DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Home and Community Based Services Rule Concerning Supportive Living Program, Section 8.515.85
Rule Number: MSB 16-03-22-B
Division / Contact / Phone:Long Term Services and Supports / Diane Byrne / 303-866-4030

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 16-03-22-B, Revision to the Medical Assistance Home and Community Based Services Rule Concerning Supportive Living Program, Section 8.515.85
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) 10 C.C.R. 2505-10 8.515.85, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at 8.515.85.J.7.a with the proposed text starting at 8.515.85.J.7.a through the end of .a. Replace the current text at 8.515.85.N.3 with the proposed text starting at 8.515.85.N.3 through the end of 8.515.85.O.1.b.ii. The effective date of this rule changes is 12/30/2016.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Home and Community Based Services Rule Concerning Supportive Living Program, Section 8.515.85
Rule Number: MSB 16-03-22-B
Division / Contact / Phone: Long Term Services and Supports / Diane Byrne / 303-866-4030

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 rules set forth at 10 CCR 2505-10 8.515.85 are being revised to include language requiring Post-Eligibility Treatment of Income (PETI) calculations to be done for eligible clients receiving Supportive Living Program (SLP) services through the Brain Injury (BI) waiver. PETI is a mandatory process set forth in federal rule at 42 C.F.R. §435.726: Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care.

   PETI calculations are done for each client receiving residential services who has income between 100% and 300% of SSI. If a client has income below that amount, a PETI is not done for them. PETI calculations are done by Case Management with a spreadsheet created by the Department. PETI protects part of the client's income, called the personal needs allowance, for federally-specified purposes, including spousal maintenance. PETI also requires clients to contribute to the cost of their residential services based on their income, and the Medicaid payment for services is correspondingly reduced. Clients with higher incomes will usually contribute more towards the cost of their services than clients with lower incomes. PETI calculations are already used for other residential services offered through the HCBS waivers.

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 C.F.R. §1396n(c), 42 C.F.R. §435.726

4. State Authority for the Rule:

Initial Review	**07/08/16**	Final Adoption	**08/12/16**
Proposed Effective Date	**12/30/16**	Emergency Adoption	

DOCUMENT #01

DO NOT PUBLISH THIS PAGE

25.5-1-301 through 25.5-1-303, C.R.S. (2015);
C.R.S. 25.5-6-704(6)

Initial Review	**07/08/16**	Final Adoption	**08/12/16**
Proposed Effective Date	**12/30/16**	Emergency Adoption	

DOCUMENT #01

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Home and Community Based Services Rule Concerning Supportive Living Program, Section 8.515.85
Rule Number: MSB 16-03-22-B
Division / Contact / Phone: Long Term Services and Supports / Diane Byrne / 303-866-4030

REGULATORY ANALYSIS

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

   Persons who receive residential SLP services through the BI waiver and have income between 100% and 300% of SSI will have part of their income protected for federally-specified purposes, such as spousal maintenance, child support, and non-covered medical costs, and will also be responsible for contributing to the cost of their services.

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

   Without this rule change, the Department will not be compliant with a federal mandate found at 42 C.F.R. §435.726: Post-eligibility treatment of income of individuals receiving home and community-based services furnished under a waiver: Application of patient income to the cost of care. The Department would be in danger of losing federal funding for this service if it continues to be out of compliance. All people receiving SLP services would be in danger of losing their residential placement and services.

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

   This rule should result in a minor cost savings to the Department, CDPHE, or DFPC. There is no anticipated effect on state revenues. The number of people that receive SLP services is currently between 150 and 170 per year, and the number of people that would be subject to PETI calculations fluctuates between 40% and 60% of that group.

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

   The probable costs of inaction would be that the Department would not be in compliance with a federal mandate, and at danger of losing federal funding for this service. The people receiving this service would be at high risk of institutionalization.

DO NOT PUBLISH THIS PAGE

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

   There are no less costly methods of achieving this rule's purpose, which is to comply with a federal mandate. This rule change is the least intrusive method of complying with the federal mandate.

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

   There are no alternative methods than this rule change for complying with the federal requirement found at 42 C.F.R. §435.726.

8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.J ENVIRONMENTAL AND MAINTENANCE REQUIREMENTS

1. A Supportive Living Program residence shall be designed, constructed, equipped, and maintained to ensure the physical safety of clients, personnel, and visitors as required by 6 CCR 1011-1, Ch. 7, § 1.111, regarding the interior and exterior environment:

   a. Interior Environment: All interior areas including attics, basements, and garages shall be safely maintained. The facility shall provide a clean, sanitary environment, free of hazards to health and safety.

      i. Potential Safety Hazards include:

         1) Cooking shall not be allowed in bedrooms. Residents may have access to an alternative area where minimal food preparation such as heating or reheating food or making hot beverages is allowed. In those facilities which make housing available to residents through apartments rather than resident bedrooms, cooking may be allowed in accordance with house rules. Only residents who are capable of cooking safely shall be allowed to do so. The facility shall document such assessment.

         2) Extension cords and multiple use electrical sockets in resident rooms shall be limited to one per resident.

         3) Power strips are permitted throughout the facility with the following limitations:

            a) The power strip must be provided with overcurrent protection in the form of a circuit breaker or fuse.

            b) The power strip must have a UL (underwriters laboratories) label.

            C) The power strips cannot be linked together when used.

            d) Extension cords cannot be plugged into the power strip.

            e) Power strips can have no more than six receptacles.

            f) The use will be restricted to one power strip per resident per bedroom.

         4) Personal Appliances shall be allowed in resident bedrooms only under the following circumstances:

            a) Such appliances are not used for cooking;

            b) Such appliances do not require use of an extension cord or multiple use electrical sockets;

            c) Such appliance is in good repair as evaluated by the administrator;

d) Such appliance is used by a resident who the administrator believes to be capable of appropriate and safe use. The facility shall document such assessment.

5) Electric blanket/Heating pad. In no event shall a heating pad or electric blanket be used in a resident room without either staff supervision or documentation that the administrator believes the resident to be capable of appropriate and safe use.

6) All interior areas including attics, basements, and garages shall be free from accumulations of extraneous materials such as refuse, discarded furniture, and old newspapers.

7) Combustibles such as cleaning rags and compounds shall be kept in closed metal containers.

8) Kerosene (fuel fired) heaters shall not be permitted within the facility. Electric or space heaters shall not be permitted within resident bedrooms and may only be used in common areas of the facility if owned, provided, and maintained by the facility.

9) Fire resistant wastebaskets. Enclosed areas on the premises where smoking is allowed shall be equipped with fire resistant wastebaskets. In addition, resident rooms occupied by smokers, even when house rules prohibit smoking in resident rooms, shall have fire resistant wastebaskets.

ii. Potential Infection/Injury Hazards

1) Insect/rodent infestations. The facility shall be maintained free of infestations of insects and rodents and all openings to the outside shall be screened.

2) Storage of hazardous substances. Solutions, cleaning compounds and hazardous substances shall be labeled and stored in a safe manner.

iii. Heating, Lighting, and Ventilation

1) Each room in the facility shall be installed with heat, lighting and ventilation sufficient to accommodate its use and the needs of the residents.

2) All interior and exterior steps and interior hallways and corridors shall be adequately illuminated.

iv. Water

1) There shall be an adequate supply of safe, potable water available for domestic purposes.

2) There shall be a sufficient supply of hot water during peak usage demands.

3) Hot water shall not measure more than 120 degrees Fahrenheit at taps which are accessible by resident.

v. There shall be a telephone available for regular telephone usage by residents and staff.

b. Exterior Environment

i. Potential Safety Hazards

1) Exterior premises shall be kept free of high weeds and grass, garbage and rubbish. Grounds shall be maintained to prevent hazardous slopes, holes, or other potential hazards.

