THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Home and Community Based Services for Elderly Blind and Disabled Rule Concerning Adult Day Section 8.491
Rule Number: MSB 15-10-29-A
Division / Contact / Phone: LTSS / Cassandra Keller / 866-5181

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 15-10-29-A, Revision to the Medical Assistance Home and Community Based Services for Elderly Blind and Disabled Rule Concerning Adult Day Section 8.491.14.I
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) 8.491.14.I, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text beginning at §8.491 through the end of §8.491.35.C with the new text provided beginning at §8.491 through the end of §8.491.30.A.1. This revision is effective March 30, 2016.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Home and Community Based Services for Elderly Blind and Disabled Rule Concerning Adult Day Section 8.491
Rule Number: MSB 15-10-29-A
Division / Contact / Phone: LTSS / Cassandra Keller / 866-5181

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 intention of this rule is to ensure providers meet both State and Federal guidelines for CIR requirements for adult day centers. Currently, it is not indicated within rule that adult day providers notify case managers (CM) at the Single Entry Point (SEP) of a critical incident within twenty-four hours. This change to the rule will make clear that a twenty-four hour reporting requirement exists for providers. This will mandate that CMs are notified of critical incidents in a timely manner and will in-turn notify the Department. With this process in place, the Department will align policies surrounding CIRs and have the ability to better collaborate with its sister agencies. That collaboration will lead to improved oversight of adult day centers as well as more comprehensive inspections by the Department of Public Health and Environment (DPHE).

Additionally, the Department has included requirements in the rule for the position of director to Adult Day Centers. These new requirements will help to ensure properly staffed ADCs at the director position. Moreover, the Department has made changes to the reimbursement section of the rule, to reflect the current reimbursement methods. The section of the rule was outdated and needed to be revised in order to inform all providers, etc. of how the Adult Day service is reimbursed.

The Department has worked closely with DPHE to develop the changes to this section of the rule, and has received buy-in on these changes. It will also alert the adult day centers trade group, LeadingAge, of these changes.

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:

   25.5-6-303, C.R.S. (2015);

Initial Review	**12/11/2015**	Final Adoption	**02/12/2016**
Proposed Effective Date	**03/30/2015**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Home and Community Based Services for Elderly Blind and Disabled Rule Concerning Adult Day Section 8.491
Rule Number: MSB 15-10-29-A
Division / Contact / Phone: LTSS / Cassandra Keller / 866-5181

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.

   Individuals who will be affected by this rule are individuals who attend Adult Day Centers on the LTSS Waivers. They will benefit from this rule change due the new clarified requirements on CIRs, but they will not bear any cost from this rule change. Adult Day Centers may have a slight additional administrative burden but the Department does not anticipate any that bearing any additional cost.

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

   All LTSS waiver clients who attend Adult Day Centers will benefit from the increased CIR reporting and additional oversight it will bring to the program.

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 a cost increase to the Department. There will also not be a cost to DPHE as in the course of their surveying they already review these type of records.

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

   The clarification to LTSS Adult Day clients significantly outweighs any additional administrative burdens on the part of the Centers.

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

   This method of CIRS reporting and oversight is the most cost effective approach, as it is required by CMS, approved by CDPHE, and requires minimal additional output from the Department.

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

   No alternative methods were considered.

8.491 ADULT DAY SERVICES

.10 Adult Day Services (ADS) means health and social services, individual therapeutic and psychological activities furnished on a regularly scheduled basis in an adult day services center, as an alternative to long term nursing facility care.

.12 Basic Adult Day Services (ADS) Center means a community-based entity that conforms to all state established requirements as described in 10 CCR 2505-10 section 8.130 and 10 CCR 2505-10 section 8.491.14.

.13 Specialized Adult Day Services (SADS) Center means a community-based entity determined by the State to be providing ~~intensive~~ health supportive services for participants with a primary diagnosis of Alzheimer's and related disorders, Multiple Sclerosis, Brain Injury, Chronic Mental Illness, Developmental Disability or post-stroke participants who require extensive rehabilitative therapies. In order to be designated as~~To be determined~~ specialized, two-thirds of an ADS C~~c~~enter's population must be participants whose physician has verified one of the above diagnoses and ~~recommended the appropriate specialized services~~determined SADS is appropriate for the participant.

