessary servicing and maintenance to be done by the client or caregiver.

5. Training and instruction on the manufacturer's instructions, servicing manuals and operating guides.

8.590.7.I. Reimbursement rate for a purchased item shall be as follows:

1. Fee Schedule items, with a HCPC or CPT code, that have a maximum allowable reimbursement rate shall be reimbursed at the lesser of submitted charges or the Department fee schedule rate.

2. Manually priced items that do not have an assigned Fee Schedule rate shall be reimbursed at the lesser of submitted charges or current manufacturer suggested retail price (MSRP) less 19.86 percent.

3. Manually priced items that do not have an MSRP or Fee Schedule rate shall be reimbursed at the lesser of submitted charges or by invoice of actual acquisition cost, minus any discount to the provider as set forth in policy, plus 17.26 percent.

8.590.7.J. Reimbursement for rental items shall be billed and paid in monthly increments unless otherwise indicated in the Medicaid Bulletin.

8.590.7.K. Reimbursement for clients eligible for both Medicare and Medicaid shall be made in the following manner:

1. The provider shall bill Medicare first unless otherwise authorized by the Department.

2. If Medicare makes payment, Medicaid reimbursement will be based on appropriate deductibles and co-payments.

3. If Medicare denies payment, the provider shall be responsible for billing the Department. Reimbursement is dependent upon the following conditions:

a. A copy of the Explanation of Medicare Benefits' shall be maintained in the provider's files when billing electronically or attached to the claim if it is billed manually; or

b. Medicaid reimbursement shall not be made if the Medicare denial is based upon provider submission error.

8.590.7.L. Reimbursement for Complex Rehabilitation Technology provided to clients shall be made when the following conditions are met:

1. The billing provider is a Complex Rehabilitation Technology Supplier;

2. The client has been evaluated or assessed, for selected Complex Rehabilitation Technology identified in the Medicaid Bulletin, by:

   a. A Qualified Health Care Professional; and

   b. A Complex Rehabilitation Technology Professional employed by the billing provider.

3. The Complex Rehabilitation Technology is provided in compliance with all applicable federal and state laws, rules, and regulations, including those rules governing the Medical Assistance Program.

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Eligibility Rule Concerning Five Percent (5%) Income Disregard, Section 8.100.4.D

Rule Number: MSB 14-09-03-A

Division / Contact / Phone: Eligibility Division / Ana Bordallo / 303-866-3558

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 14-09-03-A, Revision to the Medical Assistance Eligibility Rule Concerning Five Percent (5%) Income Disregard, Section 8.100.4.D
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) 8.100.4.D affected, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace current text at 8.100.4.D.1 with the new text provided and add the two new subparagraphs at a. and b. This revision is effective 01/01/2015.

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

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Five Percent (5%) Income Disregard, Section 8.100.4.D
Rule Number:	MSB 14-09-03-A
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 303-866-3558

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 changes amend 10 CCR 2505-10 § 8.100.4.D to incorporate changes to the rule mandated by the Patient Protection and Affordable Care Act of 2010 (ACA) as they pertain to MAGI-based methodologies. Among these changes: modification to the current regulation regarding the five percent (5%) disregard at 8.100.4.D. Currently the five percent (5%) disregard is applied across-the-board for all MAGI populations under title XIX and XXI when determining eligibility. The proposed change will only apply the five percent (5%) disregard to MAGI populations under title XIX or XXI with the highest income threshold identified as the following: MAGI Adult Program (adults), Medicaid and CHP+ program (for children), Medicaid and the CHP+ Prenatal program (for pregnant women). In addition, the five percent (5%) disregard will only be applied as a last step in determining eligibility when the individual is above the income threshold.

2. An emergency rule-making is imperatively necessary

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

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 435.603(d)(4)

4. State Authority for the Rule:

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

Initial Review	**10/10/2014**	Final Adoption	**11/14/2014**
Proposed Effective Date	**12/30/2014**	Emergency Adoption	

DOCUMENT #05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Five Percent (5%) Income Disregard, Section 8.100.4.D
Rule Number:	MSB 14-09-03-A
Division / Contact / Phone:	Eligibility Division / Ana Bordallo / 303-866-3558

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 will impact MAGI populations under title XIX or XXI with the highest income threshold identified as the following: MAGI Adult Program (adults), Medicaid and CHP+ program (for children), and Medicaid and CHP+ Prenatal program (for pregnant women). The benefit of the five percent (5%) disregard is to help those who would otherwise become ineligible.

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

   The proposed rule change will apply the five percent (5%) disregard to individuals who are not otherwise eligible due to being over the income threshold.

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.

   Changes in Medicaid financing and eligibility loss as a result of implementing the proposed rule would be expected to result in a decrease of approximately $10.5 million with an offsetting increase of $10.7 million federal funds and $500,000 in other state funds.

   Additional costs would be incurred for CBMS changes.

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

   Implementation of the proposed rule is necessary for compliance with federal regulations. There are several noteworthy potential impacts from implementing the proposed rule.

   A. There will be a loss of eligibility for clients in specific circumstances as a result of implementation of these rules. An estimated 272 clients will be expected to either lose eligibility when they reapply and new applicants won't get coverage even though they would have before the rule change. This effect will be limited to parents with FPL between 63% and 68% FPL that were either over the age of 64, or insured by Medicare.