2) Exterior staircases of three (3) or more steps and porches shall have handrails. Staircases and porches shall be kept in good repair.

2. The Supportive Living Program provider shall comply with all State and Local Laws/Codes regarding furnishings, equipment and supplies pursuant to 6 CCR 1011-1, Ch. 7, § 1.112 (Aug. 14, 2013), which is hereby incorporated by reference. The incorporation of these regulations 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.

3. Clients shall be allowed free use of all common living areas within the residence, with due regard for privacy, personal possessions, and safety of clients.

4. Supportive Living Program providers shall develop and implement procedures for the following:

a. Handling of soiled linen and clothing;

b. Storing personal care items;

c. General cleaning to minimize the spread of pathogenic organisms; and

d. Keeping the home free from offensive odors and accumulations of dirt and garbage.

5. The Supportive Living Program provider shall ensure that each client is furnished with his or her own personal hygiene and care items. These items are to be considered basic in meeting an individual’s needs for hygiene and remaining healthy. Any additional items may be selected and purchased by the client at his or her discretion.

6. There shall be adequate bathroom facilities for individuals to access without undue waiting or burden.

7. The Supportive Living Program provider shall comply with all bathroom requirements regarding handrails, handholds, and other needs of clients pursuant to 6 CCR 1101-1 Ch. 7, § 1.112(4)

a. A full bathroom shall consist of at least the following fixtures: toilet, hand washing sink, toilet paper dispenser, mirror, tub or shower, and towel rack. ~~However, any facility licensed to provide services specifically for the mentally ill prior to January 1, 1992 may have one bathroom for every eight (8) residents until either a substantial remodeling or a change of ownership occurs.~~

b. There shall be a bathroom on each floor having resident bedrooms which is accessible without requiring access through an adjacent bedroom.

c. In any facility which is occupied by one or more residents utilizing an auxiliary aid, the facility shall provide at least one full bathroom as defined herein with fixtures positioned so as to be fully accessible to any resident utilizing an auxiliary aid.

d. Bathtubs and shower floors shall have non-skid surfaces.

e. Grab bars shall be properly installed at each tub and shower, and adjacent to each toilet in any facility which is occupied by one or more residents utilizing an auxiliary aid or as otherwise indicated by the needs of the resident population.

f. Toilet seats shall be constructed of non-absorbent material and free of cracks.

g. The use of common personal care articles, including soap and towels, is prohibited.

h. Toilet paper in a dispenser shall be available at all times in each bathroom of the facility.

i. Liquid soap and paper towels shall be available at all times in the common bathrooms of the facility.

8. Each client shall have access to telephones, both to make and to receive calls in privacy.

9. The Supportive Living Staff shall maintain a clean, safe, and healthy environment, including appropriate cleaning techniques and sanitary meal preparation and delivery according to 6 CCR 1011-1, Ch. 7, § 1.109, which requires the following:

a. For facilities with less than twenty (20) beds, food shall be prepared, handled and stored in a sanitary manner, so that it is free from spoilage, filth, or other contamination, and shall be safe for human consumption.

b. Hazardous materials shall not be stored with food supplies.

c. Facilities with twenty (20) beds or more shall comply with CDPHE's March 1, 2013 regulations on Colorado Retail Food Establishments at 6 CCR 1010-2, which are hereby incorporated by reference. The incorporation of these regulations 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.

8.515.85.K COMPLAINTS AND GRIEVANCES

Each client will have the right to voice grievances and recommend changes in policies and services to both the Department and/or the Supportive Living Program provider. Complaints and grievances made to the Department shall be made in accordance with the grievance and appeal process in 10 CCR 2505-10 § 8.209.

8.515.85.M RECORDS

1. Supportive Living Providers shall develop policies and procedures to secure client information against potential identity theft. Confidentiality of medical records shall be maintained in compliance with 45 C.F.R. §§ 160.101, et seq. and 164.102, et seq. (2014), which are hereby incorporated by reference. The incorporation of these regulations 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.

2. All medical records for adults (persons eighteen (18) years of age or older) shall be retained for no less than six (6) years after the last date of service or discharge from the Supportive Living Program. All medical records for minors shall be retained after the last date of service or discharge from the Supportive Living Program for the period of minority plus six (6) years.

8.515.85.N REIMBURSEMENT

1. Supportive Living Program services shall be reimbursed according to a per diem rate, using a methodology determined by the Department. Authority for the Department to define and limit covered services is found at C.R.S. § 25.5-1-202 (2013).

2. The methodology for calculating the per diem rate shall be based on a weighted average of client acuity scores.

3. The Department shall establish a maximum allowable room and board charge for clients in the Supportive Living Program. Increases in payment shall be permitted in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard ~~inasmuch as~~if the Colorado Department of Human Services also raises ~~its~~ grant amounts.

   a. Room and board shall not be a benefit of HCBS-BI residential services. Clients shall be responsible for room and board in an amount not to exceed the Department established rate.

8.515.85.O CALCULATION OF CLIENT PAYMENT (PETI)

1. When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, the State may reduce Medicaid payment for SLP residential services. The case manager shall calculate the client payment (PETI) for 300% eligible HCBS-BI clients according to the following procedures:

   a. For 300% eligible clients who receive residential services, the case manager shall complete a State-prescribed form which calculates the client payment according to the following procedures:

i. An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed HCBS residential services room and board amount shall be paid: and

ii. For an individual with financial responsibility for others:

1) If the individual is financially responsible for only a spouse, an amount equal to the state Aid to the Needy Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income;~~.~~ or

2) If the individual is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding income from part-time employment earnings of a dependent child who is either a full-time student or a part-time student as defined at Section 8.100.1) shall be deducted from the client's gross income; and

iii~~v~~. Amounts for incurred expenses for medical or remedial care for the individual that are not subject to payment by Medicare, Medicaid, or other third party shall be deducted from the client's gross income as follows:

1) Health insurance premiums if health insurance coverage is documented in the eligibility system: deductible or co-insurance charges, and

2) Necessary dental care not to exceed amounts equal to actual expenses incurred, and

3) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred, and

4) Medications, with the following limitations:

a) The need for such medications shall be documented in writing by the attending physician. The documentation shall list the medication; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

b) Medications which may be purchased with the client's Medicaid ~~Identification~~Identification Card shall not be allowed as deductions.

c) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

d) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price.

e) Only the amount spent for medications which exceeds the current Old Age Pension Standard allowance for medicine chest expense shall be allowed as a deduction.

5) Other necessary medical or remedial care shall be deducted from the client's gross income, with the following limitations:

a) The need for such care shall be documented in writing by the attending physician. For this purpose, documentation on the URC certification form shall be considered adequate. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and, shall be renewed at least annually or whenever there is a change.

b) Any service, supply or equipment that is available under regular Medicaid, with or without prior authorization, shall not be allowed as a deduction.

6) Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

7) When the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

iv. Any remaining income-shall be applied to the cost of the SLP residential services, as defined at Section 8.515.85 and shall be paid by the client directly to the facility; and

vi. If there is still income remaining after the entire cost of residential services are paid from the client's income, the remaining income shall be kept by the client and may be used as additional personal needs or for any other use that the client desires, except that the residential service provider shall not charge more than the Medicaid rate for that service.

b. Case managers shall inform HCBS-BI clients receiving residential services of their client payment obligation on a form prescribed by the state at the time of the first assessment visit by the end of each plan period; or within ten (10) working days whenever there is a significant change in the client payment amount.

i. Significant change is defined as fifty dollars ($50) or more.

ii. Copies of client payment forms shall be kept in the client files at the case management agency, and shall not be mailed to the State or its agent, except as required for a prior authorization request, according to Section 8.515.7, or if requested by the state for monitoring purposes.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Office of Community Living Rule Concerning Consumer Directed Care for the Elderly Section 8.518
Rule Number: MSB 16-04-13-A
Division / Contact / Phone: Long Term Services and Supports / Rhyann Lubitz / 303-866-3641

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 16-04-13-A, Revision to the Medical Assistance Office of Community Living Rule Concerning Consumer Directed Care for the Elderly Section 8.518

3. This action is an adoption of: a repeal of existing rules

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

   Sections(s) 8.518, 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). No

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.518 with the proposed text starting at 8.158 through the end. The effective date of the rule change is 09/30/2016.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Office of Community Living Rule Concerning Consumer Directed Care for the Elderly Section 8.518
Rule Number: MSB 16-04-13-A
Division / Contact / Phone: Long Term Services and Supports / Rhyann Lubitz / 303-866-3641

STATEMENT OF BASIS AND PURPOSE

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

   The purpose of repealing the Consumer Directed Care for the Elderly (CDCE) rule is to remove an outdated rule that no longer applies to a current Medicaid program. The Colorado General Assembly expanded the CDCE pilot program in 2005 to include additional populations. At that time the CDCE regulation was not repealed. The Department completed a mandatory rule review in 2016 and identified this rule is no longer needed. The Consumer Directed Care regulations at section 8.510 now encompass the elderly, making section 8.518 duplicative and unnecessary. There are no Medicaid waiver members who utilize the CDCE program and the Department does not expend any funding on this program annually. Medicaid waiver members are able to receive consumer directed services through the Consumer Directed Attendant Support Services Program.

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:

   N/A

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-6-1102(6)
   HB 05-1243

Initial Review **07/08/16** Final Adoption **08/12/16**
Proposed Effective Date **09/30/16** Emergency Adoption

DOCUMENT 02

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Office of Community Living Rule Concerning Consumer Directed Care for the Elderly Section 8.518
Rule Number: MSB 16-04-13-A
Division / Contact / Phone: Long Term Services and Supports / Rhyann Lubitz / 303-866-3641

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.

   There are no classes of persons who will be affected by the repeal of this rule. The program that it regulated was discontinued in 2009.

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

   The proposed rule repeal will not have a quantitative or qualitative impact as the program that it regulated was discontinued in 2009. The Department currently allocates no funding to the program regulated by the rule.

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

   There are no probable costs to the department as a result of repealing the rule.

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

   There are no probable costs to the repeal of the rule. The benefit to the rule repeal is that it will remove obsolete unnecessary regulation.

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

   There are not less costly methods for repealing the rule, since the rule repeal does not have a cost associated with it.

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

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

8.518 ~~CONSUMER DIRECTED CARE FOR THE ELDERLY~~ REPEALED EFFECTIVE SEPTEMBER 30, 2016

~~8.518.1 DEFINITIONS~~

~~Authorized Representative means an individual designated by the eligible person, or by the guardian of the eligible person, if appropriate, who has the judgment and ability to assist the eligible person in acquiring and utilizing services under the Home and Community Based Services-Consumer Directed Care for the Elderly program (HCBS-CDCE).~~

~~Care Plan shall be as defined at 10 C.C.R. 2505-10, Section 8.390.1(C), including the funding source, frequency, amount and provider of each service. This Care Plan shall be written on a Department-prescribed Long Term Care Plan form.~~

~~Case Management shall be as defined at 10 C.C.R. 2505-10, Section 8.390.1(D).~~

~~Case Manager means an individual employed by the Single Entry Point (SEP) agency who determines functional eligibility and provides Case Management services to clients eligible under HCBS-CDCE.~~

~~Financial Management Services organization (FMS) means the entity or entities under contract with the Department to provide personnel, fiscal management services and skills training to a client receiving Personal Support Services and/or his or her Authorized Representative.~~

~~Individual Allocation means the funds made available by the Department to clients receiving Personal Support Services and administered by the FMS. These funds shall be available each month that a client meets program eligibility, and they shall be calculated based on the client's utilization history of personal care and homemaker services or the personal care and homemaker services defined in the client's Care Plan.~~

~~Personal Support Attendant means the individual who provides Personal Support Services.~~

~~Personal Support Management Training means the required training, including a final, comprehensive test provided by the Department or its designee to a HCBS-CDCE client and/or his or her Authorized Representative who is interested in directing Personal Support Services.~~

~~Personal Support Services means supportive services which are essential to the health and welfare of the client and include personal care services as defined at 10 C.C.R. 2505-10, Section 8.489 and homemaker services as defined at 10 C.C.R. 2505-10, Section 8.490 and are directed by the client and/or his or her Authorized Representative.~~

~~8.518.2 PARTICIPATION/AVAILABILITY~~

~~8.518.2.A. During the first year of implementation, HCBS-CDCE shall be available to clients residing in the counties that are served by the Longterm Care Options, Mesa County Department of Human Services and San Juan Basin Health Department Single Entry Point Agencies (SEPs).~~

~~8.518.2.B. In subsequent years, HCBS-CDCE shall be available to clients residing in the counties served by the remaining SEPs.~~

~~8.518.3 CLIENT ELIGIBILITY~~

~~8.518.3.A. To be eligible for HCBS-CDCE, a client shall:~~

~~1. Be 55 years or older.~~

2. Be willing to participate in the program.

3. Be eligible for HCBS-EBD as defined at 10 C.C.R. 2505-10, 8.485.60 et seq.

8.518.3.B. A client who wants to direct Personal Support Services shall:

1. Provide a statement from his or her primary care physician that indicates the client has sound judgment and the ability to direct his or her care or has an Authorized Representative who has the ability to direct the care on the client's behalf.

2. Demonstrate the ability to handle the financial aspects of self-directed care or has an Authorized Representative who is able to handle the financial aspects of the client's care.

3. Complete the Personal Support Management Training and pass the post-training test.

8.518.4 WAITING LIST PROTOCOL

8.518.4.A. Clients shall be enrolled in HCBS-CDCE within the capacity limits of the federal waiver based in ranking order on the following priorities:

1. Clients who receive long term home health benefits who could be served at a lesser cost to Medicaid.

2. Clients being deinstitutionalized from nursing facilities.

3. Clients being discharged from a hospital who, absent HCBS-CDCE services, would be discharged to a nursing facility at greater cost to Medicaid.

4. Clients with high Universal Long Term Care (ULTC) 100.2 assessment scores as defined at 10 C.C.R. 2505-10, Section 8.458.60, who are at risk of immediate nursing facility placement.

8.518.5 BENEFITS/SERVICES

8.518.5.A. The following benefits are available to HCBS-CDCE clients.

1. Adult day services as defined under HCBS-Elderly Blind and Disabled (EBD) at 10 C.C.R 2505-10, Section 8.491.

2. Alternative care facility services as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.495.

3. Electronic monitoring as defined under HCBS-EBD at 10.C.C.R. 2505-10, Section 8.488.

4. Home modification as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.493.

5. Homemaker services as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.490.

6. Personal care as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.489

7. Personal Support Services.

8. Respite as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.492.

9. Non-medical transportation as defined under HCBS-EBD at 10 C.C.R. 2505-10, Section 8.494.

10. A client enrolled in HCBC-CDCE shall not receive Home Care Allowance.

11. Personal care and homemaker services are not benefits if a client is receiving Personal Support Services.

8.518.6 PERSONAL SUPPORT MANAGEMENT PLAN

8.518.6.A. The HCBS-CDCE client and/or his or her Authorized Representative shall develop a written personal support management plan which shall be reviewed and approved by the case manager. The plan shall describe the following:

1. Client's current status.

2. Client's Personal Support Attendant needs.

3. Client's plans for securing Personal Support Services.

4. Client's plans for budgeting the Individual Allocation.

5. Client's plans for handling emergencies.

8.518.7 START DATE FOR SERVICES

8.518.7.A. The start date of eligibility for HCBS-CDCE services shall not occur until all of the requirements defined at 10 C.C.R. 2505-10, Section 8.485.60 have been met.