The participant's individual care plan must include documentation of their diagnosis and service goals. In addition, ~~verification and documentation of the participant's diagnosis and the recommended specialized services must be included in each participant's case record and~~ each participant's individual care plan must include the following:

A. For Medicaid participants, the case manager must forward the most recent copy of page 1 of the participant's ULTC-100.2 to the ADS C~~c~~enter as documentation of one of the above diagnoses. Documentation must be verified at the time of admission, reassessment by the case manager or whenever the re~~n;~~ is a significant change in the participant's condition.

B. For participants from other payment sources, diagnosis, and recommended specialized services must be documented in an individual care plan, or other admission form, and verified by the participant's physician. This documentation must be verified at the time of admission, or whenever there is a significant change in the participant's condition.

C. The Department or its designee will review an A~~a~~dult D~~d~~ay S~~s~~ervices C~~c~~enter's designation as a specialized facility (SADS) on an annual basis.

.14 Only participants whose needs can be met by the Adult Day Services Center within its certification category and populations served shall be admitted to the Center. Adult D~~d~~ay S~~s~~ervices shall include, but are not limited to, the following:

A. Daily monitoring to assure that participants are maintaining activities prescribed~~;~~ and assisting with activities of daily living (e.g., eating, dressing, bathing).

B. Emergency services including written procedures to meet medical crises.

C. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.

D. Nutrition services including therapeutic diets and snacks appropriate to the participant's individual care plan ~~care plan~~ and hours in which the participant is served.

E. Daily services provided to monitor the participant's health status, supervise medications, and carry out physicians' orders in participant's individual care plan ~~care plan~~ as needed.

F. Social and recreational services as prescribed to meet the participant's needs and as documented in the participant's individual care~~c~~are plan. Participants have the right to choose not to participate in social and recreational activities.

G. Adult D~~d~~ay S~~s~~ervices C~~c~~enters certified on or after July 1, 1996, or upon change of ownership, shall provide basic personal care services including bathing in emergency situations.

~~Any additional services such as physical therapy, occupational therapy and speech therapy, if such services are prescribed by the participant's physician, documented in the participant's care plan and if such services are not being provided in the participant's home. Such services must be included in the budget submitted to the State in accordance with 10 CCR 2505-10 section 8.491.30, and determined by the State to be necessary for adult day services.~~

~~H. participant's ;NE; Participant orParticipant;Participant's ;;.~~

8.491.15 DEFINITIONS

A. Director means any person who owns and operates an ADS C~~c~~enter, or is a managing employee with delegated authority by ownership to manage, control, or perform the day-to-day tasks of operating the center~~facility~~ as described in 10 CCR 2505-10 section 8.491~~5.C.22~~. All Directors hired or designated after January 1, 2016, shall meet the following qualifications:

1. At least a bachelor's degree from an accredited college or university and a minimum of two years of social services or health services experience; or

2. A high school diploma or GED equivalent, a minimum of four years of experience in a social services or health services setting, skills to work with aging adults or adults with functional impairment, and skills to supervise ADS Center staff persons.

B. Participant means any individual found to be eligible for adult day services regardless of payment source.

C. Restraint means any physical or chemical device, application of force, or medication, which is designed or used for the purpose of modifying, altering, or controlling behavior for the convenience of the facility, excluding medication prescribed by a physician as part of an ongoing treatment plan or pursuant to a diagnosis.

D. Staff means a paid or voluntary employee of the facility.

E. Universal Precautions refers to a system of infection control which assumes that every direct contact with body fluids is potentially infectious. This includes any reasonably anticipated skin, eye, or mucous membrane contact with blood-tinged body fluids or other potentially infectious material.