   B. Because Medicaid financing can vary from population to population (specifically those with different income levels), changing in the financing source for clients may change as a

result of implementing the proposed rule. For example, a client whose income was 67% prior to the implementation of the proposed rule would be 72% post implementation. While the expenditure for this example client would be 50% state fund prior to implementation, it would be 100% federally financed afterwards. It is estimated that the rule change would result in a General Fund reduction of approximately 10.5 million dollars.

C. Lastly, a small population of clients that would not have otherwise paid CHP+ premiums will be required to pay premiums. Another subset of clients would be required to pay a higher premium than they did prior to implementation of the rule. This population would be limited to future clients whose income under the current rule would have been 152-157% FPL and 208-213% respectively. The Department has not estimated the fiscal impact of this effect, but anticipates it will be small due to the narrow band of clients to which it applies.

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

   There are no alternative implementation strategies. Proposed changes are requested for compliance with federal regulations.

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 the proposed rule that were considered.

8.100.4.D. Income Disregard

1. ~~. Household income is calculated by including the MAGI-based income of every individual in the household, minus an amount equivalent to five percentage points of the Federal Poverty Level for the applicable family size. This five percent (5%) disregard is applied for each of the four MAGI programs: Parents and Caretaker Relatives, Pregnant Women, Children and Adults~~. An income disregard equivalent to five percentage points of the Federal Poverty Level for the applicable family size will be subtracted from MAGI-based income.

a. If an individual's ~~countable~~MAGI-based countable income is above the income threshold for the applicable MAGI program under title XIX (Medicaid) or title XXI (CHP+) of the Social Security Act, the five percent (5%) disregard will be applied for each qualifying MAGI program as the last step ~~in~~to determin~~ing~~e eligibility.

b. If the countable income is below the income threshold for the applicable MAGI program, the individual is income eligible and the five percent (5%) disregard will not be appl~~y~~ied ~~in~~ to determin~~ing~~e eligibility

THIS PAGE NOT FOR PUBLICATION

SECRETARY OF STATE
RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 14-06-19-A, Revision to the Medical Assistance Eligibility Rule Concerning Long-Term Care Institution Recipient Income Calculation of Patient Payment Increase to the Personal Needs Allowance (PNA) for Residents of Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Section 8.100.7.V.3.d and 8.100.7.V.f
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) 8.100.7.V.3.d and 8.100.7.V.f, 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 §8.100.7.V.3.c with new text provided. Replace current text beginning at §8.100.7.V.3.d. through §8.100.7.V.3.d.ii) with the new text provided. Renumber current subparagraphs at §8.100.7.V.3.d.ii and iii to §8.100.7.V.3.d.iii) and iv). Replace current text at §8.100.7.V.3.e. with new text provided. Replace current text at §8.100.7.V.3.f.i) with new text provided. Replace current text at §8.100.7.V.3.f.iii) with new text provided. All text indicated in blue is for clarification purposes only and should not be changed. This revision is effective 01/01/2015.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Long-Term Care Institution Recipient Income Calculation of Patient Payment Increase to the Personal Needs Allowance (PNA) for Residents of Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Section 8.100.7.V.3.d and 8.100.7.V.f
Rule Number:	MSB 14-06-19-A
Division / Contact / Phone:	Client Svs, Eligibility & Enrollment/Eric Stricca/303-866-4475

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).

Senate Bill 14-130 amends CRS 25.5-6-206-(2)(a) which increases the monthly personal needs allowance (PNA) base amount for persons who are residents of nursing facilities or intermediate care facilities for individuals with intellectual disabilities from $50 to $75 beginning January 1, 2015. Additionally, beginning January 1, 2015 the PNA base amount will be adjusted yearly at the same rate of the statewide average per diem rate increase described at CRS 25.5-6-202(9)(b)(I). The initial increase will be the new $75 base with the addition of the 2015 per diem rate increase applied.

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 USC § 1396a(o)
   42 CFR 435.725(c)(1)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   SB 14-130 amending CRS 25.5-6-206-(2) (a)

Initial Review	**10/10/2014**	Final Adoption	**11/14/2014**
Proposed Effective Date	**12/30/2014**	Emergency Adoption	

DOCUMENT #06

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Eligibility Rule Concerning Long-Term Care Institution Recipient Income Calculation of Patient Payment Increase to the Personal Needs Allowance (PNA) for Residents of Nursing Facilities or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID), Section 8.100.7.V.3.d and 8.100.7.V.f
Rule Number:	MSB 14-06-19-A
Division / Contact / Phone:	Client Svs, Eligibility & Enrollment/Eric Stricca/303-866-4475

REGULATORY ANALYSIS

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

   The rule affects two distinct populations:
   Currently, there are approximately 9,434 nursing facility residents in Colorado that receive the PNA. However, only patients that have sufficient income to pay at least $25 toward the monthly cost of their case are deemed to have a significant fiscal impact under the bill. Thus, the number of patients in long-term care that contribute to the fiscal impact is 7,760, including 214 patients in state veterans' nursing homes operated by the Department of Human Services (DHS).

   DHS operates intermediate care facilities for individuals with intellectual disabilities or related conditions (ICF/IID). Approximately 164 ICF/IID residents in DHS Regional Centers receive the PNA.