8.518.7.B. The Department or its designee shall approve the personal support management plan and establish a start date before a client can begin receiving Personal Support Services.

8.518.8 CLIENT AND AUTHORIZED REPRESENTATIVE RIGHTS AND RESPONSIBILTIIES

8.518.8.A. A client receiving or requesting Personal Support Services whose personal support management plan is disapproved by the Case Manager has the right to review that disapproval. The client shall submit a written request to the SEP stating the reasons for requesting the review and justifying the proposed management plan. The client's most recently approved personal support management plan shall remain in effect while the review is in process.

8.518.8.B. Clients receiving Personal Support Services have the right to transition back to personal care and homemaker services provided by an agency at any time. A client who wishes to transition back to agency-provided services shall contact the Case Manager, who shall coordinate arrangements for the services.

8.518.8.C. A client and/or his or her Authorized Representative is responsible for cooperating in the determination of financial eligibility, including prompt reporting of changes in income or resources and cooperating with the SEP and services providers as agreed to in the client's Care Plan.

8.518.8.D. To receive Personal Support Services, each client and/or Authorized Representative shall sign a Participant/Authorized Representative Responsibilities Form acknowledging full responsibility for:

1. Completing training.

2. Developing a personal support management plan.

3. Budgeting for Personal Support Services within the established monthly allocation.

4. Recruiting, hiring, firing and managing Personal Support Attendants.

5. Completing reference checks on Personal Support Attendants.

6. Reviewing background checks on Personal Support Attendants.

7. Determining wages for Personal Support Attendants, within the range established by the FMS.

8. Establishing work schedules.

9. Training and supervising Personal Support Attendants.

10. Following all applicable laws and rules on employing Personal Support Attendants, with the exception of those set out at 10 C.C.R. 2505-10, Section 8.518.12(B), which are the responsibility of the FMS.

11. Completing and managing all paperwork.

8.518.9 CASE MANAGEMENT FUNCTIONS

8.518.9.A. SEP agencies shall comply with SEP rules governing Case Management functions as set forth at 10 C.C.R. 2505-10, 8.390 et seq. and shall comply with the following HCBS-CDCE specific requirements.

1. The Case Manager shall provide new and current clients with information on HCBS-CDCE.

2. The Case Manager shall complete screening and intake functions as defined at 10 C.C.R. 2505-10, 8.393.21 et seq.

3. The Case Manager shall complete the ULTC 100.2 assessment to determine nursing facility level of care as defined at 10 C.C.R. 2505-10, 8.390.22 et seq.

4. If a client is determined to be ineligible for HCBS-CDCE, the SEP shall notify the client and/or his or her Authorized Representative of the denial and the client's appeal rights as defined at 10 C.C.R. 2505-10, Section 8.057.

5. The Case Manager shall develop the Care Plan after completing the client assessment and prior to the arrangement for services as defined at 10 C.C.R. 2505-10, Sections 8.390.1(C) and 8.486.51.

6. The Case Manager shall revise the Care Plan whenever a change in the client's needs results in an increase, decrease or other change in services. The Case Manager shall describe in detail reasons for the revision. When additional services include a service requiring a prior authorization request (PAR), the Case Manager shall submit the PAR to the Department's fiscal agent.

7. The Case Manager shall review and approve the personal support management plan completed by the client and/or his or her Authorized Representative. The Case Manager

shall notify the client and/or his or her Authorized Representative of the approval and establish a start date.

8. If the Case Manager determines that the personal support management plan is inadequate to meet the client's personal support needs, the Case Manager shall assist the client and/or his or her Authorized Representative with further development of the personal support management plan.

9. The Case Manager shall calculate the initial Individual Allocation for each HCBS-CDCE client who chooses Personal Support Services as follows:

   a. Calculate an average monthly payment using prior utilization expenditures for personal care and homemaker services provided by the Department, or

   b. Calculate the number of personal care and homemaker hours needed on a monthly basis as defined on the Care Plan and multiply by the Department's established rate for personal care and homemaker services.

10. The Case Manager shall provide written notification of the Individual Allocation to each client.

11. A client and/or his or her Authorized Representative who believes that he or she needs more Personal Support Service than the existing Individual Allocation will cover, may request the Case Manager to perform a reassessment. If the reassessment indicates that more personal support is justified, the client and/or his Authorized Representative shall amend the personal support management plan and the Case Manager shall complete a Prior Authorization Request (PAR) revision indicating the increase and submit it to the Department's fiscal agent.

   a. In approving an increase in the Individual Allocation, the Case Manager shall consider:

      i) Any change in the client's condition.

      ii) Discrepancies between the client's utilization history and current needs for personal support.

      iii) The appropriateness of Personal Support Attendant wages.

      iv) The quality and quantity of services provided by Personal Support Attendants for the wages they receive.

      v) Revisions in the client's budgeting of the current Individual Allocation to more effectively pay for needed services.

   b. In reducing the Individual Allocation, the Case Manager shall consider:

      i) Improvement or change in the condition.

      ii) Reasons for unspent allocated funds.

12. The Case Manager shall notify the state fiscal agent to cease payment for all existing personal care and homemaker services as of the client's Personal Support Services start date.

13. The Case Manager shall monitor the services provided, as defined at 10 C.C.R. 2505-10, 8.393.43 et seq., to ensure that they are appropriate and effective, timely, safe and meet with the client's satisfaction.

14. For effective coordination, monitoring and evaluation of clients receiving Personal Support Services, the Case Manager shall:

a. Contact the client receiving Personal Support Services and/or the Authorized Representative twice a month during the first three months to assess their personal support management, their satisfaction with care providers and the quality of services received.

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

c. Conduct a face-to-face visit with the client and/or his or her Authorized Representative when a change in the Authorized Representative occurs and contact the client and/or his or Authorized Representative twice a month for three months after this change takes place.

d. Review monthly reports to monitor client spending patterns and service utilization to ensure appropriate budgeting and follow up with the client and/or his or her Authorized Representative when discrepancies occur.

e. Contact the FMS quarterly to determine the status of each client's financial management activities.

15. Reassessment

a. The case manager shall complete a Reassessment of each client using the UTLC 100.2 assessment form before the end of the length of stay assigned at the last level of care determination for a continued stay review.

b. For clients receiving Personal Support Services, the Case Manager shall conduct a comprehensive face-to-face interview with each client and/or his or her Authorized Representative every six months. The interview shall include review of the personal support management plan and documentation from the physician that the client and/or his Authorized Representative has the ability to direct the care.

8.518.10 PRIOR AUTHORIZATION REQUEST

8.518.10.A. The Case Manager shall submit PARs to the Department according to the instructions given in the Medicaid Provider Bulletin published by the Department's fiscal agent.

8.518.10.B. The start date for a PAR shall not precede the HCBS-CDCE start date and shall not cover a period of time longer than the length of stay assigned by the SEP.

8.518.11 PROVIDER ENROLLMENT

8.518.11.A. Provider agencies shall meet requirements as defined under the HCBS-EBD program at 10 C.C.R. 2505-10, Sections 8.487.10 through 8.487.100.