8.491.20 CERTIFICATION STANDARDS

A. All ADS C~~c~~enters shall conform to all of the following State established standards:

1. ~~A.~~ General

a~~1~~. Conforms to all established State standards in the section on general provider participation requirements, as defined in 10 CCR 2505-10 section 8.130, has in effect all necessary licenses and insurance, and is in compliance with ADS regulations as determined by an annual on-site survey conducted by the Colorado Department of Public Health and Environment (CDPHE).

b.~~2~~. Proof of Medicaid certification consists of ~~A~~a completed Provider Agreement ~~between the provider and the~~approved by the Department and the Department's fiscal agent, and a letter from CDPHE stating that based on the results of the survey, the provider has been certified and/or recertified. ~~of Health Care Policy and Financing shall serve as proof of Medicaid certification.~~

~~3~~c. Denial, termination, or non-renewal of the Provider Agreement shall be for "Good Cause" as ~~provided~~ defined in 10 CCR 2505-10 section 8.076~~50 of this staff manual~~.

2. Using the State approved Critical Incident Reporting Form, Adult Day Service Center providers shall notify the participant's Single Entry Point (SEP) case manager within 24 hours of any incident or situation including:

a. Death;

b. Abuse/neglect/exploitation;

c. Serious injury to participant or illness of participant;

c. Damage to participant's property/theft;

d. Medication management;

e. Other high risk issues.

B. Environment

1. ~~The agency~~ ADS Centers shall provide a clean environment, free of obstacles that could pose a hazard to participant health and safety.

2. ~~Agencies~~ ADS Centers shall provide lockers or a safe place for participants' personal items.

3. ADS C~~c~~enters shall provide recreational areas and activities appropriate to the number and needs of the participants.

4. Drinking facilities shall be located within easy access to participants.

5. To accommodate all ADS Center activities and program needs, ADS C~~c~~enters shall provide a minimum of 40 sq. feet per participant. ADS Centers shall provide eating and resting areas consistent with the number and needs of the participants being served. Centers certified on or after July 1, 1996~~%~~, shall provide a minimum of 40 sq. feet per participant~~s~~

6. ADS Cc~~e~~enters shall provide easily accessible toilet facilities, h~~l~~and-washing facilities and paper towel dispensers. Centers must provide a facility for bathing in emergency situations.

7. ~~The C~~center~~ADS~~ Centers shall be accessible to participants with supportive devices for ambulation or in wheelchairs.

8. There shall be adequate means by which food shall be maintained at the foll~~M~~owing temperatures: Hot 140° F, Cold: 45° F.

9. All medications shall be stored in a secured area.

10. ADS Centers shall be heated to at least seventy (70) degrees during hours of operation and no more than 76 degrees in the summer months.

11. ADS Cc~~e~~enters must provide an environment free from restraints as defined at 10 CCR 2505-10 section 8.491.15.C of these rules.

12. ADS Centers, in accordance with 10 CCR 2505-10 section 8.491.14 above, must provide a safe environment for all participants, including participants exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

C. Records and Information

1. ADS Center providers shall keep such records and information necessary to document the services provided to participants receiving A~~a~~dult D~~d~~ay S~~s~~ervices. Records shall include but not be limited to:

~~1.~~

a. Name, address, sex, and age of each participant;

b. Name, address and telephone number of responsible party;~~,~~

c. Name, address and telephone number of primary physician;

d. Documentation of the supervision and monitoring of the services provided~~,~~;

e. Documentation that all participants or responsible parties were oriented to the center, the policies, and procedures relevant to the facility and the services provided;~~,~~

f. A service~~s~~ agreement signed by the participant and/or his or her designated representative and appropriate center staff;~~,~~

g. ~~An individual care plan of careP of care F~~For participants from other payment sources, receiving supportive services in a specialized ADS C~~e~~enter, individual care plans must include a primary diagnosis and a physician's signature.

2. Medical Information included in the care plan~~plan of care~~:

a. Medications the ~~client~~ participant is taking and whether they are being self-administered;~~.~~

b. Special dietary needs, if any;~~.~~

c. Any restrictions on social and/or recreational activities identified by physician in the care plan;~~.~~

d. Documentation of any nursing or medical interventions; physical, speech, and/or occupational therapy administered to participant~~s~~ whose physician has prescribed such services to be included in the participant's individual care plan ~~of care~~;~~.~~

e. Any other special health or behavioral management needs.

