THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long Term Services and Supports Rule Concerning Children's Home and Community Based Services Waiver, Section 8.506
Rule Number:	MSB 15-01-13-A
Division / Contact / Phone:	Long Term Services and Support / Dennis Roy / 866-4828

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 15-01-13-A, Revision to the Medical Assistance Long Term Services and Supports Rule Concerning Children's Home and Community Based Services Waiver, Section 8.506
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) 8.506, 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*

Delete all current text beginning at §8.506 through the end of §8.506.100, second unnumbered paragraph and replace with the new text provided beginning at §8.506 through 8.506.12.H. This revision is effective 12/30/2015.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

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

   Section 8.506 has become outdated to many of the operations and factors of the CHCBS waiver. The rule re-write is necessary to correspond with current operations, match the structure of other waivers' rules, and to provide clarity regarding eligibility, benefits, and operations.

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. (2015);
   25.5-6-901, et. Seq. CRS (2015)

Initial Review	**10/09/2015**	Final Adoption	**11/13/2015**
Proposed Effective Date	**12/30/2015**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long Term Services and Supports Rule Concerning Children's Home and Community Based Services Waiver, Section 8.506
Rule Number:	MSB 15-01-13-A
Division / Contact / Phone:	Long Term Services and Support / Dennis Roy / 866-4828

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 families of children living at the home of their parents/guardians and that are at risk for placement in an institutional setting will benefit from clarity regarding the eligibility criteria and benefits of the waiver.

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

   Case Management Agencies, In-Home Support Services Agencies, and the families of children at risk for institutional care will be quantitatively benefitted through clarification of the operations of the CHCBS waiver.

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

   There will not be any probable costs to the Department as a result of rewriting Section 8.506.

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

   The proposed rule will have no impact on costs or benefits relative to inaction.

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

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

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

   There are not alternative methods for achieving the purpose of the proposed rule.

8.506 CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM

8.506.1 Legal Basis:

The Children's Home and Community Based Services program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CHCBS program is also authorized under state law at C.R.S. § 25.5-6-901 et seq. – as amended.

8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.506.4.B

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.506.552

8.506.3 General Definitions

Assessment means the Department prescribed instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, health status, and other factors relevant to determine the client's level of functioning.

Assessment Process means collecting information from the client and appropriate collaterals pertaining to service needs, available resources, and potential funding sources and includes supporting diagnostic information from a licensed medical professional.

Case Management means assistance provided by a Case Management Agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports to enable the child to remain in his/her community based setting, the operations of which are defined in Section 8.506.4.B.

Case Management Agency means a public, private, or non-governmental non-profit agency which is certified by the State in accordance with procedures found in Provider Eligibility, Section 8.506.8, and Provider Responsibilities, Section 8.506.9, of the Children's HCBS Waiver Program rules, to provide services throughout the State.

Continued Stay Review means a reassessment by the case manager to determine the client's continued eligibility and functional level of care.

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

County Department means the Department of Human or Social Services in the county where the resident resides.

Department means the Department of Health Care Policy and Financing.

Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.

Functional Eligibility means that the client meets the criteria for long term care services as determined by the Department's prescribed instrument.

Institutional Placement means residing in an acute care hospital or nursing facility.

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

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

Professional Medical Information Page (PMIP) means the medical information signed by a licensed medical professional used as a component of the Assessment to determine the client's need for institutional care.

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

Targeting Criteria means the criteria set forth in Section 8.506.6.A.1

Utilization Review Contractor means the Department or the agency contracted with the Department to review the CHCBS waiver application for confirmation that functional eligibility and targeting criteria are met.

8.506.4 Benefits

8.506.4.A Home and Community Based Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at 26-1-114, C.R.S., as amended.

2. Case Management Agencies will complete all administrative functions of a client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

    a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible.

    b. At the time of making the initial face-to-face contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective.

    c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

    d. Verify that the child meets the eligibility requirements outlined in Client Eligibility, Section 8.506.6.

    e. Submit the assessment and documentation of the enrollment application to the Utilization Review Contractor to ensure the targeting criteria and functional eligibility criteria are met. Minimum documents required:

i. Initial Enrollment Form

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the approved initial enrollment form to the County Department for activation of a Medicaid State Identification Number.

g. Develop the Service Plan in accordance with Section 8.506.4.B.7.

h. Develop a Cost Containment Record in accordance with Section 8.506.12 at the time that the service plan is completed.

i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with 8.506.10.

4. Continued Stay Review

a. Complete a new Assessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved by the Utilization Review Contractor.

b. Review and revise the Service Plan in accordance with Section 8.506.4.B.7.

c. Calculate expected costs to the Medicaid Program, as set forth in Section 8.506.12, for the redetermination period.

d. Notify the county technician of the renewed Long Term Care certification.