8.518.12 PERSONAL SUPPORT ATTENDANTS

8.518.12.A. Personal Support Attendants shall be at least 16 years of age and demonstrate competency in caring for the client to the satisfaction of the client and/or his or her Authorized Representative.

8.518.12.B. The FMS shall be the employer of record for all Personal Support Attendants. The FMS shall be responsible for 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 and compliance with any other relevant federal, state or local laws.

8.518.13 REIMBURSEMENT

8.518.13.A. Provider agencies shall be reimbursed for services provided to eligible clients when claims are submitted in accordance with the following procedures:

1. Provider agencies shall submit claims to the fiscal agent on Department prescribed forms provided by the fiscal agent according to 10 C.C.R. 2505-10, Sections 8.040 and 8.043.

2. Provider agencies shall fill out claim forms adequately and correctly.

8.518.13.B. Provider agencies shall maintain adequate financial records for all claims, including documentation of services as specified at 10 C.C.R. 2505-10, Sections 8.040.02, 8.130 and 8.487.10.

8.518.13.C. When a client has been determined eligible for HCBS services under the 300% income standard, according to 10 C.C.R. 2505-10, Section 8.100, the Department may reduce Medicaid payment for Alternative Care Facility services according to the procedures at 10 C.C.R. 2505-10, Section 8.486.60.

8.518.13.D. Personal Support Attendants shall receive an hourly wage based on the rate negotiated between the Personal Support Attendant and the client and/or his or her Authorized Representative. The FMS shall make all payments from the client's Individual Allocation under the direction of the client and/or his or her Authorized Representative.

8.518.14 LIMITATIONS ON PAYMENT TO FAMILY [Perm Rule Change eff. 4/2/2007]

8.518.14.A. In no case shall any person be reimbursed to provide HCBS-CDCE services to his or her spouse.

8.518.14.B. Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under HCBS-CDCE, and/or be employed by the FMS to provide Personal Support Services, subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

1. The family member shall meet all requirements for employment by the following:

   a. A certified personal care agency and be employed and supervised by the personal care agency; and/or

   b. The FMS and be supervised by the client and/or his or her Authorized Representative if providing Personal Support Services.

2. The family member providing personal care shall be reimbursed at an hourly rate by the personal care agency and/or FMS which employs the family member, with the following restrictions:

   a. The maximum number of Medicaid personal care units per annual certification for HCBS-CDCE shall include any portions of the Medicaid reimbursement which are kept by the personal care agency and/or FMS for unemployment insurance, worker's compensation, FICA, cost of training and supervision and all other administrative costs.

3. If two or more HCBS-CDCE clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Parents and Caretaker Relatives at Section 8.100.1 & 8.100.4.G
Rule Number: MSB 16-05-10-A
Division / Contact / Phone: Health Information Office / Ana Bordallo / 303-866-3558

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 16-05-10-A, Revision to the Medical Assistance Rule Concerning Parents and Caretaker Relatives at Section 8.100.1 & 8.100.4.G

3. This action is an adoption of: new rules

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

   Sections(s) § 8.100.1 and § 8.100.4.G , Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace current text at 8.100.1 paragraph 38 with the proposed text at 8.100.1 paragraph 38. Replace current text at 8.100.1 paragraph 76 with the proposed text at 8.100.1 paragraph 76. Replace current text at 8.100.4.G.3 with the proposed text at 8.100.4.G.3 . Replace the current text at 8.100.4.G.4 with the proposed text starting at 8.100.4.G.4 through the end of 8.100.4.G.4.a. This rule becomes effective 10/01/2016.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Parents and Caretaker Relatives at Section 8.100.1 & 8.100.4.G
Rule Number: MSB 16-05-10-A
Division / Contact / Phone: Health Information Office / Ana Bordallo / 303-866-3558

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule changes amend 10 CCR 2505-10 §8.100.1 §8.100.4.G. to incorporate changes to the rule mandated by the Patient Protection and Affordable Care Act of 2010 (ACA) as it pertains to parents or other caretaker relatives living with a dependent child under the age of 19 years old, will not be eligible to receive MAGI-Medicaid unless the child is receiving benefits under Medicaid, Child Health Plan Plus or through the Exchange, or otherwise enrolled in minimum essential coverage. Minimum Essential Coverage is defined as qualifying health care coverage which can include most Health First Colorado (Colorado's Medicaid Program), Child Health Plan Plus, private health plans purchased through Connect for Health Colorado, and employer-sponsored health insurance. This policy will be applied to the MAGI Adult expansion category for parents or caretaker relatives ages 19 through 64 with income that ranges from 69% to 133% of the federal poverty level. Among these changes: revision to the current policy regarding the MAGI-Adult categories by adding a requirement to verify if the dependent child living in the household is currently enrolled in minimum essential coverage before enrolling the parent or caretaker in this category. Other revisions include updating language under the Parent and Caretaker Relatives category whose income does not exceed 68% of the federal poverty level, to remove language that states the dependent child in the household needs be receiving Medical Assistance. Lastly, updating definitions under 8.100.1 for a dependent child and adding a new definition for minimum essential coverage.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

Initial Review	**07/08/16**	Final Adoption	**08/12/16**
Proposed Effective Date	**09/30/16**	Emergency Adoption	

DOCUMENT #03

Patient Protection and Affordable Care Act of 2010 (ACA) and 42 CFR §435.119(c)(1)(2), 42 CFR §435.4, 42 CFR §435.116 section 5000A(f) of subtitle D of the Internal Revenue Code, as added by section 1401 of the Affordable Act.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-5-5-101(1)(b), C.R.S, section 25.5.-5-201(1)(m), C.R.S

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Parents and Caretaker Relatives at Section 8.100.1 & 8.100.4.G
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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

   With this proposed rule parents or other caretakers will not be eligible to receive MAGI-Adult Expansion unless their dependent child is receiving benefits under Medicaid, Child Health Plan Plus, through a private health plan purchased through Connect for Health Colorado, or other minimum essential coverage. The benefit of this rule change is to ensure that all children are receiving benefits and continuity of care which is a positive impact.

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

   The proposed rule will require parents or caretaker relatives to maintain or enroll children into a health plan to avoid paying fees for being uninsured and to be eligible for Medical Assistance if the child is not enrolled on minimum essential coverage.

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 Department anticipates a change in total costs in FY 2016-17 of approximately $0. Though this change should not affect total funds, it would affect fund splits and this is primarily expected to consist of an increase in State funds and the impact to the State is expected to be approximately $5,680,538 General Fund and $369,783 cash funds, with a negative offset to federal funds of $6,050,321. To arrive at these estimates, the Department assumed that this change would primarily affect clients in the MAGI Adults (without dependent children) expansion category, who have an indicator showing that a child is present in the home and would move to the MAGI Parents/Caretakers to 68% FPL category with this rule change. This assumption was driven by the current methodology that places clients in the MAGI Adults category when no information is known about the child, or when the child does not have Medicaid coverage specifically. For these calculations, the Department assumed that all MAGI Adults with the child indicator would be affected by this rule change. Currently, MAGI Parents/Caretakers 69-133% FPL receive the same federal match as MAGI Adults and also are already transferred manually from MAGI Adults to MAGI Parents/Caretakers 69-133% FPL based on a B% benchmark ID, so these clients should not be significantly affected by this change.

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

   The rule change would result in a cost to the Department and federal savings, for clients who have fallen under the 100% FMAP MAGI Adult eligibility category but would be moved to the standard match MAGI Parents/Caretakers 0-68% FPL eligibility category. The benefit of implementing this rule change would be that the Department would be in compliance with federal rule. Inaction could result in loss of federal match for the affected population, which would be more costly to the Department than this rule change, as the Department would lose federal matching funds. Inaction could also result in repayment of federal funds if the Department remains out of compliance with federal rule.