3. Documentation that the participant and/or other responsible party was provided with written information about his/her rights under state law regarding advance directives in accordance with regulations at 10 CCR 2505-10 section 8.130.3~~65.~~ Documentation as to whether the participant has executed any advance directives or declarations shall be kept in his/her case record.

4. All entries into the record shall be legible, written in ink, dated, and signed with name and title designation.

5. Records shall be maintained in such a manner as to ensure safety and confidentiality.

D. Staffing Requirements

1. All ADS C~~c~~enters must maintain a staff to participant ratio of 1:8 or lower to provide for the needs of the population served, as described above at 10 CCR 2505-10 section 8.491.12 and .13, and shall provide the following:

a. Supervision of participants at all tim~~un~~es during the operating hours of the program;

b. Immediate response to emergency situations to assure the welfare of participants;

c. Prescribed recreational and social activities;

d. Nursing services for regular monitoring of the on-going medical needs of participants and the supervision of medications. These services must be available a minimum of two hours daily and must be provided by an RN or LPN. CNAs may provide these services under the direction of a RN or an LPN. Supervision of CNAs must include consultation and oversight on a weekly basis or more according to the participant's needs.

e. Administrative, recreational, social, and supportive functions of the ADS C~~c~~enter.

2. In addition to the above services, S~~s~~pecialized A~~a~~dult D~~d~~ay ~~care~~ S~~s~~ervices (SADS) C~~c~~enters providing a restorative model of care shall have sufficient staff to provide the following:

a. Nursing services during all hours of operation. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 10 CCR 2505-10 section 8.491.20.D.1.d, above.;

~~b. Therapies, if included in the center's budget and as prescribed by the participant's physician, to meet the restorative needs of the client participant~~

E. Training Requirements

1. ADS Ccenters providing medication administration as a service must have qualified persons on their staff who have been trained in accordance with C.R.S. section 25-1.5-302.

2. All staff must be trained in the use of universal precautions as defined at 10 CCR 2505-10 section 8.491.15.E. Facilities certified prior to the effective date of these rules shall have sixty (60) days to satisfy this training requirement.

3. The ADS Center operator and staff must have training specific to the needs of the populations served, e.g., elderly, blind and disabled, and as defined in 10 CCR 2505-10 section 8.491.13 of these rules.

4. All ADS Center staff and volunteers must be trained in the handling of emergencies including written procedures to meet medical crises.

5. All required training must be documented in employees' personnel files.

F. Written Policies

1. The ADS Ccenter shall have a written policy relevant to its operation. Such policy shall include, but not be limited to, statements describing:

a.~~1~~. Admission criteria that qualify participants to be appropriately served in the center;

b. ~~2.~~ Interview procedures conducted for qualified participants and/or family member prior to admission to the center;~~,~~

c. ~~3.~~ The meals and nourishments including special diets that will be provided;

d. ~~4.~~ The hours and days of the week that the participants will be served in the center and days of the week services will be available;

e~~5~~. Medication administration;

f~~6~~. The personal items that the participants may bring with them to the center;~~,~~ and

g..~~7~~. A written, signed agreement ~~drawn up~~ between the participant or responsible party and the center outlining rules and responsibilities of the center and ~~o~~ the participant. Eeach party to the agreement shall be provided a copy.

8.491.30 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

A. Reimbursement for ADS services shall be based upon a single all-inclusive-payment rate per unit of service for each participating provider which shall be prospectively determined. Units to be billed in accordance to the current rate schedule.