5. Discharge/Withdrawal

a. At the time that the client no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:

i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.

ii. Submit a Department designated Discharge form to the Utilization Review Contractor.

iii. Submit PAR termination to the Department's Fiscal Agent.

iv. Notify County Department of termination.

v. Notify agencies providing services to the client that the child has been discharged from the waiver.

6. Transfers

a. Sending Agency responsibilities:

i. Contact the receiving case management agency by telephone and provide notification that:

1) The child is planning to transfer, per the parent(s) or guardian choice.

2) Negotiate an appropriate transfer date.

3. Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.

ii. Using a State designated form, notify the Utilization Review Contractor of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.

iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual (9 CCR 2503-5), Case Transfer Section 3.560.

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, § 3.560 is available at http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6389. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the 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.

a. Receiving agency responsibilities

i. Conduct a fact-to-face visit with the child within ten (10) working days of the child's transfer;

ii. Review and revise the Service Plan and the Prior Approval Cost Containment Record and change or coordinate services and providers as necessary.

7. Service Planning

a. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community based services. A signature from the parent(s) or guardian is required on this state designated form.

b. On a monthly basis, evaluate the effectiveness of the service plan by monitoring services provided to the child. This monitoring may include:

i. Conducting child, parent(s) or guardian, and provider interviews.

ii. Reviewing cost data.

iii. Reviewing any written reports received.

8.506.4.C In Home Support Services:

1. IHSS for CHCBS clients shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.

2. Family members of a client can only be reimbursed for extraordinary care.

8.506.4.D CHCBS clients are eligible for all other Medicaid state plan benefits.

8.506.5 Non-Benefit

8.506.5.A Tasks defined as Personal Care or Homemaker in Section 8.552

8.506.6 Client Eligibility

8.506.6.A An eligible client shall meet the following requirements:

1. Targeting Criteria:

   a. Not have reached his/her eighteenth (18^{th}) birthday.

   b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

   c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

   d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Functional Eligibility:

   a. The Utilization Review Contractor certifies, through the Case Management Agency completed assessment, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.

3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.

4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

8.506.6.B Financial Eligibility

1. Parental income and/or resources will result in the child being ineligible for Medicaid benefits.

2. The income and resources of the child do not exceed 300% of the current maximum Social Security Insurance standard maintenance allowance

3. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, Long-Term Care Medical Assistance Eligibility, Consideration of Trusts in Determining Medicaid Eligibility, Section 8.100.7.E.

8.506.6.C Roles of the County Department

1. Processing the Disability Determination Application through the contracted entity determined by the Department.

2. Certify that the child's income and/or resources does not exceed 300% of SSI.

3. Ensure that the parent(s) or guardian is in contact with a case management agency.

4. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility within five (5) workings days of determination.

8.506.7 Waiting List

8.506.7.A The number of clients who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.

8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

8.506.7.C The waiting list shall be maintained by the Utilization Review Contractor.

8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the Utilization Review Contractor will use for the individual's placement on the waiting list.

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the Utilization Review Contractor will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the Utilization Review Contractor that an opening for the CHCBS waiver is available the Case Management Agency shall:

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

2. Update the existing functional level of care assessment in the official client record.

3. Reassess for eligibility criteria as set forth at 8.506.6.

4. Notify the Utilization Review Contractor of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.8 Provider Eligibility

8.506.8.A Providers shall enter into an agreement with the Department to conform to all federal and state established standards for the specific service they provide under the HCBS-CHCBS waiver.

8.506.8.B Providers must comply with the requirements of 10 CCR 2505-10, Section 8.130.

8.506.8.C Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure statute and regulations.

8.506.8.D IHSS providers shall conform with IHSS Rules in Section 8.552.

8.506.9 Provider Responsibilities

8.506.9.A CHCBS Providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining, and terminating employees;

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section C.R.S. 19-3-307 (2005).

   This rule incorporates by reference C.R.S. § 19-3-307 (2015). The incorporation of this statute excludes later amendments, or editions of, the referenced material. It is available at: http://www.lexisnexis.com/hottopics/colorado/. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the 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.

8.506.9.B CHCBS Providers shall:

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

2. Ensure client records and documentation of services are made available at the request of the case manager, Department, or Utilization Review Contractor.

3. Ensure that adequate records are maintained.

   a. Client records shall contain:

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

      ii. Name, address and phone number of child's Case Manager.

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

      iv. Special health needs or conditions of the client.

      v. Documentation of the specific services provided which includes:

      vi. Name of individual provider.

      vii. The location for the delivery of services.

      viii. Units of service.