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 January 1, 2015 increase to the personal needs allowance base amount from $50 to $75 and the simultaneous onset of an annual adjustment to the personal needs allowance quantitatively changes the set $50 personal needs allowance that has not kept up with the cost of living. The qualitative impact is enabling the persons who are residents to keep enough of their income to pay for personal needs that are not covered by the nursing facilities or intermediate care facilities for individuals with intellectual disabilities.

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.

   Cost to HCPF —With approximately 7,760 nursing facility residents affected by the bill, there is a statewide reduction in patient payments of $211,460 per month in 2015 and $229,463 per month in 2016. In FY 2014-15, HCPF expenditures increase by $1,057,300 ($211,460 * 5 mo.) with a fund split, $517,971 will be from the General Fund ($539,329 federal funds).

In FY 2015-16, the bill results in HCPF payments to nursing facilities of $2,645,540 (($211,460 * 6 mo.)+($229,463 * 6 mo.)), consisting of $1,296,050 out of the General Fund ($1,349,490 federal funds). These HCPF expenditures include backfill for Resident payments at state veteran nursing homes. The 214 nonveteran residents affected by PNA under the bill account for $29,157 (214 * $27.25 * 5 mo.) in FY 2014-15 and $72,957 ((214 * $27.25 * 6 mo.)+(214 * $29.57 * 6 mo.)) in FY 2015-16.

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

   SB 14-130 has been signed into law, inaction is not an option.

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

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

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

   There were no alternative methods that were considered to achieve the purpose of the rule.

8.100.7.V. Long-Term Care Institution Recipient Income

3. Calculation of Patient Payment

a. Specific instructions for computing the patient payment amount are contained in this volume under The "Status of Long-Term Care institution Care" Form, AP-5615

b. Once an applicant for Nursing Facility Medical Assistance has been determined eligible for Medical Assistance, the Eligibility Site shall determine the patient payment due to the Nursing Facility which is to be applied to the Medicaid reimbursement for the cost of care. That patient payment is calculated by:

i) Determining all applicable income of the recipient

ii) Deducting all applicable allowable monthly income adjustments, which include:

1) Personal Needs Allowance

2) If applicable, Monthly Income Allowance for the community spouse.

3) If applicable, Family Dependent Allowance

4) If applicable, Home Maintenance Allowance

5) If applicable, Trustee/Maintenance Fees: actual fees, with a maximum of $20 per month

6) If applicable, Mandatory Income Tax Withheld

7) Mandatory garnishments repaying Federal assistance overpayment

8) Medical or remedial care expenses that are not subject to payment by a third party:

a) Medicare Part B Premium expenses, if applicable, are deductible only for the first and second month in the Nursing Facility.

b) Medicare Part D Premium expenses, if applicable, are ongoing deductions.

c) Other medical and remedial expenses covered under the Nursing Facility PETI (NF PETI) program are not deductible. NF PETI-approved expenses are allowed only for residents with a patient payment, but do not change the patient payment amount. For NF

PETI, see the Section 8.482.33 in this volume "Post Eligibility Treatment of Income".

c.~~)~~. Long-Term Care Insurance

Long-Term Care insurance payments are not counted as income for eligibility purposes. However, they are income available for a patient payment. The patient payment shall include the client's income after the allowable deductions and any Long-Term Care insurance payments for the month. In the event that the patient payment is greater than the cost of care, the Long-Term Care insurance payment shall be applied before the client's income.

i) If Long-Term Care insurance is received for the month, and:

1) If, after all deductions, the client has income available for a patient payment, add this to the amount of the Long-Term Care insurance to determine the total patient payment.

a) If the total amount is greater that the allowable cost of care, the Long-Term Care insurance is applied before the client's income, or;

b) If after all deductions, the client does not have income available for the patient payment, only the Long-Term Care insurance payment is used.

d. ~~The amount to be reserved for personal needs is $50 per month with the following exceptions:~~Personal Needs Allowances

i) Non-Veteran related personal needs allowance

1) Prior to January 1, 2015 the personal needs allowance base amount is $50 per month.

2) Effective January 1, 2015 the personal needs allowance base amount is $75 per month and will be adjusted annually at the same rate as the statewide average of the nursing facility per diem rate net of patient payment pursuant to C.R.S. § 25.5-6-202(9)(b)(I). Each yearly adjustment will set a new base amount.

a) The first annual rate adjustment to the new $75 base amount will occur on January 1, 2015.

ii) Veterans-related personal needs allowance

Effective 07/01/91, the personal needs allowance shall be $90 per month for a veteran in a Long-Term Care institution who has no spouse or dependent child and who receives a non-service connected disability pension from the U.S. Veterans Administration. The personal needs allowance shall also be $90 per month for the widow(er) of a veteran with no dependent children.

1) Public Law requires that a veteran, without a spouse or dependent child, who enters a Long-Term Care institution have their veteran's pension reduced to $90 which is to be reserved for their personal needs. This reduction in pension is not applicable to veteran's who reside in a State Veteran's Nursing facility. If a veteran, who does not reside in a State

Veteran's Nursing facility, receives a pension reduction of $90 he/she is allowed to apply this $90 to his/her personal needs allowance. It is not considered income toward the patient payment. The same regulation applies to a widow of a veteran without any dependent children.