1. A unit is defined as:

one (1) unit = a partial day = three (3) to five (5) hours of service

two (2) units = a full day = more than five (5) hours of service

~~8.491.32 The ADS Ccenter's rate of reimbursement shall be the lower of:~~

~~A. The maximum allowable applicable Medicaid rate for either~~

~~1. Basic ADS Centers-the maximum rate shall not exceed $18.00 per unit of service, as defined above, except that the Department may adjust the maximum rate based upon future appropriations; or~~

~~2. Specialized ADS Centers-the maximum rate shall not exceed $23.00 per unit, as defined above, except that the Department may adjust the maximum rate based upon future appropriations.~~

~~B. The ADS Ccenter's private-pay charges to the general public for similar services.~~

~~C. The projected cost of ADS, as determined by the Department of Health Care Policy and Financing, after review of a cost report/budget to be submitted by the ADS center annually by such date and in a format as prescribed by the Department, with copies of any and all audit reports prepared within the previous twelve-month period.~~

~~Failure to timely submit the required cost report to the Department shall result in the Department assigning the Ccenter's costs have not changed and assigning a cost figure at 100% of the prior year's reported cost per unit. Failure to submit the cost report a second consecutive year shall result in the Department assigning a cost figure at 00% of the most recently reported met information. Cost reports submitted late shall not be considered until the next year's review.~~

~~Cost reports shall be reviewed by the Department for appropriateness, with consideration given to: changes in type and intensity of services being provided, the previous year's reported costs adjusted forward by increases in the annual Consumer Price Index (CPI-W as of the beginning of the State fiscal year), and costs of comparable ADS centers in the State.~~

~~The Department shall notify the provider by September 1 of each year of any costs determined to be inappropriate. The provider must submit any additional documentation supporting the costs in question within thirty (30) days of notification. Ssupporting documentation received after that thirty-day period will not be considered until the next rate-setting period.~~

~~D. The amount billed.~~

~~8.491.33 Upon completion of its review, the Department of Health Care Policy and Financing shall notify each ADS Ccenter provider of its approved cost per unit and its rate to be effective October 1. Adjustments in the approved cost per unit shall not be made until the next year's cost reporting and rate-setting period.~~

8.491.34 For new ADS centers the Department shall determine a rate per unit, taking into consideration the following criteria: anticipated costs reported by the provider, costs and rates of comparable ADS centers, any prior owner's reported costs, and proposed private pay charges to the general public for similar services. The determined rate per unit shall remain in effect until the next year's cost reporting and rate-setting period.

8.491.35 EXCLUSIONS:

A. Transportation to and from adult day services centers shall be reimbursed as non-medical transportation, and these costs shall not be included as part of the adult day services rate.

B. There shall be no reimbursement for ADS provided to any participant who is a resident of any residential care facility, except for services as defined at 10 CCR 2505-10 section 8.491.14.H.

C. There shall be no reimbursement for overnight services in an AD

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:	Revision to the Medical Assistance Health Programs Rule Concerning Rural Health Clinics, Reimbursement, Section 8.740.7
3. This action is an adoption of:	Amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   10 CCR 2505-10 Section 8.740.7, Colorado Department of Health Care Policy and Financing

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 §8.740.7.B.2 with new text provided. Insert new text provided at §8.470.7.3 through the end of §8.740.7.C.3 immediately following current text at §8.740.7.B.2.b. All text indicated in blue is for clarity only and should not be changed. This revision is effective 03/30/2016/

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule: Revision to the Medical Assistance Health Programs Rule Concerning Rural Health Clinics, Reimbursement, Section 8.740.7
Rule Number: MSB 15-10-19-A
Division / Contact/Phone: Health Programs Benefits & Operations Division / Amanda Forsythe/x6459

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 rule language limits RHC reimbursement to a prospective payment for all services provided to a client during a single visit. Reimbursing at this per visit encounter rate does not adequately compensate RHCs for the expense of providing LARC. The proposed rule revision is intended to facilitate better access to LARC for Colorado Medicaid clients living in areas serviced by RHCs, by ensuring adequate reimbursement for the provision of LARC. Carving out reimbursement for LARC from the prospective payment model will increase the payment rate to RHCs for providing LARC to Colorado Medicaid; this will in turn increase the availability of these services and contraceptives to Colorado Medicaid clients in areas served by RHCs.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or
   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   Social Security Act §1905(a)(2)(B) and §1902(bb)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   C.R.S. 25.5-4-401; and C.R.S. 25.5-5-102(1)