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

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

xi. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.2.

xii. Personnel records for each employee shall contain:

1. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

2. Documentation of training.

3. Documentation of supervision and performance evaluation.

4. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.506.

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

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

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

b. Documentation of communication/coordination with any additional providers.

8.506.9.C Responsibilities specific to IHSS Provider Agencies

1. Eligible IHSS Agencies will conform to all certification standards set forth at 10 C.C.R 2505-10, Section 8.552.5

2. IHSS Agencies will adhere to all responsibilities outlined at 10 C.C.R. 2505.10, Section 8.552.6

3. Ensure that only Health Maintenance Activities are delivered to CHCBS clients through the IHSS benefit.

8.506.9.D Responsibilities Specific to Case Management Agencies

1. Case Management Agencies will obtain a specific authorization to provide CHCBS case management benefits to clients as set forth in Provider Enrollment Section 8.487.

2. Verify that the IHSS care plan developed by IHSS providers is in accordance with both Sections 8.506.4.C and 8.552 of this volume.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the waiver.

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

8.506.10.C The first date for which services can be authorized is the latest date of the following:

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

2. The assigned start date on the certification page of the Assessment.

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

8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Assessment.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Service Plan results in a change in services.

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

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

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

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

8.506.11 Reimbursement

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

1. Submitted charges; or

2. A fee schedule as determined by the Department.

8.506.12 Cost Containment

8.506.12.A The Department shall be responsible for ensuring that, on average, services delivered to the child are within the Department's cost containment requirements for the respective level of institutional care.

8.506.12.B The case manager must identify costs as part of the Service Plan. This Cost Containment Record shall be on a Department prescribed form and include all estimated:

1. Waiver benefit services and units, as defined at 8.506.2.

2. State Plan benefit services and units.

8.506.12.C The costs of the benefit services identified in the Cost Containment Record shall be totaled and divided by the number of days remaining before the end of the child's current enrollment period.

8.506.12.D The cost per day for the child shall be compared against the Department designated cost per day of institutional care to determine cost effectiveness.

8.506.12.E The Case Manager will revise the child's Cost Containment Record anytime that a significant change in the Service Plan results in an increase or change in the services to be provided.

8.506.12.F The Case Manager will submit the Cost Containment Record to the Utilization Review Contractor for approval at the time of the child's initial enrollment onto the CHCBS waiver, or any time that a revision to the Cost Containment Record increases by a Department prescribed amount.

8.506.12.G Approval of the Cost Containment Record by the Department only ensures that the cost of the services does not exceed the equivalent cost of the appropriate institutional care.

8.506.12.H Approval of the Cost Containment Record form does not constitute automatic Medicaid reimbursement for authorized services identified within the record.

~~8.506 CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM~~

~~The Children's HCBS Waiver Program (formerly known as the Katie Beckett Waiver Program), is a waiver program for disabled children who are at risk of institutionalization in a hospital or nursing facility and who would not otherwise be eligible for Medicaid due to parental income and/or resources.~~

~~The services provided under this program serve as alternatives to Medicaid hospital or nursing facility services for children, birth through seventeen (17) years of age, and who meet the established minimum criteria for hospital or nursing facility level of care as determined by the Utilization Review Contractor. The services provided through this Children's HCBS Waiver Program shall include all state plan Medicaid benefits and case management services. These services, when deemed to be appropriate and adequate by the child's physician, shall be provided in the home or community. The Children's HCBS Waiver Program shall be administered by the Colorado Department of Health Care Policy and Financing (the State).~~

~~8.506.10 Eligibility~~

~~8.506.11 Program Eligibility~~

~~A. Services shall be provided to children who meet all the following program eligibility requirements:~~

~~1. The child has not reached his/her eighteenth (18th) birthday; and~~

~~2. The child is living at home with parent(s) or guardian and is at risk of institutional placement, as determined by the Utilization Review Contractor; or is in an acute care hospital or nursing facility and can be returned home and safely cared for in the home, and the child's parent(s) or guardian choose to receive services in the home or community instead of an institution, with the provision of Children's HCBS Waiver Program services; and~~

~~3. The child's physician certifies that the quality and quantity of services and supports identified in the Care Plan are sufficient to meet the needs of the child in the home setting; and~~

~~4. The Utilization Review Contractor certifies, through the ULTC-100 (Long Term Care Client Assessment Certification and Transfer) form, in conjunction with the Pediatric Functional Assessment Instrument, that the child meets the established minimum criteria for hospital or nursing facility level of care; and~~

~~5. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs; and~~

~~6. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State; and,~~

~~7. The child receives a waiver service on a monthly basis.~~

~~8.506.12 Financial Eligibility~~

~~Services shall be provided to children who meet all the following financial eligibility requirements:~~