2) To verify if those veterans residing in State Veteran's Nursing facilities are receiving a non-service connected pension you may request their award letter from the Department of Veterans Affairs or call the Department of Veterans Affairs and verify through contact. If they are receiving any amount in a non-service connected pension they are entitled to a $90 personal needs allowance so long as they do not have a spouse or dependent child. The same regulation applies to a widow of a veteran without any dependent children.

iii) For aged, disabled, or blind Long-Term Care institution recipients engaged in income-producing activities, an additional amount of $65 per month plus one-half of the remaining gross income may be retained by the individual.

~~iii~~iv) Effective September 15, 1994, aged, disabled, or blind Long-Term Care institution residents, HCBS or PACE recipients with mandatory withholdings from earned or unearned income to cover federal state, and local taxes may have an additional amount included as a deduction from the patient payment. The patient payment deduction must be for a specific accounting period when the taxes are owed and expected to be withheld from income or paid by the individual in the accounting period. The Eligibility Site must verify that the taxes were withheld. If the taxes are not paid, the Eligibility Site must establish a recovery. The deduction is also applicable for any Federal pensions with mandated tax withholdings from unearned income despite the individual earner being institutionalized. All other pensions will discontinue the tax withholding once notified that the recipient is receiving institutionalized care through Medicaid, thus signifying that the withholding was not mandatory. This deduction does not apply to individuals who have elected to have taxes withheld from their earnings as a means to receiving a greater tax refund.

e. The reserve specified in section 8.100.7.V.3.~~b~~d.iii. of this volume shall apply to Long-Term Care institution residents who are engaged in income-producing activities on a regular basis. Types of income-producing activities include:

i) work in a sheltered workshop or work activity center;

ii) "protected employment" which means the employer gives special privileges to the individual;

iii) an activity that produced income in connection with a course of vocational rehabilitation;

iv) employment training sessions;

v) activities within the facility such as crafts products and facility employment.

f. In determining the personal needs reserve amount for Long-Term Care institution residents engaged in income-producing activities:

i) The ~~$50~~personal needs allowance ~~for personal needs~~ is reserved from earned income only when the person has insufficient unearned income to meet this need;

ii) In determining countable earned income of a Long-Term Care institution resident, the following rules shall apply:

1) $65 shall be subtracted from the gross earned income.

2) The result shall be divided in half.

3) The remaining income is the countable earned income and shall be considered in determining the patient payment.

iii) When the ~~$50~~personal needs allowance is reserved from unearned income, the additional reserve is computed based on the total gross earned income.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services Home Modification Rule for the Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493.3
Rule Number:	MSB 14-06-04-A
Division / Contact / Phone:	Long Term Services and 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 14-06-04-A, Revision to the Medical Assistance Home and Community Based Services Home Modification Rule for Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493.3
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) 8.493, 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 first unnumbered paragraph at §8.493.1 with new text provided. Insert new text provided at §8.493.2.B immediately following §8.493.2.A.6. Replace current text at §8.493.3.B with new text provided. Replace current text at §8.493.3.E with new text provided. Replace current text at §8.493.4.B with new text provided. Replace current text at §8.493.4.F.6. with new text provided. Replace current text at §8.493.7.B.4.a. – d. with new text provided. Replace current text at §8.493.7.C with new text provided. All text indicated in blue is for clarity only and should not be changed. This revision is effective 12/30/2014.

*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 Home Modification Rule for the Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493.3
Rule Number:	MSB 14-06-04-A
Division / Contact / Phone:	Long Term Services and 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).

   Description: The rules set forth at 10 CCR 2505-10 Section 8.493 are being revised to allow the Department to meet a Legislative directive and appropriate to raise the cap for the Home Modification benefit. This appropriation indicated the Department was responsible for bringing forward a rule change to the Medical Services Board that increases the amount of money available to the benefit within the feasible amount available within the approved funding. This amount stands to be approximately $2,500 above the current $10,000 limit indicated in Section 8.493.

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. (2014);
   C.R.S. 25.5-6-704

Initial Review	**10/10/2014**	Final Adoption	**11/14/2014**
Proposed Effective Date	**12/30/2014**	Emergency Adoption	

DOCUMENT #07

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Home and Community Based Services Home Modification Rule for the Persons with Brain Injury Waiver, Community Mental Health Supports Waiver, Spinal Cord Injury Waiver, and Elderly, Blind, and Disabled Waiver, Section 8.493.3
Rule Number:	MSB 14-06-04-A
Division / Contact / Phone:	Long Term Services and 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.

   Persons who utilize the Home Modification benefit in the Elderly, Blind, and Disabled waiver, the Brain Injury waiver, the Community Mental Health Supports waiver, and the Spinal Cord Injury waiver will benefit from an increase in the cap on the Home Modification funds available to them. Budget projections anticipate that the allocation provided by legislation will enable the Department to raise the maximum available amount by $2,500. There is no cost to the Department.

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

   This rule will have a positive economic impact on persons who choose to use the additional $2,500 in funds. Additionally, we have clarified that individuals can receive repairs or maintenance to their pre-existing home modifications assuming they have remaining funds. Persons who have access to the Home Modification benefit but who do not choose to utilize the additional funds will not be impacted.

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 is no cost to the Department. The funds are available to the Department via an appropriation and directive from the State Legislature which indicates that the Department is responsible for using the funds to increase the Home Modification benefit cap.

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

   The Department is revising the rule to remove the $10,000 lifetime cap, which will enable the Department to meet the Legislative directive.