Initial Review	**12/11/2015**	Final Adoption	**02/12/2016**
Proposed Effective Date	**03/30/2016**	Emergency Adoption	

DOCUMENT #03

Title of Rule: Revision to the Medical Assistance Health Programs Rule Concerning Rural Health Clinics, Reimbursement, Section 8.740.7
Rule Number: MSB 15-10-19-A
Division / Contact/Phone: Health Programs Benefits & Operations Division / Amanda Forsythe/x6459

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 amendment will benefit Colorado Medicaid-eligible women of childbearing age residing in areas served by RHCs. The Federal Government will bear the bulk of the costs based on the federal financial participation (FFP) of 90% for family planning services. The state will bear the remaining costs (10%) which will be offset by savings from preventing unintended pregnancies.

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 probable impact of this amendment will be the expansion of access to LARC for Colorado Medicaid-eligible women of childbearing age residing in areas served by RHCs. The Colorado Department of Public Health and Environment estimates that each $1 spent on LARC avoids $5.85 in future costs. https://www.colorado.gov/pacific/sites/default/files/HPF_FP_UP-Cost-Avoidance-and-Medicaid.pdf. In addition, avoiding unintended pregnancies increases the ability of families to lift themselves out of poverty.

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

   The probable cost to the Department of the proposed rule amendment is $133,258 for Federal Fiscal Year 2016. There are no other probable costs associated with the implementation or enforcement of the proposed amendment, to the Department or other agency.

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

   The probable costs of inaction are related to the unplanned pregnancies for Colorado Medicaid clients residing in areas served by Rural Health Clinics. The costs

of inaction include more unintended pregnancies in rural areas. Benefits of inaction are no spending increases in the short term.

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

   The purpose of the proposed rule is to increase the availability of long acting reversible contraceptives to the Medicaid members that reside in rural areas. A Rural Health Clinic is often the only provider in the geographic area it serves and the current reimbursement methodology of only paying the Medicare rate for an inclusive visit restricts access of the Medicaid members to long acting reversible contraceptives. There is no method to increase the number of providers that receive fee schedule reimbursement in these areas. Changing the RHC reimbursement to pay for long acting reversible contraceptives increases the access of this device in the rural areas.

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

   The Department worked with the Colorado Department of Public Health and Environment to secure alternative funding from the state legislature to continue a statewide program of providing long acting reversible contraceptives in Title X clinics at little or no cost to the patient. The law that would allow funding was not passed by the legislature. That alternative method to achieve the purpose was rejected by the legislature which led to the determination to amend the State Plan to allow for Medicaid reimbursement through the fee schedule.

8.740.7 REIMBURSEMENT

8.740.7.A. The Department shall reimburse Rural Health Clinics a per visit encounter rate. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.740.7.B. The encounter rate shall be the higher of:

1. The Prospective Payment System (PPS), as defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, BIPA is incorporated herein by reference. No amendments or later editions are incorporated. The Acute Care Benefits Section Manager at the Colorado Department of Health Care Policy and Financing may be contacted at 1570 Grant Street, Denver, Colorado 80203, for a copy of BIPA, or the materials may be examined at any publications depository library.

2. The Medicare rate.

   a. The Medicare rate for hospital based Rural Health Clinics with ~~less~~ fewer ~~-~~than 50 beds shall be based on actual costs.

   b. The Medicare rate for all other Rural Health Clinics is the Medicare upper payment limit for Rural Health Clinics.

8.740.7.C. The Department will reimburse Long-Acting Reversible Contraception (LARC) and Non-surgical Transcervical Permanent Female Contraceptive Devices separate from the Rural Health Clinic per visit encounter rate. Reimbursement will be the lower of:

1. 340B acquisition costs;

2. Submitted charges; or

3. Fee schedule as determined by the Department.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long-Term Services and Supports Rule Concerning Consumer Directed Attendant Support Services, Section 8.510
Rule Number:	MSB 15-10-09-A
Division / Contact / Phone:	Long Term Services and Supports / Rhyann Lubitz / x3641

