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Title of Rule: Revision to the Medical Assistance Rule concerning In-Home Support Services, Section 8.552
Rule Number: MSB 17-10-17-A
Division / Contact / Phone: OCL/LTSS / Erin Thatcher / 303-866-5788

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 17-10-17-A, Revision to the Medical Assistance Rule concerning In-Home Support Services, Section 8.552
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) 8.552, 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 the current text at 8.552.1 through the end of 8.552.9 with the proposed text. This rule is effective April 30, 2018.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

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

   The current rule does not designate authority to any one party to develop and approve IHSS Care Plans, resulting in multiple disputes between the IHSS agency and the case management agency. The rule amendment promotes case management initiation of services, coordination, and authority. The current rule does not thoroughly define or describe key components of IHSS which results in varied interpretation by each party. The amended rule addresses the necessary processes and procedures in IHSS delivery, which will improve service delivery for the participants served through IHSS. The current rule does not emphasize Independent Living Core Services (ILCS), a statutorily-required service to be offered to participants by IHSS agencies. The amended rule adds emphasis on these services and direction to the agencies to improve implementation of ILCS as a benefit of IHSS.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-6-1203 through 25.5-6-1205, C.R.S. (2017)

Initial Review	**02/09/18**	Final Adoption	**03/09/18**
Proposed Effective Date	**04/30/18**	Emergency Adoption	

DOCUMENT #04

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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.

   Participants choosing In-Home Support Services under the Home and Community-Based Services (HCBS) waivers: Elderly, Blind, and Disabled (EBD), Spinal Cord Injury (SCI), and Children's HCBS (CHCBS).

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

   Case managers and case management agencies will have additional responsibility to initiate and authorize care plans, which will require training. Following training, case managers will spend time and resources on creating effective care plans. IHSS agencies may require internal process changes due to clarifications in the rules. Some IHSS agencies will be required to increase the duties of their registered nurse. Some IHSS participants may experience a change in hours or services as case managers and IHSS agencies review and revise care plans in full consideration of the participants needs.

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 anticipated costs to the Department or any other agency related to this rule. We anticipate that there will be better utilization of Medicaid resources as case managers and IHSS agencies streamline their processes in IHSS.

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

   The costs of this proposed rule are related to agency training and internal process changes which will occur because of this rule. The benefits are improving processes for participants, case managers, and IHSS agencies. Without action, IHSS could experience operational inefficiency.

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

   No less costly methods have been identified as this rule has few fiscal impacts on agencies and participants.

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 considered utilizing technical assistance with case management agencies and training to IHSS agencies to clarify roles and responsibilities. Ultimately it was determined that having clearly defined rules for IHSS is preferred to ensure consistent service delivery throughout Colorado.

8.552 IN-HOME SUPPORT SERVICES

8.552.1 DEFINITIONS

A. Attendant means a person, or a family member including a spouse, who is directly employed by an In-Home Support Services (IHSS) Aagency to provide IHSS to a client and meets the qualifications as defined at 10 C.C.R 2505-10, § 8.552.6.K.

B. Authorized Representative (AR) means an individual designated by the client, or by the parent or guardian of the client receiving services, if appropriate, who has the judgment and ability to assist the client in acquiring and receiving services as defined in C.R.S. Section 25.5-6-1202.

C. Care Plan means a written plan of care developed between the client or the client's Authorized Representative, IHSS Agency and Case Management Agency that is authorized by the Case Manager. Case Manager means an individual who determines functional eligibility and provides casemanagement services to eligible individuals eligible enrolled in a Home and Community Based Services (HCBS) Waiver. under the Children's Home and Community Based Services (CHCBS) Waiver program at 10 C.C.R. 2505-10, §Section 8.506, the Home and Community Based Services for the Elderly, Blind, and Disabled (HCBS-EBD) Waiver program 10 C.C.R. 2505-10, §Section 8.485 or the Home and Community Based Services for Persons with Spinal Cord Injury (HCBS-SCI) Waiver program 10 C.C.R. 2501-10, §Section 8.517.

D. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.Care Plan means a written plan of care between the client or the client's Authorized Representative authorized by the Case Manager.

E. Extraordinary Care means a service which exceeds the range of care a Family Member would ordinarily perform in a household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the client and avoid institutionalization.

F. Family Member means any person related to the client by virtue of blood, marriage, adoption, or common law.

G. Health Maintenance Activities means those routine and repetitive skilled health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/shethey were physically able, or that would be carried out by fFamily mMembers or friends if they were available. These aActivities include any excluded Ppersonal Ccare tasks as defined in 10 C.C.R 2505-10 §Section 8.489, as well as services skilled tasks provided typically performed by a Certified Nursing Assistant (CNA)) and nursing services or licensed nurse that do not require the clinical assessment and judgement of a licensed nurse.. In the event of the observation of new symptoms or worsening condition that may impair the client's ability to direct their care, the agency, in consultation with the client, shall contact the client's physician receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the client's record.

H. Homemaker Services means general household activities provided in the home of an eligible client to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

I. Inappropriate Behavior means documented verbal, sexual or physical threats or abuse committed by the client or Authorized Representative toward Attendants, Case Managers, or the IHSS Agency.

J. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of institutions. These services include but are not limited to: information and referral services, independent living skills training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and institutions to home and community-based living, or upon leaving secondary education.

K. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the client or client's ~~a~~Authorized ~~r~~Representative, including Health Maintenance Activities and support for activities of daily living or instrumental activities of daily living, P~~p~~ersonal C~~c~~are services and H~~h~~omemaker services.