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

This rule revision does not increase the cost to the Department for providing the Home Modification benefit, but rather enables the Department to utilize the appropriation granted by the Legislature.

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 removal of the $10,000 lifetime cap on the Home Modification benefit via the revision to Section 8.493 is necessary for the Department to access and distribute the appropriated funds and meet the Legislative directive.

8.493 HOME MODIFICATION

8.493.1 DEFINTIONS

Eligible Client means a client who is enrolled in the followinga Home and Community-Based Services (HCBS) waivers: for Persons with Brain Injury, Spinal Cord Injury, Persons with Major Mental IllnessCommunity Mental Health Supports, or Persons who areor Elderly, Blind and Disabled.

Home Modification means specific modifications, adaptations or improvements in an Eligible Client's existing home setting which, based on the client's medical condition:

1. Are necessary to ensure the health, welfare and safety of the client, and

2. Enable the client to function with greater independence in the home, and

3. Are required because of the client's illness, impairment or disability, as documented on the ULTC-100.2 form and the care plan; and

4. Prevents institutionalization of the client.

Home Modification Provider means a provider agency that has met all the standards for Home Modification described in 10 C.C.R. 2505-10, Section 8.493.5.B and is an enrolled Medicaid provider.

8.493.2 BENEFITS

8.493.2.A. Home Modifications, adaptations, or improvements may include but are not limited to the following:

1. Installing or building ramps.

2. Installing grab-bars and installing other durable medical equipment as part of a larger Home Modification project.

3. Widening doorways.

4. Modifying bathrooms.

5. Modifying kitchen facilities.

6. Installing specialized electric and plumbing systems that are necessary to accommodate medically necessary equipment and su-pplies.

8.493.2.B. Previously completed Home Modifications shall be eligible for maintenance or repair within the client's remaining allotment while remaining subject to 8.493.3, Exceptions and Restrictions.

8.493.3 EXCEPTIONS AND RESTRICTIONS

8.493.3.A. Modifications to an existing home that are not a direct medical or remedial benefit to the client are not a benefit.

8.493.3.B. Duplicate adaptations, modifications or improvements, and or modifications as a part of new construction costs are not a benefit.

8.493.3.C. The Department may deny requests for Home Modification projects that exceed usual and customary charges or do not meet industry standards.

8.493.3.D. Home Modification projects are not a benefit in any type of certified or non-certified congregate facility, as defined in 10 C.C.R. 2505-10, Sections 8.485.50 F. and G.

8.493.3.E. There shall be a lifetime cap of ~~$10,000~~$12,500 per client.

8.493.3.F. Volunteer work on a Home Modification project approved by the Department shall be completed under the supervision of the Home Modification Provider as stated on the bid.

8.493.4 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES

8.493.4.A. The SEP case manager shall consider alternative funding sources to complete the Home Modification. These alternatives shall be documented in the case record.

8.493.4.B. The SEP case manager shall obtain prior approval by submitting a Prior Authorization request form (PAR) to the Department for Home Modification projects estimated at between $1,000.00 and $12,500~~10,000~~.00.

8.493.4.C. The SEP case manager may approve Home Modification projects estimated at less than $1,000.00 without prior authorization.

8.493.4.D. The Department may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Modification request.

8.493.4.E. Home Modifications estimated to cost $1,000.00 or more shall be evaluated according to the following procedures:

1. An occupational therapist shall assess the client's needs and the therapeutic value of the requested Home Modification. When an occupational therapist with experience in Home Modification is not available, a Department-approved physical therapist or other qualified individual may be substituted. A report specifying how the Home Modification would contribute to a client's ability to remain in or return to his/her home, and how the Home Modification would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

2. The occupational therapist services may be provided by a home health agency and billed to Medicaid Home Health consistent with Home Health rules set forth in 10 C.C.R. 2505-10, Section 8.520, including physician orders and plans of care.

3. The SEP case manager and the occupational therapist shall consider less expensive alternative methods of addressing the client's needs. The case manager shall document these alternatives in the client’s case file.

8.493.4.F. The SEP case manager shall follow a bid process according to the following procedures:

1. The SEP case manager shall solicit and receive bids from at least two Home Modification Providers.

2. The bids shall include a breakdown of the costs of the project including:

   a. Description of the work to be completed.

b. Estimate of the materials and labor needed to complete the project.

c. Estimate for building permits, if needed.

d. Estimated timeline for completing the project.

e. Name, address and telephone number of the Home Modification Provider.

f. Signature of the Home Modification Provider.

3. Home Modification Providers have a maximum of 30 days to submit a bid for the Home Modification project after the SEP case manager has solicited the bid.

4. The SEP case manager shall submit copies of the bids and occupational therapist's evaluation with the PAR to the Department. The Department shall authorize payment to the lowest bidder.

5. The SEP case manager may request approval of bid that is not the lowest by submitting a written justification or explanation to the Department with the PAR.

6. If the SEP case manager has made three attempts to obtain a written bid from Home Modification Providers and the Home Modification Providers have not responded within 30 ~~calender~~calendar days, the case manager may accept one bid. Documentation of the contacts and an explanation of these attempts shall be attached to the PAR.

7. A revised PAR and bid request shall be submitted according to the procedures outlined in this Section for any changes from the original approved PAR.