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 15-10-09-A, Revision to the Medical Assistance Long-Term Services and Supports Rule Concerning Consumer Directed Attendant Support Services, 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) 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)? Yes
   If yes, state effective date: 12/11/2015
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace all current text in § 8.510.1 DEFINITIONS with new text provided.
Replace current text at §8.510.5.B with new text provided.
Replace current text at §8.510.6.B with new text provided.
Remove current text at §8.510.6.C through the end of §8.510.6.C.4.
Replace current text at §8.510.6.D with new text provided.
Replace current text at §8.510.6.E with new text provided.
Replace current text at §8.510.6.E.6 with new text provided.
Replace all current text in §8.510.85 with new text provided.
Replace current text at §8.510.10.86.B with new text provided.
Remove current text at §8.510.86.C.
Replace current text at §8.510.9.C with new text provided.
Replace current text at §8.510.10.C with new text provided.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Replace current text beginning at §8.510.11.B through the end of §8.510.11.B.3.i) with new text provided.
Replace current text at §8.510.12.B with new text provided.
Replace current text at §8.510.13.C with new text provided.
Replace current text at §8.510.14.H with new text provided.
All text indicated in blue is for clarification only and should not be changed.
This revision is effective 03/30/2016.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long-Term Services and Supports Rule Concerning Consumer Directed Attendant Support Services, Section 8.510
Rule Number:	MSB 15-10-09-A
Division / Contact / Phone:	Long Term Services and Supports / Rhyann Lubitz / x3641

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).

With this rulemaking, the Department is changing the employment model for CDASS attendants who are compensated through a Financial Management Services (FMS) vendor. Up until now, clients of a waiver program could choose between an Agency with Choice (AwC) FMS model and a Fiscal Employer Agent (F/EA) FMS model. The rule change will eliminate the AwC model and keep the F/EA model for the following reasons: Under the AwC model the FMS vendor and the client act as joint employers of the CDASS attendant. Overtime and travel time costs incurred due to multiple clients utilizing the same CDASS attendant through an FMS vendor under the AwC model are out of the client's control. The F/EA model allows the client or authorized representative to be the sole employer of the CDASS attendant. Under the F/EA model, overtime and travel costs would be predictable and managed within the client's individualized budget for services. The ability to accurately budget for services is essential to be successful in a consumer-directed service option.

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);
   C.R.S. 25.5-6-1102(6)

Initial Review — Final Adoption **02/12/2016**

Proposed Effective Date **03/30/2016** — Emergency Adoption

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Long-Term Services and Supports Rule Concerning Consumer Directed Attendant Support Services, Section 8.510
Rule Number:	MSB 15-10-09-A
Division / Contact / Phone:	Long Term Services and Supports / Rhyann Lubitz / x3641

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 utilizing CDASS through the Agency with Choice model will be required to transition to the Fiscal Employer Agent model (F/EA).

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

   Clients utilizing CDASS through the Agency with Choice model will be required to transition to the Fiscal Employer Agent model (F/EA). This transition will be facilitated by the client selected Financial Management Service (FMS) vendor and supported by the CDASS training and operations vendor. The F/EA model per member per month reimbursement for FMS activities is a lower reimbursement level which will offer cost savings. Clarifying language in the rule for a CDASS client to maintain employment relationships with two attendants provides case managers with the ability to ensure clients active with CDASS are able to utilize a backup attendant in the event their primary attendant is not able to be present. System prompts in the FMS vendor portal requiring case managers to verify all requirements and forms have been completed prior to completing a prior authorization request for services allows additional assurance prior to implementation of services that all necessary actions have been completed.

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

   The F/EA model per member per month reimbursement for FMS activities is a lower reimbursement level which will offer cost savings.

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

   The costs and benefits of changing this rule greatly outweigh continued inaction. The AwC model is being removed and the F/EA model is being retained as the only FMS model to afford health, safety and welfare assurances to CDASS recipients and provide protection to clients' allocation for services. The AwC model requires compensation for overtime and travel time costs incurred across multiple clients utilizing the same CDASS attendants and FMS vendor. Under the AwC model, the individual has no control over the CDASS attendant incurring overtime and travels costs but would still be responsible for paying those costs.