L. In-Home Support Services (IHSS) Agency means an agency that is ~~certified by the state department~~certified by the Colorado Department of Public Health and Environment, enrolled in the Medicaid program and provides I~~i~~ndependent L~~l~~iving C~~c~~ore S~~s~~ervices~~ as defined~~ .

~~. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of institutions. These services include but are not limited to: information and referral services, independent living skills training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and institutions to home and community-based living, or upon leaving secondary educationsection 26-8.1-102 (3), C.R.S. In-Home Support Services.~~

M. ~~IHSS Planmeans a written plan of IHSS between the client or the client's aAuthorized rRepresentative and the IHSS agency . The IHSS Plan shall include a statement of allowable attendant and personal care service hours and a detailed listing of amount, scope and duration of each service to be provided for each day and visit., The IHSS Plan shall also include documentation of the level of oversight by a licensed health care professional determined by the client or the client's authorized representative and the IHSS agency, documentation that adequate staffing including backup staff will be available to provide necessary services, a dispute resolution process, and who will be providing each service. The IHSS Plan shall be signed by the client or the client's authorized representative and the IHSS agency.~~Licensed Medical Professional means the primary care provider of the client~~a person~~ who possess one of the following medical licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN) as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

N. Personal Care means services which are furnished to an eligible client in the client's home to meet the client's physical, maintenance and supportive needs, when those services are not skilled Personal Care, do not require the supervision of a nurse, and do not require physician's orders.

8.552.2 ELIGIBILITY

8.552.2.~~-~~A. To be eligible for IHSS a client shall meet the following criteria:

1. Be enrolled in a Medicaid program approved to offer IHSS.

1. Be enrolled in the HCBS-EBD, HCBS-SCI, or CHCBS Waiver programs; and

2. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition statement from his/her primary physician, stating that the client or client's guardian has sound judgment and the ability to self-direct- care. If the client is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.

3. If a client is required by the Physicians Attestation to have an Authorized Representative or elects to have an Authorized Representative, the client must delegate an Authorized Representative mustwho has the judgment and ability to assist the client in acquiring and using services, oran Authorized Representative who has the judgment and ability to assist in acquiring and using services, or

a. -Obtain assistance from an —The IHSS agencyIHSS Agency that is able and willing to support the client as necessary to participate in IHSS.

5 For a client with an unstable medical condition, the physician's statement shall include a recommendation regarding whether additional in-home monitoring is necessary and if so, the amount and scope of the in-home monitoring.

8.552.2.-B. IHSS A client shall no longer be eligible wheneligibility for a client will end if:

1. The client is no longer enrolled in the HCBS-EBD, HCBS-SCI or CHCBS Waiver programs. a Medicaid program approved to offer IHSS.

2. The client's medical condition deteriorates causing an unsafe situation for the client or the Attendant as -as documenteddetermined by the client's Licensed Medical Professionalcare physician.

3. The client refuses to designate an aAuthorized rRepresentative or receive assistance from an IHSS agencyIHSS Agency when the client is unable to direct their own care as documented by the client's Licensed Medical Professionalunable to direct his/her own care as documented by the physician on the Physician Attestation of Consumer Capacity form.

4. The client provides false information or false records.

8.552.3 IHSS SERVICES

8.552.3.A. Covered sServices shall beare -for the benefit of only the client. -Services for and not for the benefit of -other persons are not reimbursable. living in the home.

8.552.3.B. Services include available for eligible adults:

1. Homemaker as defined at 10 C.C.R. 2505-10, §Section 8.490

2. Personal C~~c~~are as defined at 10 C.C.R. 2505-10, §~~Section~~ 8.489

3. Health Maintenance Activities

8.552.3.C. Services available for eligible children:

1. Health Maintenance Activities

8.552.4 CLIENT AND AUTHORIZED REPRESENTATIVE PARTICIPATION AND SELF-DIRECTION ~~PROVIDER ELIGIBILITY~~

8.552.4.A. A client or ~~client's~~ their ~~a~~Authorized ~~r~~Representative ~~has the right~~ may self-direct the following aspects of service delivery: ~~to:~~

1. Present a person(s) of ~~his/her~~ their own choosing to the IHSS Agency as a potential ~~a~~Attendant. The client must have adequate Attendants to assure compliance with all tasks in the Care Plan.

2. Train ~~and schedule~~ ~~a~~Attendant(s) to meet ~~his/her~~their needs.

3. Dismiss ~~a~~Attendants who are not meeting ~~his/her~~their needs.

4. ~~Directly~~ S~~s~~chedule, manage, and supervise ~~a~~Attendants with the support of the IHSS Agency.

5. Determine, in conjunction with the IHSS Agency, the level of ~~oversight~~ in-home supervision as recommended by the client's~~a~~ L~~l~~icensed ~~health care~~Medical P~~p~~rofessional.

6. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.

7. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.

8.~~9.~~ Request a re-assessment, as described at 10 C.C.R. 2505-10, § 8.393.2.D, if level of care or service needs have changed.

8.552.4.B. An

Authorized Representative is not allowed to be reimbursed for IHSS Attendant services for the client they represent.

8.552.4.C. If the client is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements: ~~listed below.~~

1. Must be at least 18 years of age.

2. Must have known the client for at least two years. For children under the age of two, the Authorized Representative must have known the child for the duration of their life.

3. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.

8.552.4.D. The Authorized Representative must attest to the above requirement on the Authorized Representative Designation for In-Home Support Services (IHSS) form.

8.552.4.E. IHSS clients who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS client.