~~A. Parental income and/or resources will result in the child being ineligible for SSI; and~~

~~B. The income of the child does not exceed 300% of the current maximum SSI standard maintenance allowance; and~~

~~C. The resources of the child do not exceed the maximum SSI allowance; and~~

~~D. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, SSI Financial Eligibility Requirements, Consideration of Trusts In Determining Medicaid Eligibility, Section 8.110.52 of this manual.~~

~~8.506.13 Repealed, effective August 1, 2005~~

~~8.506.2 Waiting List Guidelines~~

~~A. When an opening becomes available:~~

~~1. Children who are determined by the Utilization Review Contractor to have an exceptional or immediate medical need shall be given priority based on medical need and shall be placed at the top of the waiting list; The Utilization Review Contractor shall be responsible for reviewing the initial request, and should an immediate medical need be identified, conduct the final review to determine if the client is appropriate for placement on the waiting list.~~

~~2. Exceptional or immediate medical need means a life-threatening disease/illness or medical condition which requires acute medical intervention, as determined by the Utilization Review Contractor and such medical treatment is not considered to be experimental, and the child meets all other relevant eligibility criteria.~~

~~3. Children who are not determined to have an exceptional or immediate medical need shall be placed on a waiting list in the order in which the application is received by the Utilization Review Contractor.~~

~~The first child on the waiting list shall be reassessed for medical and financial eligibility and, if determined to still be eligible, assigned the next available opening.~~

~~B. The Utilization Review Contractor is responsible for maintaining and monitoring the waiting list~~

~~C. The Utilization Review Contractor is responsible for noticing the case management agency that the child has been placed on the waiting list.~~

~~D. The Utilization Review Contractor shall assure that no more than 630 clients are served on the Program at any one time state-wide.~~

~~8.506.3 Roles and Responsibilities of the County Department~~

~~The County Department shall:~~

~~A. Assist in completing an Application for Assistance;~~

~~B. Obtain from the child's parent(s) or guardian an SSI Denial Letter which they have obtained from the Social Security Administration, District Office Responsible for making the determination which documents that the parent's income and/or resources would render the child ineligible for Medicaid if it were deemed available to him/her;~~

~~C. Certify that the child's income and/or resources does not exceed 300% of SSI;~~

~~D. Assist in completing an MS-10 (Recipient Insurance Information To Be Used By The Colorado Medicaid Program Form);~~

~~E. Ensure the parent(s) or guardian are informed of all state plan Medicaid benefits available to the child;~~

~~F. Provide a list of certified case management agencies; and~~

~~G. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility.~~

~~8.506.4 Documentation~~

~~A. In the event the County Department is able to provide the above documentation to recommend assessment, the following will occur:~~

~~1. Upon recommendation of assessment, the child's parent(s) or guardian must inform the County Department of the name of the certified Children's HCBS Waiver Program case management agency of their choice so the County Department can forward the assessment.~~

~~2. The County Department shall forward the assessment within fifteen (15) working days to the certified Children's HCBS Waiver Program case management agency of choice.~~

~~3. The County Department shall notify the case manager within five (5) working days of any changes in the child's income, which might affect the eligibility status.~~

~~B. In the event the County Department is unable to obtain the above documentation to recommend assessment, the following will occur:~~

~~1. The County Department shall deny the child's request; and~~

~~2. The County Department shall notify the child's parent(s) or guardian, in writing, of the denial and right to appeal in accordance with procedures found in the Colorado Department of Human Services Income Maintenance Staff Manual (9 CCR 2503-1), Administrative Procedures Section 3.830.~~

~~8.506.5 Case Management~~

~~Case management is assistance provided by a case management agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports, including In-Home Support Services, to enable the child to remain in his/her community-based setting.~~

~~Case management agency is a public, private, or private for non-profit agency which is certified by the State in accordance with procedures found in the General Certification Standards for Case Management Agencies, Section 8.506.97, of the Children's HCBS Waiver Program rules, to provide services throughout the State.~~

~~8.506.51 Roles and Responsibilities of the Case Management Agency~~

~~Case management agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at 26-1-114, C.R.S., as amended.~~

~~The case management agency shall:~~

~~A. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact;~~

~~B. Ensure the parent(s) or guardian are informed of In-Home Support Services and all state plan Medicaid benefits available to the child;~~

~~C. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community based services (Individual Choice Statement). A signature is required on this State designated form~~

~~D. Assist in completing the identification information on the ULTC-100.2 form; Submit the ULTC-100.2 to the Utilization Review Contractor to determine whether the level of care criteria is met;~~