8. Home Modification projects shall be initiated within 60 days of signed approval from the Department.

8.493.4.G. If a property to be modified is not owned by the client or the client's family, the SEP case manager shall obtain a letter from the owner of the property authorizing modifications to the property prior to initiation of the project and allowing the client to leave the modification in place if the property is vacated by the client.

8.493.5 PROVIDER RESPONSIBILITIES

8.493.5.A. Home Modification Providers shall conform to all general certification standards and procedures set forth in 10 C.C.R. 2505-10, Section 8.487.11.

8.493.5.B. Home Modification Providers shall be licensed in the city or county in which they propose to provide Home Modification services to perform the work proposed, if required by that city or county.

8.493.5.C. The Home Modification Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work.

8.493.5.D. The Home Modification Provider shall assure that the project complies with local and/or state building codes. In areas where there is no building authority, the Home Modification Provider shall assure that the project complies with the appropriate provisions of the 2003 edition of the International Residential Code and the accessibility provisions contained within the 2003 edition of the International Building Code. The Home Modification project shall also comply with the Colorado Plumbing Code as adopted by the Colorado Examining Board of Plumbers and the National Electrical Code as adopted by the Colorado Electrical Board, effective July 1, 2005. No

amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. Copies of the 2003 International Building Code and copies of the rules and regulations of the State Electrical Board and State Examining Board of Plumbers are available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

8.493.5.E. All Home Modification projects shall be inspected and approved by a state, local or county building inspector or a licensed engineer, architect, contractor or any other person as designated by the Department.

8.493.5.F. Copies of building permits and inspection reports shall be submitted to the SEP case manager and all problems noted on inspections shall be corrected before the Home Modification Provider submits a final invoice for the payment. In the event that a permit is not required, the Home Modification Provider shall submit to the SEP case manager a signed statement indicating that a permit is not required.

8.493.6 REIMBURSEMENT

8.493.7 Payment for Home Modification services shall be the lower of the billed charges or the prior authorized amount. Reimbursement shall be made in two payments per Home Modification.

8.493.7.A. The Home Modification Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits and initial labor costs.

8.493.7.B. Final payment shall be made when the Home Modification project has been completed and the SEP agency has in the client's file copies of:

1. Signed lien waivers for all labor and materials, including lien waivers from sub-contractors.

2. Required permits.

3. One year written warranty on parts and labor.

4. Final inspection documentation verified by the SEP case manager and documented in the client's file that the Home Modification has been completed through:

    a. Contact with the building inspector or other inspector as referenced at 10 C.C.R. 2505-10, Section 8.493.5.E~~,~~ or

    b. Contact with the client~~,~~ or

    c. Contact with the family member or responsible party~~,~~ or

    d. By conducting an on-site visit.

8.493.7.C. The Home Modification Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily. If another Home Modification Provider is required to complete the work, the original Home Modification Provider shall be paid only the difference between the amount paid originally to the Home Modification Provider and the amount needed to complete the Home Modification paid to the second Home Modification Provider, up to the $~~10,000~~$12,500.00 maximum lifetime cap.

8.493.7.D. The Home Modification Provider shall not be reimbursed for durable medical equipment available as a Medicaid state plan benefit unless the purchase and installation of the equipment is part of a larger Home Modification project.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Community Living Benefits Rule Concerning Consumer Directed Attendant Support Services, 10 CCR 2505-10 Section 8.510
Rule Number:	MSB 14-07-15-A
Division / Contact / Phone:	Long Term Services and Supports/Kelly Jepson/303-866-5365

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 14-07-15-A, Revision to the Medical Assistance Community Living Benefits Rule Concerning Consumer Directed Attendant Support Services, 10 CCR 2505-10 Section 8.510
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) Section 8.510, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace all current text beginning at §8.510.1 Definitions through the end of the unnumbered paragraphs before §8.510.2 with the current text provided. Replace current text at §8.510.2.A.3 with new text provided. Replace current text at §8.510.4.A with new text provided. Replace current text at §8.510.6.A. through the end of §8.510.6.D.7. with new text provided beginning at §8.510.6.A. through the end of §8.510.6.E.7. with new text provided. Remove current text at §8.510.8.G and renumber current paragraphs H and I to G and H. Add new section beginning at §8.510.85 through the end of §8.510.86.C. Replace current text at §8.510.11.B.1. with new text provided. Replace current text provided at §8.510.13.A.3 and .5 with new text provided. Replace current text at §8.510.14.D with new text provided. Replace current text at §8.510.14.I with new text provided. Replace current text beginning at §8.510.16.A through §8.510.16.C with new text provided. Remove current text at §8.510.16.D and renumber current subparagraph

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

E. to D. All text indicated in blue is for clarity only and should not be changed. This revision is effective 12/30/2014.

*to be completed by MSB Board Coordinator

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Title of Rule:	Revision to the Medical Assistance Community Living Benefits Rule Concerning Consumer Directed Attendant Support Services, 10 CCR 2505-10 Section 8.510
Rule Number:	MSB 14-07-15-A
Division / Contact / Phone:	Long Term Services and Supports/Kelly Jepson/303-866-5365

STATEMENT OF BASIS AND PURPOSE

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

   The current FMS contract will expire on December 31, 2014. This fact, in addition to the Affordable Care Act requirement to offer health insurance, prompted the Department to begin stakeholder engagement sessions on the FMS structure in Colorado. These sessions occurred over a four month process beginning in August 2013. Based on stakeholder feedback, the Department is amending the rules the reflect the choice of FMS vendors and the choice of FMS models. The two FMS models are allowed and defined by the Centers for Medicaid Services (CMS). The models allow clients who direct their own services to choose the level of employer responsibilities they want.