8.552.4.F. The client and their Authorized Representative must adhere to IHSS Agency policies and procedures.

8.552.5 IHSS AGENCY PROVIDER ELIGIBILITY

8.552.5.-A. The IHSS Agency shall conform to all certification standards and proceduresrequirements set forth at 10 C.C.R. 2505-10, Section § 8.487 and shall meet additional requirements set forthdefined in § 8.552.6.

8.552.5.B. The provider agreement for an IHSS Agency may be terminated, denied, or non-renewed from participation in the program pursuant to 10 C.C.R. 2505-10, §Sections 8.487.70 and 8.487.808.076.5.

8.552.6 IHSS AGENCY PROVIDER RESPONSIBILITIES

8.552.6.A. The IHSS Agency shall assure and document that all clients were are offered provided the following:

1. Independent Living Core Servicespeer counseling including, but not limited to

a. cross-disability peer counseling, nformation and referral services, ndividual and systems advocacy.An IHSS Agency must provide a list of the full scope of Independent Core Living Services provided by the agency to each client on an annual basis. The IHSS Agency must keep a record of each client's choice to utilize or refuse these services.

2.

2. Attendant training, oversight and supervision by a licensed health care professional employed by the IHSS who is at minimum a Registered Nurse (RN).

3.

8.552.6.B. The IHSS agency shall provide 24-hour back-up service for scheduled visits to clients at any time an scheduled aAttendant is not available.. 1. The IHSS agency shall,At at the time the IHSS Care pPlan is developed , the IHSS Agency shall ensure that adequate staffing is available. Staffing must, includeing backup staff Attendants, to ensure necessary services will be provided in accordance with the Care Plan.

to ensure necessary services will be provided.

8.552.6.

C. 8.552.6.B. The IHSS Agency shall adhere to the following:

1. If the IHSS Agency admits clients with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the agency or have other effective back-up plans to ensure the needs of the client areis met.

2. The IHSS Agency shall only accept clients for care or services based on a reasonable assurance that the needs of the client can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.

   a. There shall be documentation in the Care Plan or client record of the agreed upon days and times of services to be provided based upon the client's needs that is updated at least annually.

3. If an IHSS Agency receives a referral of a client who requires care or services that are not available at the time of referral, the IHSS Agency shall advise the client or their Authorized Representative and the Case Manager of that fact.

   a. The IHSS Agency shall only admit the client if the client or the client'stheir Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.

4. The IHSS Agency shall ensure orientation is provided to clients or Authorized Representatives who are new to IHSS or request re-orientation through The Department's prescribed process. Orientation shall include instruction in the philosophy, policies and procedures of IHSS and information concerning client rights and responsibilities.

5. The IHSS Agency will keep written service notes documenting the services provided at each visit.

. The IHSS agency shall provide intake and orientation service to clients or aAuthorized rRepresentatives who are new to IHSS. Orientation shall include instruction in the philosophy, policies and procedures of IHSS and information concerning client rights and responsibilities.8.552.6.C. The IHSS Agency is the legal employer of a client's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by The Department.

8.552.6.D. The IHSS Aagency shall assure assist all clients in interviewing and selecting an Attendant when requested, and maintain documentation of the IHSS Agency's assistance and/or the client's refusal of such assistance. and document that all clients were offered assistance in selecting an aAttendant

8.552.6.E. The IHSS Agency will complete an intake assessment following referral from the Case Manager. The IHSS Agency will develop a Care Plan in coordination with the Case Manager and client. Any proposed services outlined in the Care Plan that may result in

an increase in authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to start of services.

8.552.6.~~-~~F. The IHSS Agency shall ensure that a current Care Plan is in the client's record, and that Care Plans are updated with the client at least annually or more frequently in the event of a client's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.

1. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope and duration of each service to be provided to the client for each day and visit. The Care Plan shall be signed by the client or the client's Authorized Representative and the IHSS Agency.~~.~~

2. In the event of the observation of new symptoms or worsening condition that may impair the client's ability to direct their care, the IHSS Agency, in consultation with the client or their Authorized Representative and Case Manager, shall contact the client's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the client's revised Care Plan, with the client and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval. ~~.~~

~~8.552.6.E. The IHSS agency shall ensure that a current IHSS Plan is in the client's record and send the IHSS Planto the appropriate single entry point agency case manager within five days after any change in the IHSS Plan.~~

8.552.6.G. ~~F.~~ The IHSS Agency shall either contract with or ~~have on staff~~employ a state-~~-~~licensed health care professional, who is at the minimum a R~~r~~egistered N~~n~~urse (RN). The IHSS Agency's licensed health care professional is responsible for the following activities:

1. Administer a skills validation test for Attendants. Skills validation must be completed prior to service delivery unless postponed by the client or Authorized Representative to prevent interruption in services. -The reason for postponement shall be documented by the IHSS in the client's file. -In no event shall the skills validation be postponed for more than 30 days after services begin to prevent interruption in services.

2. ~~who will verify~~Verify and document ~~a~~Attendant skills and competency to perform IHSS and basic ~~consumer~~ client safety procedures. ~~as described in 10 C.C.R~~

~~2~~3. Counsel Attendants and staff on difficult cases and potentially dangerous situations.

~~4~~3. Consult with the client, Authorized Representative or Attendant in the event a medical issue arises.

~~5~~4. Investigate complaints and critical incidents within ten (10) calendar days as defined in 10 C.C.R 2505-10 § 8.487.15.

~~5~~6. Verify the Attendant follows all tasks set forth in the Care Plan.

~~6~~7. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the client, their Authorized Representative, or the Case Manager.