~~E. Begin assessment activities within ten (10) calendar days upon receipt of the referral~~

~~Assess child's health and social needs to determine whether or not program services are both appropriate and cost effective;~~

~~E. Verify that the child meets the appropriate level of care (hospital or nursing facility) criteria as determined by the Utilization Review Contractor;~~

~~F. Arrange for and complete at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible within thirty (30) calendar days of receipt of the referral;~~

~~G. Initiate a new level of care review by telephoning the Utilization Review Contractor should the face-to-face contact indicate that the child is more independent/functional than is indicated by the information on the certified ULTC-100.2, or that the child's medical condition has improved;~~

~~H. Notify the child's parent(s) or guardian and arrange for the development of the Care Plan and Prior Approval Cost Containment Record within thirty (30) calendar days;~~

~~I. Develop a Prior Approval Cost Containment Record form of services and projected costs. The case manager must identify costs as part of the Care Plan and the Cost Containment Record to be submitted to the State for review. The State shall be responsible for ensuring that, on average, each Care Plan is within the level of care State cost containment requirements. Approval of the Cost Containment Record form does not constitute automatic Medicaid reimbursement for Authorized Services identified. State An approval only makes sure that the cost of services does not exceed the equivalent cost of appropriate institutional care;~~

~~J. Develop and submit the In-Home Support Services Authorization as described in §8.552.3, In-Home Support Services, Program Eligibility;~~

~~K. Submit a copy of the approved Enrollment Form to the County Department for activation of a Medicaid State Identification Number;~~

~~L. Notify the child's parent(s) or guardian within ten (10) calendar days that the child has been placed on the waiting list;~~

~~M. Document whether and how the services provided are meeting the child's needs, as defined in the Care Plan, and ensure that the child continues to meet cost containment criteria;~~

N. Evaluate effectiveness by monitoring services provided to the child in meeting the needs stated in the Care Plan. This monitoring shall include conducting child, parent(s) or guardian, and provider interviews and reviewing cost data and any written reports received. Such evaluations shall be performed at the discretion of the case manager, but no less frequently than quarterly;

O. Complete a reassessment of each child, at a minimum, every twelve (12) months before the end of the length of stay assigned by the Utilization Review Contractor. A ULTC-100.2 may be valid for no more than a 12 month period.

P. Submit a care Plan and Prior Approval Cost Containment Record to the State demonstrating continued cost-effectiveness whenever a change in the Care Plan results in an increase or change in the services to be provided.

8.506.6 Roles and Responsibilities of the Utilization Review Contractor

The Utilization Review Contractor shall:

A. Determine, at admission, that the level of care criteria is met in accordance with 8.506.11,A,4.;

B. For continued stay review, renew or deny child assessment based on a twelve (12) month reassessment process;

C. Maintain and monitor the waiting list (Utilization Review Contractor only);

D. Notify case management agency when there is a Program opening;

E. Notify the child's parents) or guardian, the County Department, case management agency, and the State, in writing, if the child does not require the level of care provided in an institution, and of the child's right to an appeal.

8.506.7 Care Plan

8.506.71 Definition

The Care Plan is a document that identifies how services and supplies provided will meet the child's needs.

The supplies that are identified are described in quantifiable terms. All service required to meet these needs in the home or community shall be listed. The purpose and the expected outcome of the services shall be included in the Care Plan.

8.506.72 Requirements of Care Plan

A. The Care Plan shall consist of a Needs Section, Plan Section, and Purpose Section.

1. Needs Section shall identify and list specific (medical) conditions and needs for which services, supplies, and providers are required to maintain the child in the home or community. The areas of need shall include, but not be limited to, the following:

a. medical needs;

b. functional needs; and

c. home/environmental needs.

2. Plan Section shall identify and quantify all services and suppliers required to meet the needs of the child, including case management and In-Home Support Services. The plan shall include a process, developed in coordination with the child's family and the child's physician, by which the child may receive necessary care if the client's family or care provider is unavailable due to an emergency situation or to unforeseen circumstances. The service listing shall identify payment sources (i.e., family or informal supports, parental out-of pocket expenditures, private insurance, case management costs).

3. Purpose Section shall be a statement of a measurable goal that the case manager, child's parent(s) or guardian and service providers expect to obtain during the period covered by the Care Plan.

B. The case manager shall send a copy of the Care Plan and Signature Page to the parent(s) or guardian. The parent(s) or guardian must review and approve the Care Plan. The parent(s) or guardian must sign and date the Signature Page and return it to the case manager.

C. The case manager shall send a copy of the Care Plan and Signature Page to the child's physician. The physician must review the Care Plan and attest that, in his/her opinion, the quantity and quality of care planned for the child in the home or community is sufficient for the child's needs, and that such care/services can be safely and adequately provided by the caregiver. The physician must sign and date the Signature Page and return it to the case manager.