This requirement could negatively impact an individual's allocation for services because funds that could be used for client services would instead be used to pay travel and overtime costs.

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

   There are no less costly or intrusive methods to manage attendants' overtime and travel time costs within CDASS. Department staff have reviewed alternative implementation methods, each resulting in increased costs or decreased client control over services.

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

   There were several alternative measures considered but all created additional issues regarding limiting client choice in a consumer directed delivery options. Options reviewed included implementing a CDASS attendant 40 hour work week cap and restricting the CDASS attendant to working for only one client. Members of the Participant Directed Programs Policy Collaborative reviewed available options and recommended a removal of the AwC model.

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 a 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 Financial Management Services (FMS) authorized for attendant support services and administrative fees paid to the FMS.

Attendant means the individual who meets qualifications in 10 CCR 2505-10, § 8.510.8 who provides CDASS as determined by 10 CCR 2505-10, § 8.510.3 and is hired by the client or by a contracted FMS vendor.

Attendant Support Management Plan (ASMP) means the documented plan for clients to manage their care as determined by 10 CCR 2505-10, § 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 10 CCR 2505-10, § 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 Supports (LTSS).

Case Management Agency (CMA) means a Department approved agency within a designated service area where an applicant or client can obtain Long Term 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 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 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.

Financial Management Services (FMS) means an entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual client allocations for CDASS.

Fiscal/Employer Agent (F/EA) is an FMS model where the FMS is an agent of the client as the employer. The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative. The F/EA pays workers and vendors on the participant's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both employer and employee Social Security and Medicare Taxes.

Functional Eligibility means an applicant or client meets the criteria for Long Term Services and Supports as determined by the Department's prescribed instrument as ~~outlined~~ defined in 10 CCR 2505-10, ~~§~~ 8.401.

Functional Needs Assessment means a component of the Assessment process which includes a comprehensive evaluation using the ULTC (Uniform Long Term Care) 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 Practice Act and the Colorado Nurse Practice Act.

Long Term Services and Supports (LTSS) means Nursing Facilities, Intermediate Care Facilities for the Intellectually/Developmentally Disabled (ICF/IDD), 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 Services and Supports Certification Period means the designated period of time in which a client is functionally eligible to receive 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. Methods ~~Including~~include but are 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 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 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 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 10 CCR 2505-10, §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 training 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. Complete previous employment reference checks on Attendants
6. Follow all relevant laws and regulations applicable to client's supervision of Attendants
7. Explain the role of the FMS to the Attendant
8. Budget for Attendant care within the established monthly and CDASS Certification Period Allocation
9. 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. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement
11. 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
13. 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 ~~when using~~in 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.~~D~~C. Client/AR responsibilities for Verification:

1. Sign and return a responsibilities acknowledgement form for activities listed in 10 CCR 2505-10, §8.510.6 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 10 CCR 2505-10, § 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. 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.H. Attendants may not attend training provided by the Training and Operations Vendor 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 Attendants' 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 2505-10 and the contract with the Department.

8. Maintain system prompts in the FMS vendor portal requiring case managers to verify all requirements and forms have been completed prior to completing a prior authorization request for services.

9. Comply with all requirements set forth by the Affordable Care Act

~~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 Attendants~~

~~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~~B. In addition to the requirements set forth at 10 CCR 2505-10, §8.510.9.A, ~~The~~ 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~~. This statute is hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.510.86 SELECTION OF FMS VENDORS

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

8.510.86.B The client/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 client/AR shall select either the AwC or F/EA FMS model at the time of enrollment into CDASS. The client 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. Employment relationships with two Attendants must be maintained while participating in 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 10 CCR 2505-10, § 8.523.11.K.1. 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 10 CCR 2505-10, §8.510.13, the following steps may be taken:

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

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 CCR 2505-10, §~~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 10 CCR 2505-10, § 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 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 10 CCR 2505-10, § 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 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 CCR 2505-10, §~~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 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 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 who choose a family member as a care provider, shall document the choice on the Attendant Support Services management plan.