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

   The Department is not aware of less costly methods for achieving the purpose of the proposed rule at this time. This is the only method through which the Department can come into compliance with federal rule.

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

   There are no alternative methods for the proposed rule that were considered.

8.100.1 Definitions

300% Institutionalized Special Income Group is a Medical Assistance category that provides Long-Term Care Services to aged or disabled individuals.

1619b is section 1619b of the Social Security Act which allows individuals who are eligible for Supplemental Security Income (SSI) to continue to be eligible for Medical Assistance coverage after they return to work.

AB - Aid to the Blind is a program which provides financial assistance to low-income blind persons.

ABD - Aged, Blind and Disabled Medical Assistance is a group of Medical Assistance categories for individuals that have been deemed to be aged, blind, or disabled by the Social Security Administration or the Department.

Adult MAGI Medical Assistance Group provides Medical Assistance to eligible adults from the age of 19 through the end of the month that the individual turns 65, who do not receive or who are ineligible for Medicare.

AND - Aid to Needy Disabled is a program which provides financial assistance to low-income persons over age 18 who have a total disability which is expected to last six months or longer and prevents them from working.

AFDC - Aid to Families with Dependent Children is the Title IV federal assistance program in effect from 1935 to 1997 which was administered by the United States Department of Health and Human Services. This program provided financial assistance to children whose families had low or no income.

AP-5615 is the form used to determine the patient payment for clients in nursing facilities receiving Long Term Care.

Alien is a person who was not born in the United States and who is not a naturalized citizen.

Ambulatory Services is any medical care delivered on an outpatient basis.

Annuity is an investment vehicle whereby an individual establishes a right to receive fixed periodic payments, either for life or a term of years.

Applicant is an individual who is seeking an eligibility determination for Medical Assistance through the submission of an application.

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

Application for Public Assistance is the designated application used to determine eligibility for financial assistance. It can also be used to determine eligibility for Medical Assistance.

Blindness is defined in this volume as the total lack of vision or vision in the better eye of 20/200 or less with the use of a correcting lens and/or tunnel vision to the extent that the field of vision is no greater than 20 degrees.

Burial Spaces are burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the

individual or are held for his or her use, including necessary and reasonable improvements or additions to or upon such burial spaces such as: vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

Burial Trusts are irrevocable pre-need funeral agreements with a funeral director or other entity to meet the expenses associated with burial for Medical Assistance applicants/recipients. The agreement can include burial spaces as well as the services of the funeral director.

Caretaker Relative is any relation by blood, marriage or adoption who is within the fifth degree of kinship to the dependent child, such as: a parent; a brother, sister, uncle, aunt, first cousin, first cousin once removed, nephew, niece, or persons of preceding generations denoted by prefixes of grand, great, great great, or great-great-great; a spouse of any person included in the above groups even after the marriage is terminated by death or divorce; or stepparent, stepbrother, stepsister, step-aunt, etc.

Case Management Services are services provided by community mental health centers, clinics, community centered boards, and EPSDT case managers to assist in providing services to Medical Assistance clients in gaining access to needed medical, social, educational and other services.

Cash Surrender Value is the amount the insurer will pay to the owner upon cancellation of the policy before the death of the insured or before maturity of the policy.

Categorically Eligible means persons who are eligible for Medical Assistance due to their eligibility for one or more Federal categories of public assistance.

CBMS - Colorado Benefits Management System is the computer system that determines an applicant’s eligibility for public assistance in the state of Colorado.

CDHS -Colorado Department of Human Services is the state department responsible for administering the social service and financial assistance programs for Colorado.

Children MAGI Medical Assistance group provides Medical Assistance coverage to tax dependents or otherwise eligible applicants through the end of the month that the individual turns 19 years old.

Child Support Services is a CDHS program that assures that all children receive financial and medical support from each parent. This is accomplished by locating each parent, establishing paternity and support obligations, and enforcing those obligations.

Citizen is a person who was born in the United States or who has been naturalized.

Client is a person who is eligible for the Medical Assistance Program. “Client” is used interchangeably with “recipient” when the person is eligible for the program.

CMS - Centers for Medicare and Medicaid Services is the Federal agency within the US Department of Health and Human Services that partners with the states to administer Medicaid and CHP+ via State Plans in effect for each State. Colorado is in Region VIII.

CHP+ - Child Health Plan Plus is low-cost health insurance for Colorado's uninsured children and pregnant women. CHP+ is public health insurance for children and pregnant women who earn too much to qualify for The Medical Assistance Program, but cannot afford private health insurance.

COLA - Cost of Living Adjustment is an annual increase in the dollar value of benefits made automatically by the United States Department of Health and Human Services or the state in OASDI, SSI and OAP cases to account for rises in the cost of living due to inflation.

Colorado State Plan is a written statement which describes the purpose, nature, and scope of the Colorado's Medical Assistance Program. The Plan is submitted to the CMS and assures that the program is administered consistently within specific requirements set forth in both the Social Security Act and the Code of Federal Regulations (CFR) in order for a state to be eligible for Federal Financial Participation (FFP).

Common Law Marriage is legally recognized as a marriage in the State of Colorado under certain circumstances even though no legally recognized marriage ceremony is performed or civil marriage contract is executed. Individuals declaring or publicly holding themselves out as a married couple through verbal or written methods may be recognized as legally married under state law. C.R.S. § 14-2-104(3).

Community Centered Boards are private non-profit organizations designated in statute as the single entry point into the long-term service and support system for persons with developmental disabilities.

Community Spouse is the spouse of an institutionalized spouse.

Community Spouse Resource Allowance is the amount of resources that the Medical Assistance regulations permit the spouse staying at home to retain.

Complete Application means an application in which all questions have been answered, which is signed, and for which all required verifications have been submitted.

The Department is defined in this volume as the Colorado Department of Health Care Policy and Financing which is responsible for administering the Colorado Medical Assistance Program and Child Health Plan Plus programs as well as other State-funded health care programs.

Dependent Child is a child who lives with a parent, legal guardian, caretaker relative or foster parent and is under the age of 1~~8~~9, or, is age 18 and a full-time student, and expected to graduate by age 19.

Dependent Relative for purposes of this rule is defined as one who is claimed as a dependent by an applicant for federal income tax purposes.

Difficulty of Care Payments is a payment to an individual as compensation for providing additional care to an individual who qualifies for foster care and lives in the home of the care provider. This additional care must be required due to a physical, mental, or emotional handicap suffered by the foster care individual.

Disability means the inability to do any substantial gainful activity (or, in the case of a child, having marked and severe functional limitations) by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of l2 months or more.

Dual Eligible clients are Medicare beneficiaries who are also eligible for Medical Assistance.

Earned Income is defined for purposes of this volume as any compensation from participation in a business, including wages, salary, tips, commissions and bonuses.

Earned Income Disregards are the allowable deductions and exclusions subtracted from the gross earnings. Income disregards vary in amount and type, depending on the category of assistance.

Electronic Data Source is an interface established with a federal or state agency, commercial entity, or other data sources obtained through data sharing agreements to verify data used in determining eligibility. The active interfaces are identified in the Department's verification plan submitted to CMS.

Eligibility Site is defined in this volume as a location outside of the Department that has been deemed by the Department as eligible to accept applications and determine eligibility for applicants.

Employed means that an individual has earned income and is working part time, full time or is self-employed, and has proof of employment. Volunteer or in-kind work is not considered employment.

EPSDT- Early Periodic Screening, Diagnosis and Treatment is the child health component of the Medical Assistance Program. It is required in every state and is designed to improve the health of low-income children by financing appropriate, medically necessary services and providing outreach and case management services for all eligible individuals.