D. If a child is enrolled in more than one children's program and case management services are an authorized benefit, the case management agencies shall collaborate and specify in the Care Plan their unduplicated roles, responsibilities, and the services to be provided by each case management agency.

5.506.73 Revisions to Care Plan and Prior Approval Cost Containment Record

A. When a change results in an increase in the cost of services/supplies being provided, the case manager may seek telephone approval from the State. Approval is contingent upon submission of a revised Care Plan, and Prior Approval Cost Containment Record and Authorization for In-Home Support Services within ten (10) working days of telephone approval.

B. When a change results in a decrease in the cost of services/supplies being provided, no revision to the Care Plan or Prior Approval Cost Containment Record is necessary.

8.506.80 Cost Containment

8.506.81 Definition

The Prior Approval Cost Containment Record is a document that identifies the cost effective alternative compared to the equivalent cost of appropriate institutional (hospital or nursing facility) level of care.

8.506.82 State Calculation of Cost Containment Amount

For each level of care, the cost to Medicaid, on a per capita basis, is equal to or less man institutional (hospital or nursing facility) costs.

The State shall annually compute me equivalent monthly cost of nursing facility care in accordance with Section 8.485.100, HCBS-EBD, State Calculation of Cost Containment Amount.

~~The average daily per capita expenditures for acute care services to institutional (hospitalized) children shall be the per diem amount as reported on the most recent approved HCFA 372 report. This figure shall be computed annually to be effective January 1 for the current calendar year.~~

~~8.506.83 Requirements of Cost Containment Record~~

~~A. The Cost Containment Record shall include date and signature of the case manager.~~

~~B. The case manager shall determine that the total costs for services are less man or equivalent to the cost of appropriate institutional care, as calculated by the State, utilizing the Prior Approval Cost Containment Record. Such costs to implement the Care Plan shall include case management services.~~

~~8.506.84 Revisions to Cost Containment Record~~

~~The State shall approve or disapprove the revised maximum authorization for services within thirty (30) calendar days of receipt of the revised Prior Approval Cost Containment Record.~~

~~8.506.9 Program Enrollment Documentation~~

~~A. Completed enrollment forms shall be submitted to the State within thirty (30) calendar days of receipt of the certified ULTC-100.2 form by the case manager from the Utilization Review Contractor indicating that an opening has been designated for the child. A complete packet includes:~~

~~1. Enrollment Form;~~

~~2. Individual Choice Statement/Signature Page;~~

~~3. Care Plan;~~

~~3. Prior Approval Cost Containment Record;~~

~~4. SSI Denial Letter which documents that the child is ineligible for Medicaid due to parental income and/or resources; and~~

~~6. Utilization Review Contractor's certified ULTC-100.2 form; and~~

~~7. In-Home Support Services Authorization.~~

~~B. After review by the State, if all requirements are met, copies of the Enrollment Form and Prior Approval Cost Containment Record will be returned to the case manager with the authorization signatures from the State.~~

~~C. The effective date/enrollment date shall be no earlier than the start date on the Utilization Review Contractor certified ULTC-100.2 form. A certified ULTC-100 form does not constitute program enrollment. No services, including case management, may be authorized prior to the date of Program enrollment.~~

~~D. An Enrollment Form, Care Plan, Individual Choice Statement/Signature Page, ULTC-100.2 and Prior Approval Cost Containment Record, and In-Home Support Services Authorization may be valid for no more than a twelve (12) month period.~~

~~8.506.91 Maintenance of Case Records~~

A. The case manager must create and maintain a case record for each child referred to the Children's HCBS Waiver Program. The case record must include:

1. Name, address, date of birth, phone number and any other identifying information about the child;

2. Documentation mat eligibility for Medicaid has been determined by the County Department;

3. Documentation of the Utilization Review Contractor's level of care determination (ULTC-100); Enrollment Form, initial assessment materials, including the Individual Choice Statement/Signature Page, documentation of the referral, Care Plan, Prior Approval Cost Containment Record, and SSI Denial Letter;

4. Documentation of case management;

5. Case activity, including documentation of monitoring. All services, including case management, shall be evaluated as to effectiveness in reaching me goal of the Care Plan; and

6. Whenever the case manager fails to comply with any regulation for case management services for the Children's HCBS Waiver Program, due to circumstances outside the case manager's control, me circumstances must be documented in the case record.