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 1396n

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   25.5-6-1101 et.Seq. CRS (2013)

Initial Review	**10/10/2014**	Final Adoption	**11/14/2014**
Proposed Effective Date	**12/30/2014**	Emergency Adoption	

DOCUMENT #08

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Community Living Benefits Rule Concerning Consumer Directed Attendant Support Services, 10 CCR 2505-10 Section 8.510
Rule Number:	MSB 14-07-15-A
Division / Contact / Phone:	Long Term Services and Supports/Kelly Jepson/303-866-5365

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 enrolled in CDASS under an HCBS waiver and the existing FMS contractor will be affected by this rule because the State is moving from one FMS agency to a choice of three. The scope of the FMS contractor will no longer include the training and customer service functions, which will now be overseen by a separate Training and Operations contractor. CDASS clients will benefit from this rule change as it provides a choice of vendors as well as a choice of FMS models. CDASS clients and case managers will now receive CDASS training from the Training and Operations contractor.

   Attendants who provide CDASS might be impacted by this change if the client for whom they work opts for the Agency with Choice (AwC) model. Under the AwC model, the FMS may be responsible to offer health insurance to attendants if it meets the criteria established under the Affordable Care Act (ACA).

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

   This rule revision enables the Department to offer the choice of employer model, which allows CDASS clients to choose how much employer responsibility they have. The client will also have a choice in FMS agency. The proposed rule has no direct quantitative impact on CDASS clients. Qualitative impacts include the addition of FMS agencies, a Training and Operations agency, and employer models for the client to choose from.

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.

   These rules do not directly impact the cost to the Department or any other agency.

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

   This rule revision enables the Department to implement changes recommended by stakeholders. Inaction or failure to implement these rules will prohibit the Department from offering multiple FMS agencies and models to CDASS clients.

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 methods to the State aside from implementing this rule revision.

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 additional FMS agencies provide more choice to clients receiving CDASS under an HCBS waiver. Stakeholders recommended the Department implement these changes. This rule revision enables the Department to achieve those objectives.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

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

Agency with Choice (AwC) means an Financial Management Services (FMS) model where the FMS and the client/authorized representative are co-employers of CDASS Attendants. Under the AwC model, the FMS is the employer.

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

Attendant means the individual who meets qualifications in § 8.510.8 who provides CDASS as determined by § 8.510.3 and is hired by the client and/ or by through the a contracted FMS organizationvendor.

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

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

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

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

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

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

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

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

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

Department means the Department of Health Care Policy and Financing.

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

~~Fiscal~~ Financial Management Services ~~organization~~ (FMS) means ~~the~~ an entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual client allocations for CDASS. ~~who may serve as the employer of record for Attendants, to provide personnel management services, fiscal management services, and skills training to a client/AR receiving CDASS.~~

Fiscal/Employer Agent~~cy~~ (F/EA) is an FMS model where the FMS is an agent of the client as the employer.

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

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

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

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

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

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

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

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

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

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

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

Training and Operations Vendor means the organization contracted by the Department to provide training to CDASS Clients/authorized representatives, provide training to case managers on participant direction, and provide customer service related to participant direction.

8.510.2 ELIGIBILITY

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

1. Choose the CDASS service delivery option

2. Meet medical assistance Financial Eligibility requirements

3. Meet Long Term Services and Supports~~Care~~ Functional Eligibility requirements

4. Be eligible for an HCBS Waiver with the CDASS option

5. Demonstrate a current need for Attendant support

6. Document a pattern of stable health that necessitates a predictable pattern of Attendant support and appropriateness of CDASS services

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

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

8.510.3 CDASS SERVICES

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

8.510.3.B Services include:

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

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

    b. Meal preparation

    c. Dishwashing

    d. Bed making

    e. Laundry

    f. Shopping for necessary items to meet basic household needs

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

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

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

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

d. Bladder/Bowel Care:

    i) Assisting client to and from the bathroom

    ii) Assistance with bed pans, urinals, and commodes

    iii) Changing of incontinence clothing or pads

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

    v) Emptying ostomy bags

e. Personal hygiene:

    i) Bathing including washing, shampooing, and shaving

    ii) Grooming

    iii) Combing and styling of hair

    iv) Trimming, cutting, and soaking of nails

    v) Basic oral hygiene and denture care

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

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

h. Assistance with mobility

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

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

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

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

k. Cleaning and basic maintenance of durable medical equipment

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

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

3. Health Maintenance Activities. Routine and repetitive health related tasks furnished to an eligible client in the community or in the client's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include:

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

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

c. Mouth care performed when:

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

ii) in the presence of communicable disease

iii) the client is unconscious

iv) oral suctioning is required

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

e. Feeding:

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

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

iii) Syringe feeding

iv) Feeding using apparatus

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

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

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

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

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

k. Respiratory care:

i) Postural drainage

ii) Cupping

iii) Adjusting oxygen flow within established parameters

iv) Suctioning of mouth and nose

v) Nebulizers

vi) Ventilator and tracheostomy care

vii) Prescribed respiratory equipment

8.510.4 ATTENDANT SUPPORT MANAGEMENT PLAN

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

1. Current health status

2. Needs and requirements for CDASS

3. Plans for securing CDASS

4. Plans for handling emergencies

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

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

7. Designation of an Authorized Representative

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

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

8.510.5 TRAINING ACTIVITIES

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

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

8.510.6 CLIENT/AR RESPONSIBILITES

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

1. Attend ~~FMS t~~raining provided by the Training and Operations Vendor; clients who cannot attend training shall designate an AR

2. Develop an ASMP

3. Determine wages for each Attendant not to exceed the rate established by the Department. Wages shall be established in accordance with Colorado Department of Labor and Employment standards including, but not limited to, minimum wage and overtime requirements.