8.~~7.~~ Provide in-home supervision for the client as agreed upon by the client or their Authorized Representative.

8.552.6.H-.~~G~~ At the time of enrollment and following any change of condition, the IHSS Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the client record.

1. The IHSS Agency shall collaborate with the client or client's ~~a~~Authorized ~~r~~Representative to determine the level of ~~oversight and~~ supervision provided by the IHSS Agency's licensed health care professional beyond the requirements set forth at C.R.S. Section 25.5-6-1203.

2. The client may decline recommendations for in-home supervision. The IHSS Agency must document this choice in the client record and notify the Case Manager. The IHSS Agency and their licensed health care professional, Case Manager, and client or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

~~8.552.6.F. The decision about the level of oversight shall be documented by the IHSS agency in the IHSS plan.~~

~~8.552.6. H.H Oversight and monitoring by the licensed health care professional may include the following activities~~

~~1.. Counsel aAttendant staff on difficult cases and potentially dangerous situations.~~

~~2. Consult with the client, authorized representative or attendant in the event a medical issue arises.~~

~~3. Investigate complaints and critical incidents within 10 working days.~~

~~4. Assure that the attendant is following directives found in the IHSS .~~

8.552.6~~. .~~I. The IHSS Agency shall assure and document that all ~~a~~Attendants have received basic training in the ~~provision~~ delivery of IHSS prior to the start of services. ~~In lieu of basic training, the IHSS agency's licensed professional may administer a skills validation test.~~

~~8.552.6. J.~~ Attendant training shall include~~, but not be limited to~~:

1. Development of interpersonal skills focused on addressing the needs of persons with disabilities.

2. Overview of IHSS as a service-delivery option of consumer -direction.

3. Instruction on basic first aid administration.

4. Instruction on safety and emergency procedures.

5. Instruction on infection control techniques, including universal precautions.

6. Mandatory reporting procedures.

8.552.6.. Training may be modified if an attendant demonstrates competence in a given area.8.552.6.J.

8.552.6. L health care care Training and service delivery unless postponed by the client or Authorized Rkills validation epresentative to prevent interruption in services. In no event shall the waived skills validation be postponed for more than 30 days after services beginepresentative to prevent interruption in services. In no event shall the ato prevent interruption in services. .uthorized representative to prevent interruption in services. In no event shall the training or skills validation be postponed for more than 30 days after services begin.

8.552.6.. The IHSS Agency shall allow the client or aAuthorized rRepresentative to provide individualized Attendant training that is specific to his/hertheir own needs and preferences.

The agency shall not request additional units of service to be authorized on the PAR for 24-hour back-up care. The agency will coordinate with the Case Manager to reallocate previously authorized units to the appropriate service category prior to submission of billing.

8.552.6. N. The IHSS agency shall provide functional skills training to assist clients or authorized rRepresentatives in developing skills and resources to maximize their independent living and personal management of health care.

8.552.6.O. The IHSS agency may discontinue IHSS to a client when:

1. Equivalent care in the community has been secured, or

2. The client has exhibited inappropriate behavior toward the attendant and the -Department has determined that the IHSS agency has made adequate attempts at dispute resolution and dispute resolution has failed. Inappropriate behavior includes, but is not limited to, documented verbal, sexual or physical abuse.

8.552.6.P. The IHSS agency shall provide 30 days advance written notice to the client detailing the inappropriate behavior prior to discontinuing services. Upon provider discretion, the provider may allow the client or client representative to use the 30-day notice period to correct the problem.

8.552.6.Q. The IHSS agency shall send a copy of the 30-day written discontinuation notice to the single entry point case manager the same day the notice is sent to the client.

8.552.6. O. The IHSS agency shall allow the client or the client's aAuthorized rRepresentative to directly schedule, manage, and supervise aAttendants.

8.552.6.K. With the support of the IHSS Agency, Attendants must adhere to the following:

1. Must be at least 18 years of age and demonstrate competency in caring for the client to the satisfaction of the client or Authorized Representative.

2. May be a Family Member subject to the reimbursement and service limitations in 10 C.C.R. 2505-10, Section 8.552.8.

34. Must be able to perform the assigned tasks on the Care Plan-.

4. Shall not, in exercising their duties as an IHSS Attendant, 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 as defined in C.R.S. Section 25.5-6-1203.

5~~a~~. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.

8.552.6.L. The IHSS Agency shall provide functional skills training to assist clients and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

8.552.7 ~~SINGLE ENTRY POINT~~ CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.552.7.A. The Case Manager shall provide information and resources about IHSS to eligible clients, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.

8.552.7.B. The Case Manager will initiate a referral to the IHSS Agency of the client or Authorized Representative's choice, including an outline of approved services as determined by the Case Manager's most recent assessment. The referral must include the Physician Attestation, assessment information, and other pertinent documentation to support the development of the Care Plan.

8.552.7.C. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:~~.~~

1. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.

2. If the client requires an Authorized Representative, the Authorized Representative Designation for In-Home Support Services (IHSS) form or In-Home Support Services (IHSS) Client and Provider Agency Responsibilities form must be completed.

8.552.7.D. Upon the receipt of the Care Plan, the Case Manager shall:

1. Review the Care Plan in a timely manner to ensure there is no disruption or delay in the start of services.

2. Ensure all required information is in the client's Care Plan and that services are appropriate given the client's medical or functional condition. If needed, request additional information from the client, their Authorized Representative, the IHSS Agency, or Licensed Medical Professional regarding services requested.

3. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.

4. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the client's eligible benefits.