8.506.92 Monitoring and Coordinating

A. Case managers shall document whether and how the services provided are meeting the child's needs, as defined in the Care plan, and ensure that the child continues to meet the cost containment criteria. Monitoring shall include conducting child, parent(s) or guardian and provider interviews and reviewing cost data and any written reports received from service providers. Case manager shall have, at a minimum, telephone contact with the child's parent(s) or guardian on a monthly basis. These contacts must be documented in the case file.

B. Case managers shall be responsible for coordinating information with the parents) or guardian, child's physician, service providers, County Department, Community Centered Board, and others, as necessary, to ensure the effective delivery of services and support for the child.

8.506.93 Reassessment

A. Reassessments are initiated by the case management agency, at a minimum, every twelve (12) months before the end of the length of stay on the ULTC 1002 form following Program Guidelines except for the Waiting List Guidelines outlined in Section 8.506.2.The following documents shall be renewed/revised and sent to the State no later man fifteen (15) working days prior to the expiration of the current ULTC 100.2 form:

1. Enrollment form;

2. ULTC 100.2 form;

3. Care Plan;

4. Prior Approval Cost Containment Record; and

5. Individual Choice Statement/Signature Page.

B. The case manager may initiate a level of care review more frequently, when warranted by significant changes in the child's situation.

C. The case manager must document verification of the child's Medicaid eligibility with the County Department. If the child is Medicaid eligible and meets the level of care criteria, the case manager shall conduct a reassessment in accordance with this section.

D. If the child is not Medicaid eligible and/or does not meet the level of care criteria, the case manager shall refer the child to the County Department or other community agencies for possible services, as appropriate, within ten (10) working days of notification of Children's HCBS Waiver Program denial.

8.506.94 Case Management Agency/Intercounty Transfer Procedures

A. The sending case management agency shall:

1. Contact the receiving case management agency by telephone and provide notification that, the child is planning to transfer (per parent(s) or guardian choice); negotiate an appropriate transfer date, and forward case file to the receiving case Rev eff management agency;

2. Forward copies of pertinent records and forms to the receiving case management agency within five (5) working days of the child's transfer;

3. Notify the State and the Utilization Review Contractor of the transfer within thirty (30) calendar days, using a State designated form, indicating effective date, name of new case management agency, and type of transfer,

4. If an intercounty transfer, notify the income maintenance technician to follow intercounty transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual (9 CCR 2503-1), Intercounty Transfer Section 3.140.3.

B. The receiving case management agency shall:

1. Conduct a face-to-face visit with the child within ten (10) working days of the child's transfer;

2. Review and revise the Care Plan and the Prior Approval Cost Containment Record and change or coordinate services and providers as necessary.

8.506.95 Termination

A. The child shall be terminated from the Program when one of the following occurs:

1. The child no longer meets the level of care criteria for hospital or nursing facility placement as determined by the Utilization Review Contractor;

2. The physician can no longer certify that the quality and quantity of services and supports provided are able to meet the needs of the child in the home or community;

3. The child's own income and/or resources put him/her in excess of the allowable 300% of the SSI standard maintenance allowance or SSI personal assets limit;

4. The parent's income and/or resources decrease, and the child becomes Medicaid eligible without the use of the Children's HCBS Waiver Program;

5. The cost of services and supports provided in the home or community exceed the cost effectiveness guidelines of the Program;

6. Eighteen (18) years of age;

7. The parent(s) or guardian choose hospital or nursing facility services rather than the Children's HCBS Waiver Program services;

8. The family chooses to discontinue the Children's HCBS Waiver Program (e.g., moves out of state, no longer needs the Medicaid coverage); or,

9. The child expires.

B. The case manager shall notify all providers listed on the Care Plan within ten (10) working days of termination;

C. The case manager shall notify the State, Utilization Review Contractor, and the County Department, within ten (10) calendar days of termination, on a State designated form;

D. The case manager shall provide appropriate referrals to other community agencies, including the County Department, if the child needs continued assistance to remain in the home or community, within five (5) working days of written notice of termination;

E. The reason for termination and all agency referrals shall be documented in the child's case record;

F. The case manager shall inform the child's parent(s) or guardian in writing on a State designated form of the termination from the Children's HCBS Waiver Program, ten (10) calendar days before the effective date of the termination.

8.506.96 Client Rights

A. The case manager shall inform the child's parent(s) or guardian of the client's rights in accordance with procedures found in the HCBS-EBD, Client Rights Section, 8.485.300.

B. Children denied Program enrollment shall be informed of their appeal rights in accordance with procedures found in the Recipient Appeals Protocols/Process, Section 8.057 of this manual.

8.506.97 General Certification Standards for Case Management Agencies

A. Certification standards for the Children's HCBS Waiver Program case management agencies shall be the same as those prescribed for provider agencies in accordance with procedures found in the HCBS-EBD, General Certification Process Section 8.487.20.