4. Determine the required credentials for Attendants

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

~~6. Ensure FMS receives hiring agreements prior to Attendants providing services~~

5~~7~~. Complete~~ing~~ previous employment reference checks on Attendants

6~~8~~. Follow all relevant laws and regulations applicable to client's supervision of Attendants

7~~9~~. Explain the role of the FMS~~-~~ to the Attendant

8~~10~~. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation

9~~11~~. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and client/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS services

10~~2~~. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement

11~~3~~. Authorize the FMS to make any changes in the Attendant wages

12. Understand that misrepresentation or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. Client/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS

135. Completing and managing all paperwork and maintaining employment records

14. Select an FMS vendor upon enrollment into CDASS.

8.510.6.B. Client/AR responsibilities for CDASS ~~Services~~when using the F/EA FMS model:

1. Recruit, hire, fire and manage Attendants

2. Train Attendants to meet client needs

3. Terminate Attendants who are not meeting client needs

4. Operate as the sole employer of the attendant

5. Complete necessary employment related functions through the FMS agent, including hiring and termination of Attendants and employer related paperwork necessary to obtain an employer tax ID

8.510.6.C Client/AR responsibilities for CDASS when using the AwC FMS model

1. Select and discharge Attendants

2. Serve as the manager for CDASS Attendants

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

4. Ensure FMS receives hiring agreements prior to Attendants providing services

8.510.6.~~C.~~D. Client/AR responsibilities for Verification:

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

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

1. Right to receive instruction on managing CDASS.

2. Right to receive program materials in accessible format.

3. Right to receive notification of changes to CDASS.

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

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

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

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

8.510.7 AUTHORIZED REPRESENTATIVES

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

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

8.510.8 ATTENDANTS

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

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

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

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

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

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

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

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

8.510.8.~~I~~H. Attendants may not attend ~~FMS~~ training provided by the Training and Operations Vendor ~~training~~ during instruction.

8.510.85 FINANCIAL MANAGEMENT SERVICES

8.510.85. A The FMS vendor shall be responsible for the following tasks without regard to the FMS model selected by the client/AR

1. Collect and process timesheets submitted by attendants.

2. Conduct payroll functions including withholding employment related taxes such as worker's compensation insurance, unemployment compensation insurance, withholding of all federal and state taxes, compliance with federal and state laws regarding overtime pay and minimum wage requirements.

3. Distribute paychecks in accordance with timelines established by the Colorado Department of Labor and Employment.

4. Submit authorized claims for CDASS provided to eligible client.

5. Verify Aattendants' citizenship status and maintain copies of the I-9 documents.

6. Track and report utilization of client allocations.

7. Comply with Department regulations at 10 CCR 2505 and the contract with the Department.

8.510.85.B The FMS vendor operating under the AwC model shall be responsible for the following in addition to the requirements set forth at 8.510.9.A:

1. Operate as the primary employer of Aattendants

2. Ensuring execution of the hiring agreement between the FMS, the client, and the attendant

3. Comply with all requirements set forth by the Affordable Care Act, including, but not limited to the provision of health insurance.

8.510.85.C. The FMS vendor operating under the F/EA model shall be responsible for obtaining designation as a Fiscal/Employer Agent per Section 3504 of the IRS Code in addition to the requirements set forth at 8.510.9.A.

8.510.86 SELECTION OF FMS VENDORS

8.510.86.A The cClient/AR shall select an FMS vendor at the time of enrollment into CDASS from the up to three vendors contracted with the Department.

8.510.86.B The cClient/AR shall remain with the selected FMS vendor until the selection of FMS is changed during the yearly designated open enrollment period.

8.510.86.C The cClient/AR shall select either the AwC or F/EA FMS model at the time of enrollment into CDASS. The cClient shall provide the FMS and attendants at least thirty days' notice of changing FMS models.

8.510.9 START OF SERVICES

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

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

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

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

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

8.510.10 SERVICE SUBSTITUTION

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

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

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

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

8.510.11 ENDING CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

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

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

1. Mandatory re-training conducted by the contracted Training and Operations Vendor ~~FMS~~

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

3. Discontinuation according to the following:

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

8.510.12 TERMINATION

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

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

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

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

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

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

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

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

8.510.13 INVOLUNTARY TERMINATION

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

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

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

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

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

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

6. Instances of convicted fraud and/or abuse

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

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

8.510.14 CASE MANAGEMENT FUNCTIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

5. Utilize Department overspending protocol when needed to assist clients

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

8.510.15 ATTENDANT REIMBURSEMENT

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

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

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

8.510.16 REIMBURSEMENT TO FAMILY MEMBERS

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

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

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

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

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

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

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

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