5. Collaborate with the client or their Authorized Representative and the IHSS Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.

6. Authorize cost-effective and non-duplicative services via the prior authorization request (PAR). Provide a copy of the PAR to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.

7. Work collaboratively with the IHSS Agency, client, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.

a. Case Manager will complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the client's rights to fair hearing, and appeal procedures.

8.552.7.E. The ~~single entry point c~~Case ~~m~~Manager shall ensure cost-effectiveness and non-duplication of services by:

1. ~~1.~~ Documenting the discontinuation of previously authorized agency-based care, including Homemaker, Personal Care, and long-term home health services that ~~shall be~~ are being replaced by IHSS.

2~~2~~. Documenting and justifying any need for ~~both~~additional in-home services including but not limited to acute ~~long~~or long-term home health services, hospice, traditional HCBS services, and private duty nursing. ~~and IHSS.~~

a. A client may receive services from multiple Attendants or agencies if appropriate for the client's level of care and documented service needs.

3. Ensuring the client's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan, and requesting additional information as needed.

4. Coordinating transitions from a hospital, nursing facility, or other agency to IHSS. Assisting client with transitions from IHSS to alternate services if appropriate.

5. Collaborating with the client or their Authorized Representative and the IHSS Agency in the event of any change in condition. The Case Manager shall request an updated Physician Attestation of Consumer Capacity form. The Case Manager may revise the Care Plan as appropriate given the client's condition and functioning.

6. Completing a reassessment if requested by the client as described at 10 C.C.R. 2505-10, § 8.393.2.D., if level of care or service needs have changed.

~~3. Ensuring all required information is in the client's IHSS Plan.~~

~~4. Authorizing cost-effective and non-duplicative services via the prior authorization request (PAR). A client may receive services from multiple aAttendants if they are not reimbursed for providing the same service at the same time.~~

5. Reviewing the IHSS prior authorization request (PAR) and giving approval prior to services rendered.

6. Ensuring that the IHSS plandelineates services to be provided and the physician's statement Physician Attestation of Consumer Capacity form is completed. or authorized representative's signed statement If applicable, an Authorized Representative Designation for In-Home Support Services (IHSS) form or In-Home Support Services (IHSS) Client and Provider Agency Responsibilities form are must be completed prior to PAR approval.

7. Documenting the amount of heath care provider oversight determined by the client in conjunction with the IHSS agency.

8.552.7.F. The Case Manager shall not authorize more than one consumer-directed program on the client's prior authorization request (PAR).

8.552.7.G. The Case Manager shall participate in training and consultative opportunities with The Department's Consumer-Directed Training & Operations contractor.

8.552.7.H. Additional requirements for Case Managers:

1. Contact the client or Authorized Representative once a month during the first three months of receiving IHSS services to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.

2. Contact the client or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.

3. Contact the client or Authorized Representative when a change in Authorized Representative occurs, and continue contact once a month for three months after the change takes place.

4. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the agency, and supervision provided. The Case Manager must document and keep record of the following:

a. IHSS Care Plans;

b. In-home supervision needs as recommended by the Physician;

c. Independent Living Core Services offered and provided by the IHSS Agency; and

d. Additional supports provided to the client by the IHSS Agency.

8.552.7.I. Start of Services

1. Services may begin only after the requirements defined at 10 C.C.R. 2505-10, § 8.552.2, 8.552.6.E., 8.552.6.I., and 8.552.7.C. have been met.

2. The Case Manager shall establish a service period and submit a prior authorization request (PAR), providing a copy to the IHSS Agency prior to the start of services.

8.552.8 REIMBURSEMENT AND SERVICE LIMITATIONS

8.552.8.A. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and prior authorization request (PAR) must be submitted and approved by the Case Manager and received by the IHSS Agency prior to services being rendered. Services rendered in advance of approval and receipt of these documents are not reimbursable~~Reimbursement for IHSS shall occur only upon approval of the IHSS Care Plan and after the (PAR) has been submitted and approval is received by both the single entry point cCase mManager and the IHSS agency~~.

8.552.8.~~-~~B. ~~For~~ IHSS ~~p~~Personal C~~c~~are services must comply with the rules for reimbursement set forth at 10 C.C.R. 2505-10 § 8.489.50. IHSS ~~and~~ H~~h~~omemaker services must comply with the rules for reimbursement set forth at ~~, the reimbursement rate shall be the same as for personal care and homemaker services under the HCBS-EBD Waiver set forth at 10 C.C.R. 2505-10~~ §~~Section 8.489.50 and at~~ 10 C.C.R. 2505-10 § ~~Section~~ 8.490.5~~0~~.

~~8.552.8.C. For IHSS Health Maintenance Activities the reimbursement rate shall be a blended average equal to 1/8th of a two-hour home health aide visit. The unit of service shall be 15 minutes.~~

8.552.8.C. Family Members are authorized to provide only P~~p~~ersonal C~~c~~are services or Health Maintenance Activities for eligible adults and Health Maintenance Activities for eligible children.

8.552.8.D. Services rendered by A~~a~~n Attendant who shares living space with the client ~~member of the client's household~~ or Family Members are reimbursable only when there is a determination by the Case Manager, made prior to the services being rendered, that the services meet the definition of Extraordinary Care. ~~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 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 is necessary to assure the health and welfare of the client and avoid institutionalization.~~

8.552.8.E. ~~For clients enrolled in HCBS-EBD and HCBS-SCI Waivers, a family~~ Family Members shall not be reimbursed for more than forty (40) hours of P~~p~~ersonal C~~c~~are services in a seven (7) day period.