B. Case management agencies operated by Community Centered Boards shall also meet the General Provisions set forth in the Community Centered Boards Section of the Department of Human Services, Developmental Disabilities Services, Rules and Regulations, Chapter 2 (2 CCR 503-1).

C. Case management agencies operated by Community Centered Boards shall also meet all standards in the Case Management Services Section of the Department of Human Services, Developmental Disabilities Services, Rules and Regulations, Chapter 5 (2 CCR 503-1).D. Case management agencies are required to apply specifically for certification as a Children's HCBS Waiver Program provider and have a Provider Agreement with the State.

~~E. Case management agencies shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.~~

~~8.506.98 Monitoring Process For Case Management Agencies~~

~~Case management agencies are subject to inspection, review and audit by the State Department.~~

~~8.506.99 Termination or Non-Renewal of Provider Agreements~~

~~Termination or non-renewal of Provider Agreements shall be in accordant: with procedures found in the HCBS-EBD, Termination or Non-Renewal of Provider Agreements Section 8.487.70.~~

~~8.506.100 Reimbursement For Case Management Services~~

~~Case management agencies shall bill the fiscal agent and shall be reimbursed for case management activity in fifteen minute increments.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Payment Reform Rule Concerning Federally Qualified Health Centers, Section 8.700
Rule Number:	MSB 15-08-25-A
Division / Contact / Phone:	Payment Reform / Zabrina Perry / x4370

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 15-08-25-A, Revision to the Medical Assistance Payment Reform Rule Concerning Federally Qualified Health Centers, Section 8.700
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.700.1, 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 all current text beginning at §8.700.1 through the end of the second unnumbered paragraph that ends immediately before §8.700.2 with the new text provided. This revision is effective 12/31/2015

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Payment Reform Rule Concerning Federally Qualified Health Centers, Section 8.700
Rule Number:	MSB 15-08-25-A
Division / Contact / Phone:	Payment Reform / Zabrina Perry / x4370

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 change will revise the Definitions section of the Federally Qualified Health Center (FQHC) rules, which currently define a billable "visit" as a face-to-face encounter between a center client and an eligible provider, to place the additional requirement that a billable "visit" be a one-on-one face-to-face encounter between a center client and an eligible provider. Group sessions will not generate a billable encounter for any FQHC services.
   This rule change will reduce ambiguity and clarify how group sessions at FQHCs are billed, and how the costs and visits will be incorporated into the calculations for the per-visit encounter rate for each FQHC. Reducing this ambiguity is increasingly important as more FQHCs offer group sessions (such as the newly allowed diabetes self-management education), and as the Department of Health Care Policy and Financing works to make managed care entities (such as behavioral health organizations that offer services such as group psychotherapy sessions) at full risk for paying FQHCs their per-visit encounter rates.

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. § 1396a(bb)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-4-401, C.R.S. (2015)

Initial Review	**10/09/2015**	Final Adoption	**11/13/2015**
Proposed Effective Date	**12/30/2016**	Emergency Adoption	

DOCUMENT #01

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Payment Reform Rule Concerning Federally Qualified Health Centers, Section 8.700
Rule Number:	MSB 15-08-25-A
Division / Contact / Phone:	Payment Reform / Zabrina Perry / x4370

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 affect the 372,677 Medicaid members that receive medical services at FQHCs.

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

   Total expenditures for services received at FQHCs during the last fiscal year was $166,486,657.00, or approximately $447.00 per member. However, no qualitative or quantitative service impacts are expected as a result of this rule change. Care will continue to be delivered as it has in the past.

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.

   None.

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

   This proposed rule will reduce ambiguity, while inaction will leave the rule with inherent ambiguity, which is an undesirable status.

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

   N/A

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

   The alternative is to leave the rule as it is, with inherent ambiguity, which is an undesirable status.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.

~~Federally Qualified Health Center (FQHC) means a hospital-based or free standing center that meets the FQHC definition found in Section 1905(1)(2)(B) of the Social Security Act. Section 1905(1)(2)(B) of the Social Security Act is incorporated by reference. This rule does not include any later amendments to or editions of the incorporated material. A copy of Section 1905(1)(2)(B) of the Social Security Act is available for public inspection for a reasonable charge at the Colorado Department of Health Care Policy and Financing, 1570 Grant St, Denver, Colorado 80203. A copy of the incorporated material is also available for a reasonable charge from the U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, Pennsylvania 15250-7954. The incorporated material may also be examined at any state publications depository library.~~.

Visit means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist or clinical social worker providing the services set forth in 8.~~-~~700.3. Group sessions do not generate a billable encounter for any FQHC services.