Equity Value is the fair market value of land or other asset less any encumbrances.

Ex Parte Review is an administrative review of eligibility during a redetermination period in lieu of performing a redetermination from the client. This administrative review is performed by verifying current information obtained from another current aid program.

Face Value of a Life Insurance Policy is the basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or other special provisions.

Fair Market Value is the average price a similar property will sell for on the open market to a private individual in the particular geographic area involved. Also, the price at which the property would change hands between a willing buyer and a willing seller, neither being under any pressure to buy or to sell and both having reasonable knowledge of relevant facts.

FBR - The Federal Benefit Rate is the monthly Supplemental Security Income payment amount for a single individual or a couple. The FBR is used by the Aged, Blind and Disabled Medical Assistance Programs as the eligibility income limits.

FFP - Federal Financial Participation as defined in this volume is the amount or percentage of funds provided by the Federal Government to administer the Colorado Medical Assistance Program.

FPL - Federal Poverty Level is a simplified version of the federal poverty thresholds used to determine financial eligibility for assistance programs. The thresholds are issued each year in the Federal Register by the Department of Health and Human Services (HHS).

Good Cause is the client's justification for needing additional time due to extenuating circumstances, usually used when extending deadlines for submittal of required documentation.

Good Cause for Child Support is the specific process and criteria that can be applied when a client is refusing to cooperate in the establishment of paternity or establishment and enforcement of a child support order due to extenuating circumstances.

HCBS are Home and Community Based Services are also referred to as "waiver programs". HCBS provides services beyond those covered by the Medical Assistance Program that enable individuals to remain in a community setting rather than being admitted to a Long-Term Care institution.

In-Kind Income is income a person receives in a form other than money. It may be received in exchange for work or service (earned income) or a non-cash gift or contribution (unearned income).

Inpatient is an individual who has been admitted to a medical institution on recommendation of a physician or dentist and who receives room, board and professional services for 24 hours or longer, or is expected to receive these services for 24 hours or longer.

Institution is an establishment that furnishes, in single or multiple facilities, food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

Institutionalization is the commitment of a patient to a health care facility for treatment.

Institutionalized Individual is a person who is institutionalized in a medical facility, a Long-Term Care institution, or applying for or receiving Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE).

Institutionalized Spouse is a Medicaid eligible client who begins a stay in a medical institution or nursing facility on or after September 30, 1989, or is first enrolled as a Medical Assistance client in the Program of All Inclusive Care for the Elderly (PACE) on or after October 10, 1997, or receives Home and Community Based Services (HCBS) on or after July 1, 1999; and is married to a spouse who is not in a medical institution or nursing facility. An institutionalized spouse does not include any such individual who is not likely to be in a medical institution or nursing facility or to receive HCBS or PACE for at least 30 consecutive days. Irrevocable means that the contract, trust, or other arrangement cannot be terminated, and that the funds cannot be used for any purpose other than outlined in the document.

Insurance Affordability Program (IAP) refers to Medicaid, Child Health Plan *Plus* (CHP+), and premium and cost-sharing assistance for purchasing private health insurance through state insurance marketplace.

Legal Immigrant is an individual who is not a citizen or national and has been permitted to remain in the United States by the United States Citizenship and Immigration Services (USCIS) either temporarily or as an actual or prospective permanent resident or whose extended physical presence in the United States is known to and allowed by USCIS.

Legal Immigrant Prenatal is a medical program that provides medical coverage for pregnant legal immigrants who have been legal immigrants for less than five years.

Limited Disability for the Medicaid Buy-In Program for Working Adults with Disabilities means that an individual has a disability that would meet the definition of disability under SSA without regard to Substantial Gainful Activity (SGA).

Long-Term Care is Medical Assistance services that provides nursing-home care, home-health care, personal or adult day care for individuals aged at least 65 years or with a chronic or disabling condition.

Long-Term Care Institution means class I nursing facilities, intermediate care facilities for the mentally retarded (ICF/MR) and swing bed facilities. Long-Term Care institutions can include hospitals.

Managed care system is a system for providing health care services which integrates both the delivery and the financing of health care services in an attempt to provide access to medical services while containing the cost and use of medical care.

Medical Assistance is defined as all medical programs administered by the Department of Health Care Policy and Financing. Medical Assistance/Medicaid is the joint state/federal health benefits program for individuals and families with low income and resources. It is an entitlement program that is jointly funded by the states and federal government and administered by the state. This program provides for payment of all or part of the cost of care for medical services.

Medical Assistance Required Household is defined for purposes of this volume as all parents or caretaker relatives, spouses, and dependent children residing in the same home.

Minimal Verification is defined in this volume as the minimum amount of information needed to process an application for benefits. No other verification can be requested from clients unless the information provided is questionable or inconsistent.

Minimum Essential Coverage is the type of coverage one must maintain to be in compliance with the Affordable Care Act in order to avoid paying a penalty for being uninsured. Minimum essential coverage may include but not limited to: Medicaid; CHP+; private health plans through Connect for Health Colorado; Medicare; job-based insurance, and certain other coverage.

MMMNA - Minimum Monthly Maintenance Needs Allowance is the calculation used to determine the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MAGI - Modified Adjusted Gross Income refers to the methodology by which income and household composition are determined for the MAGI Medical Assistance groups under the Affordable Care Act. These MAGI groups include Parents and Caretaker Relatives, Pregnant Women, Children, and Adults. For a more complete description of the MAGI categories and pursuant rules, please refer to section 8.100.4.

MAGI-Equivalent is the resulting standard identified through a process that converts a state's net-income standard to equivalent MAGI standards.

MIA - Monthly Income Allowance is the amount of institutionalized spouse's income that the community spouse is allowed to retain to meet their monthly living needs.

MSP - Medicare Savings Program is a Medical Assistance Program to assist in the payment of Medicare premium, coinsurance and deductible amounts. There are four groups that are eligible for payment or part-payment of Medicare premiums, coinsurance and deductibles: Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLIMBs), Qualified Disabled and Working Individuals (QDWIs), and Qualifying Individuals – 1 (QI-1s).

Non-Filer is an individual who neither files a tax return nor is claimed as a tax dependent. For a more complete description of how household composition is determined for the MAGI Medical Assistance groups, please refer to the MAGI household composition section at 8.100.4.E.

Nursing Facility is a facility or distinct part of a facility which is maintained primarily for the care and treatment of inpatients under the direction of a physician. The patients in such a facility require supportive, therapeutic, or compensating services and the availability of a licensed nurse for observation or treatment on a twenty-four-hour basis.

OAP - Old Age Pension is a financial assistance program for low income adults age 60 or older.

OASDI - Old Age, Survivors and Disability Insurance is the official term Social Security uses for Social Security Act Title II benefits including retirement, survivors, and disability. This does not include SSI payments.

Outpatient is a patient who is not hospitalized overnight but who visits a hospital, clinic, or associated facility for diagnosis or treatment. Is a patient who does not require admittance to a facility to receive medical services.

PACE - Program of All-inclusive Care for the Elderly is a unique, capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

Parent and Caretaker Relative is a MAGI Medical Assistance group that provides Medical Assistance to adults who are parents or Caretaker Relatives of dependent children.

Patient is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health, or lessening of illness, disability, or pain.

PEAK – the Colorado Program Eligibility and Application Kit is a web-based portal used to apply for public assistance benefits in the State of Colorado, including Medical Assistance.

PNA - Personal Needs Allowance means moneys received by any person admitted to a nursing care facility or Long-Term Care Institution which are received by said person to purchase necessary clothing, incidentals, or other personal needs items which are not reimbursed by a Federal or state program.