~~8.552.8. E. The agency shall not submit billing for excessive hours that are not justified by the documentation of services provided, or by the client's medical or functional condition. This includes billing all units prior authorized when the allowed and needed services do not require as much time as that authorized.~~

8.522.8.F. Health Maintenance Activities ~~Health maintenance activities~~ may include related P~~p~~ersonal C~~c~~are and H~~h~~omemaker services if such tasks are completed during the H~~h~~ealth M~~m~~aintenance visit and are secondary and contiguous to the H~~h~~ealth M~~m~~aintenance A~~a~~ctivity.

8.552.8.G. Restrictions on allowable P~~p~~ersonal C~~c~~are units shall not apply to parents who provide Attendant services to their eligible adult children under In-Home Support Services as set forth at 10 C.C.R. 2505-10 § Section 8.485.204.D. ~~. A client's Authorized Representative may not be reimbursed by Medicaid for the provision of IHSS.~~

8.552.8.H. The IHSS Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved PAR. The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.

8.522.8.I. The IHSS Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.

8.552.8.J. Services by an Authorized Representative to represent the client are not reimbursable. IHSS services performed by an Authorized Representative for the client that they represent are not reimbursable.

8.552.8.K. An IHSS Agency shallMay not be reimbursed for more than 24 hours of IHSS service in one day by an Attendant for one or more clients collectively.

8.552.8.L. A client cannot receive IHSS and Consumer Directed Attendant Support Services (CDASS) at the same time.

8.552.8.M. Independent Living Core Services, attendant training, and oversight or supervision provided by the IHSS Agency's licensed health care professional are not separately reimbursable.- No additional compensation is allowable for IHSS Agencies for providing these services.

8.552.9 DISCONTINUATION AND TERMINATION OF IN-HOME SUPPORT SERVICES

8.552.9.-A. A client may elect to discontinue IHSS -or use an alternate service-delivery option at any time.

8.552.9.B A client may be discontinued from IHSS when equivalent care in the community has been secured.

8.552.9.-C. The Case Manager may terminate a client's participation in IHSS for the following reasons:

1. The client or their Authorized Representative fails to comply with IHSS program requirements as defined in 10 C.C.R. 2505-10 § 8.552.4, or

2. A client no longer meets program criteria, or

3. The client provides false information, false records, or is convicted of fraud, or

4. The client or their Authorized Representative exhibits Inappropriate Behavior and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.

    a. The IHSS Agency and Case Manager are required to assist the client or their Authorized Representative to resolve the Inappropriate Behavior and to

document all attempts to resolve the Inappropriate Behavior prior to notice of termination.

8.552.9.-D. When an IHSS Agency discontinues services, the agency shall give the client and the client's Authorized Representative written notice of at least 30 days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice shall be considered given when it is documented that the client or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the Case Management Agency.

1. Exceptions will be made to the requirement for advanced notice when the IHSS Agency has documented that there is an immediate threat to the client, IHSS Agency, or Attendants.

2. Upon IHSS Agency discretion, the agency may allow the client or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

8.552.9.E. If continued services are needed with another agency, the current IHSS Agency shall collaborate with the Case Manager and client or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the client's safety and welfare.

8.552.9.F. In the event of discontinuation or termination from IHSS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for termination, information about the client's rights to fair hearing, and appeal procedures. Once notice has been given, the client or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Nursing Facility Post Eligibility Treatment of Income- Incurred Medical Expenses, Section 8.482.33
Rule Number: MSB 17-11-03-A
Division / Contact / Phone: LTSS / Richard Clark / 6518

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 17-11-03-A, Revision to the Medical Assistance Rule concerning Nursing Facility Post Eligibility Treatment of Income- Incurred Medical Expenses, Section 8.482.33
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) 8.482.33, 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 the current text at 8.482.33 with the proposed text beginning at 8.482.33 through the end of 8.482.33. This rule is effective April 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Nursing Facility Post Eligibility Treatment of Income- Incurred Medical Expenses, Section 8.482.33
Rule Number: MSB 17-11-03-A
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STATEMENT OF BASIS AND PURPOSE

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

   The rule change updates regulations to reflect recent changes in related Medicaid State Plan Benefits. Nursing Facility PETI should not be used if a service is billable under the State Plan. The rule also applies standard timely filing deadlines which were previously unaddressed.

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:

   §1902(r)(1)(A) of the Social Security Act, 42 CFR § 435.832

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);

Initial Review	**2/9/18**	Final Adoption	**3/9/18**
Proposed Effective Date	**4/30/18**	Emergency Adoption	

DOCUMENT #05

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Rule Number: MSB 17-11-03-A
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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.

   The rule affects Nursing Facility billing practices. Individuals in Nursing Facilities under Medicaid must contribute a portion of their income to the cost of care. The patient share can be adjusted to accommodate medically necessary services not covered under Medicaid. The rule change reflects recent changes to the State Plan Dental and Vision service benefit to ensure covered services are not being reimbursed through the Nursing Facility PETI procedure.

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

   Nursing Facility Providers will need to ensure that the service request is not already covered by the Medicaid State Plan. They will also have a standard timely filing placed in effect.

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.

   No effect to the HCPF budget. The regulation identifies the proper avenue for billing a service for nursing facility residents.

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

   Implementation would clarify the rule and necessary items for billing practices. This would result in less confusion on the providers.

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

   There is no cost associated with this rule revision.

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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 rule revision is reactive to other benefit changes. This is regulatory maintenance.