Pregnant Women is a MAGI Medical Assistance group that provides Medical Assistance coverage to pregnant women whose MAGI-based income calculation is less than 185% FPL, including women who are 60 days post-partum.

Premium means the monthly amount an individual pays to participate in a Medicaid Buy-In Program.

Provider is any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding a current valid license or certificate to provide such services or to dispense such goods.

Psychiatric Facility is a facility that is licensed as a residential care facility or hospital and that provides inpatient psychiatric services for individuals under the direction of a licensed physician.

Public Institution means an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

Questionable is defined as inconsistent or contradictory tangible information, statements, documents, or file records.

Reasonable Compatibility refers to an allowable difference or discrepancy between the income an applicant self attests and the amount of income reported by an electronic data source. For a more complete description of how reasonable compatibility is used to determine an applicant's financial eligibility for Medical Assistance, please refer to the MAGI Income section at 8.100.4.C

Reasonable Explanation refers to the opportunity afforded an applicant to explain a discrepancy between self-attested income and income as reported by an electronic data source, when the difference is above the threshold percentage for reasonable compatibility.

Recipient is any person who has been determined eligible to receive benefits.

Resident is any individual who is living within the state and considers the state as their place of residence. Residents include any unempancipated child whose parent or other person exercising custody lives within the state.

RRB - Railroad Retirement Benefits is a benefit program under Federal law 45 U.S.C. § 231 et seq that became effective in 1935. It provides retirement benefits to retired railroad workers and families from a special fund, which is separate from the Social Security fund.

Secondary School is a school or educational program that provides instruction or training towards a high school diploma or an equivalent degree such as a High School Equivalency Diploma (HSED).

SGA – Substantial Gainful Activity is defined by the Social Security Administration. SGA is the term used to describe a level of work activity and earnings. Work is "substantial" if it involves performance of significant physical or mental activities or a combination of both, which are productive in nature. For work

activity to be substantial, it does not need to be performed on a full-time basis. Work activity performed on a part-time basis may also be substantial gainful activity. “Gainful” work activity is work performed for pay or profit; or work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

Single Entry Point Agency means the organization selected to provide case management functions for persons in need of Long-Term Care services within a Single Entry Point District.

Single Streamlined Application or “SSAp” is the general application for health assistance benefits through which applicants will be screened for Medical Assistance programs including Medicaid, CHP+, or premium and cost-sharing assistance for purchasing private health insurance through a state insurance marketplace.

SISC- Supplemental Income Status Codes are system codes used to distinguish the different types of state supplementary benefits (such as OAP) a recipient may receive. Supplemental Income Status Codes determine the FFP for benefits paid on behalf of groups covered under the Medical Assistance program.

SSA - Social Security Administration is an agency of the United States federal government that administers Social Security, a social insurance program consisting of retirement, disability, and survivors' benefits.

SSI - Supplemental Security Income is a Federal income supplement program funded by general tax revenues (not Social Security taxes) that provides income to aged, blind or disabled individuals with little or no income and resources.

SSI Eligible means an individual who is eligible to receive Supplemental Security Income under Title XVI of the Social Security Act, and may or may not be receiving the monetary payment.

TANF - Temporary Assistance to Needy Families is the Federal assistance program which provides supportive services and federal benefits to families with little or no income or resources. It is the Block Grant that was established under the Personal Responsibility and Work Opportunity Reconciliation Act in Title IV of the Social Security Act.

Tax Dependent is anyone expected to be claimed as a dependent by a Tax-Filer.

Tax-Filer is an individual, head of household or married couple who is required to and who files a personal income tax return.

Third Party is an individual, institution, corporation, or public or private agency which is or may be liable to pay all or any part of the medical cost of an injury, a disease, or the disability of an applicant for or recipient of Medical Assistance.

Title XIX is the portion of the federal Social Security Act which authorizes a joint federal/state Medicaid program. Title XIX contains federal regulations governing the Medicaid program.

TMA - Transitional Medical Assistance is a Medical Assistance category for families that lost Medical Assistance coverage due to increased earned income or loss of earned income disregards.

ULTC 100.2 is an assessment tool used to determine level of functional limitation and eligibility for Long-Term Care services in Colorado.

Unearned Income is the gross amount received in cash or kind that is not earned from employment or self-employment.

VA - Veterans Affairs is The Department of Veterans Affairs which provides patient care and Federal benefits to veterans and their dependents.

8.100.4.G. MAGI Covered Groups

1. For MAGI Medical Assistance, any person who is determined to be eligible for Medical Assistance based on MAGI at any time during a calendar month shall be eligible for benefits during the entire month.

2. Children applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website.

    a. Children are eligible for Children's MAGI Medical Assistance through the end of the month in which they turn 19 years old. After turning 19, the individual may be eligible for a different Medical Assistance category.

3. Parents and Caretaker Relatives applying for Medical Assistance whose total household income does not exceed 60% of the federal poverty level (MAGI-equivalent) shall be determined financially eligible for Medical Assistance. Parents or Caretaker Relatives eligible for this category shall have a dependent child in the household. ~~receiving Medical Assistance.~~

    a. A dependent child is considered to be living in the home of the parent or caretaker relative as long as the parent or specified relative exercises responsibility for the care and control of the child even if:

        i) The child is under the jurisdiction of the court (for example, receiving probation services);

        ii) Legal custody is held by an agency that does not have physical possession of the child;

        iii) The child is in regular attendance at a school away from home;

        iv) Either the child or the relative is away from the home to receive medical treatment;

        v) Either the child or the relative is temporarily absent from the home;

        vi) The child is in voluntary foster care placement for a period not expected to exceed three months. Should the foster care plan change within the three months and the placement become court ordered, the child is no longer considered to be living in the home as of the time the foster care plan is changed.

4. Adults applying for Medical Assistance whose total household income does not exceed 133% of the federal poverty level shall be determined financially eligible for Medical Assistance. This category includes adults who are parents or caretaker relatives of dependent children whose income exceeds the income threshold to qualify for the Parents and Caretaker Relatives MAGI category and who meet all other eligibility criteria.

    a. A dependent child living in the household of a parent or caretaker relative shall have minimum essential coverage, in order for the parent or caretaker relative~~s~~ to be eligible for Medical Assistance under this category. Refer to section 8.100.4.G.3.a on who is considered a dependent child.

5. Pregnant Women whose household income does not exceed 185% of the federal poverty level (MAGI-equivalent) are eligible for the Pregnant Women MAGI Medical Assistance program. Medical Assistance shall be provided to a pregnant woman for a period beginning with the date of application for Medical Assistance through the last day of the month following 60 days from the date the pregnancy ends. Once eligibility has been approved, Medical Assistance coverage will be provided regardless of changes in the woman's financial circumstances.

6. A pregnant legal immigrant who has been a legal immigrant for less than five years is eligible for Medical Assistance if she meets the eligibility requirements for expectant mothers listed in 8.100.4.G.6. This population is referenced as Legal Immigrant Prenatal.

7. A child whose mother is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as “Eligible Needy Newborn”. This coverage also applies in instances where the mother received Medical Assistance to cover the child’s birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.

    a. To receive Medical Assistance under this category, the birth must be reported verbally or in writing to the County Department of Human Services or eligibility site. Information provided shall include the baby’s name, date of birth, and mother’s name or Medical Assistance number. A newborn can be reported at any time by any person. Once reported, a newborn meeting the above criteria shall be added to the mother’s Medical Assistance case, or his or her own case if the newborn does not reside with the mother, according to timelines defined by the Department. If adopted, the newborn’s agent does not need to file an application or provide a Social Security Number or proof of application for a Social Security Number for the newborn