8.482 RESIDENT INCOME AND POSSESSIONS

8.482.33 Nursing Facility Post Eligibility Treatment of Income – Incurred Medical Expenses (PETI-IME)

Effective April 8, 1988, with respect to the post-eligibility treatment of income of individuals who are institutionalized there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by Colorado Medicaid or third party insurance, including health insurance premiums, deductibles or co-insurance; dental care; hearing aids, supplies, and care; corrective lenses, eye care, and supplies; and other incurred expenses for medical or remedial care that are not subject to payment by a third party.

A. All PETI-IME expenses in excess of $400 per calendar year shall be prior authorized by the Department or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supplies, to validate that the requested expense is not a benefit of the Medicaid program, and to determine if the expenses requested are a duplication of expenses previously prior authorized.

B. Prior Authorization Request Process:

For allowable PETI-IME expenses that exceed $400 per client in a calendar year, costs shall be prior authorized by the Department or its designee. The process is as follows:

1. Prior authorization requests must be submitted to the Department as prescribed by the State through the Provider Web Portal. In addition to the information requested on the web portal form, the following attachments must be included:

a. For All PETI-IME requests: The medical necessity form signed by the physician and resident or resident representative.

b. For All PETI-IME requests: An itemized invoice for the service or supply being requested.

c. Additionally, for Hearing Aids: an audiogram

d. Additionally, for Health Insurance: premium statement and health Insurance card (front and back).

e. Additionally, for Dental: Medicaid denial of coverage.

~~1.~~2 Prior authorizations will be certified by T~~t~~he Department based on the following criteria:

a. The request is not a benefit of the Medicaid program.

b. The cost of the request does not exceed the basic Medicaid rate for such services or supply.

c. The special medical service or supply is medically necessary.

3~~2~~. The Department or its designee shall review and approve/deny the Prior Authorization Request within fifteen working days of receipt. The Provider Web Portal shall reflect the status of the request.

4~~3~~. Upon receipt of the approved Prior Authorization Request (PAR), the nursing facility shall ~~adjust the patient payment by the~~submit the ~~amount authorized~~PETI-IME reimbursement on the following month's Medicaid billing or on the nursing facility's next billing cycle.

a. PETI-IME PAR requests must be submitted within the timely filing period of 120 days from the date of service.

b. For approved PETI-IME PARs requested prior to services rendered, the Department has the discretion to close the PAR if reimbursement is not requested within 12 months from the date of Department approval.

~~c~~C. Private health insurance premiums, deductibles, or co-insurance as defined by state law.

~~4~~1~~5~~. Monthly premium payment paid by the resident for private health insurance.

a. If premium payments exceed the patient payment amount for one month, a monthly average is calculated by dividing the total premium by the number of months of coverage. The resulting amount is to be applied as a monthly PETI-IME expense for the months of coverage.

2~~62~~. Health insurance premiums will be allowed for the resident only.

3~~73~~. Private Health insurance premiums, deductibles, and coinsurance must be reviewed by the Department or its designee yearly for final approval.

a. If duplicate coverage has been purchased, only the cost of the least expensive policy will be allowed. Premiums, deductibles and co-insurances which the Department or its designee determine to be too expensive in relation to coverage purchased shall not be allowed.

b. Upon approval, private health insurance premiums are billable for 12 months.

D. The allowable expenses for special medical services are subject to the following criteria:

1. General Instructions (applies to all special medical services).

a. If the client does not make a patient payment; then no PETI-IME will be allowed.

b. Costs will be allowed only if they are not a benefit of the Medicaid program, or not a benefit of other insurance coverage the resident may have.

c. All allowable costs must be for items that are medically necessary as described in section 8.~~011~~076.1.8, and medical necessity must be documented by the attending physician. The physician statement must be current, within one year of the authorization.

d. The resident or resident representative must agree to the purchase of the service/equipment and related charge, with signed authorization in the resident's record.

e. Nursing facilities are not permitted to assess a surcharge or handling fee to ~~the~~

~~f. resident's~~ the resident's income.

f~~g~~. The allowable costs for services and supplies may not exceed the basic Medicaid rate.

g~~h~~. In the case of damage or loss of supplies, replacement items may be requested with relevant documentation. If the damage or loss is due to negligence on the part of the nursing facility, the nursing facility is responsible for the cost of replacement.

h~~i~~. Costs will not be allowed if the equipment, supplies or services are for cosmetic reasons only.

i~~j~~. Monthly PETI-IME payments may not exceed the monthly patient payment. Approval for reimbursement shall only be allowed if the provider agrees to accept installment payments.

j~~k~~. For special medical services/supplies provided but not yet paid for, the encumbrance agreement and monthly payment schedule must be documented in the resident's record, as well as receipts of payment.

2. Dental Care Instructions

In 2013, the state legislature passed Senate Bill 242 which authorized the Department to create a new limited dental benefit in Medicaid for adults age 21 and over. Once the

benefit has been exhausted, then a PETI-IME request may be submitted to the Department for approval for the additional services.

a. Documentation showing the allowed benefit has been exhausted for the current year shall be attached to the prior authorization request.

b. The signed medical necessity form and itemized invoice shall be attached to the prior authorization request.

3. Hearing Aid Instructions

a. All referrals for hearing aids must be authorized by the attending physician, and must include an evaluation for suitability and specifications of the appropriate appliance performed by a licensed audiologist.

b. Purchase of new hearing aids to replace pre-existing hearing aids must include documentation of necessity of replacement of the pre-existing hearing aid.

c. Documentation attached to the prior authorization request should include the signed medical necessity form, itemized invoice and audiogram.

4. Corrective Lenses Instructions

PETI-IME expenses for corrective lenses will be limited to services not covered under 10 CCR 2505-10, section § 8.203 Vision Services.

a. The evaluation of the need for corrective eyeglasses (lenses) must be a part of a comprehensive general visual examination conducted by a licensed ophthalmologist or optometrist.

b. The medical necessity for prescribed corrective lenses should not be based on the determination of the refractive state of the visual system alone, but should be identified by the current procedural terminology in the Physician Current Procedures Terminology (CPT) Code as established by the American Medical Association.

i. Documentation attached to the prior authorization request should include the signed medical necessity form and itemized invoice.

5. All documentation of the incurred expenses must be available in the client's financial and medical record for audit purposes by the Department or its designee. Lack of documentation shall cause the ~~patient payment deduction~~PETI-IME to be disallowed ~~causing the requesting facility to be overpaid by the Medicaid program~~and shall be considered an overpayment subject to recovery by the Department. Documentation shall include:

a. Printed copy of approved PAR.

b. Copy of all attachments to the PAR.

c. Yearly Activity Log that includes the dental, vision and PETI-/IME reimbursement activity. Specifically:

1) Member number and name receiving the service;

2) Type of service requested;

3) Date service was requested by the member;

4) Date PAR was added to Provider Web Portal:

5) Date PAR was approved by the Department;

6) Date facility received payment forfrom Medicaid for service;

7) Date service provider was paid by the facility;

8) Date service was rendered to the member;

9) When/if the member's personal needs account funds were used;

10) When applicable, documentation that the member's personal needs account was reimbursed;

11) Documentation that the member was still at the facility when the service was rendered;

d. All documentation must be kept forshall be retained for -six years.

8.482.33 POST ELIGIBILITY TREATMENT OF INCOME

Effective April 8, 1988, with respect to the post-eligibility treatment of income of individuals who are institutionalized there shall be taken into account amounts for incurred expenses for medical or remedial care that are not subject to payment by Colorado Medicaid or third party insurance, including health insurance premiums, deductibles or co-insurance, dental care, hearing aids, supplies and care, and corrective lenses, eye care, and supplies, and other incurred expenses for medical or remedial care that are not subject to payment by a third party.

A. All PETI expenses in excess of $400 per calendar year must be prior authorized by the Department or its designee. The purpose of the prior authorization process is to verify the medical necessity of the services or supplies, to validate that the requested expense is not a benefit Of the Medicaid program, and to determine if the expenses requested are a duplication of expenses previously prior authorized.

B. Health insurance premiums, deductibles, or co-insurance as defined by state law.

1. Monthly premium payment paid by the resident for health insurance. If payments exceed the patient payment amount for one month, a monthly average is calculated by dividing the total premium by the number of months of coverage. The resulting amount is to be applied as a monthly PETI expense for the months of coverage.

2. Medicare premiums are not an allowable deduction except in "medical only" eligibility cases and only for the first two months not covered by Medicaid.

3. Health insurance premiums will be allowed for the resident only.

4. Health insurance premiums will only be allowed if the health, insurance information is entered into the automated system for purposes of third party recovery.

5. Health insurance premiums, deductibles, and coinsurance must be reviewed by the Department or its designee for final approval. If duplicate coverage has been purchased, only the cost of the least expensive policy will be allowed. Premiums, deductibles and co-insurances which the Department or its designee determine to be too expensive in relation to coverage purchased shall not be allowed.

C. The allowable expenses for special medical services (dental care, hearing corrective lenses) are subject to the following criteria:

1. General Instructions (applies to all special medical services).

a. All PETI expenses exceeding $400 per calendar year for equipment, supplies, or services must be authorized by the Department or its designee to be considered an allowable cost.

b. Costs will be allowed only if they are not a benefit of the Medicaid program, or not a benefit of other insurance coverage the resident may have.

c. All allowable costs must be documented in the resident's record with date of purchase and receipt of payment, whether or not these costs meet the requirements for prior authorization. Lack of documentation shall cause the patient payment deduction to be disallowed, causing the provider to be overpaid by the Medicaid program.

d. All allowable costs must be for items that are medically necessary as described in 8.011, and medical necessity must be documented by the attending physician. The physician statement must be current, within one year of the authorization.

e. The resident or legally-appointed guardian must agree to the purchase of the service/equipment and related charge, with signed authorization in the resident's record.

f. Nursing facilities are not permitted to assess surcharge or handling fee to the resident's income.

g. For special medical services/supplies provided but not yet paid for, the encumbrance agreement and monthly payment schedule must be documented in the resident's record, as well as receipts of payment.

h. The allowable costs for services and supplies may not exceed the basic Medicaid rate.

i. In the case of damage or loss of supplies, replacement items may be requested with relevant documentation. If the damage or loss is due to negligence on the part of the nursing facility, the nursing facility is responsible for the cost of replacement.

j. Costs will not be allowed if the equipment, supplies or services are for cosmetic reasons only.

k. If the client does not make a patient payment; then no PETI will be allowed.

l. PETI payments may not exceed the patient payment Payments made over a period of time shall only be allowed if the provider agrees to accept installment payments.

2. Dental Care Instructions

a. Prescription of dentures (partial or full plate, fixed or removable) must be made by a licensed dentist (Doctor of Dental Surgery, Doctor of Medical Dentistry).

b. The prescription (as defined in 10 CCR 2505-10 section 8.482.33.2.a.) must be part of a comprehensive evaluation to determine the medical necessity and suitability for wearing dentures.

c. Oral and maxillofacial surgery that is required to render soft-tissue and bony structures suitable for wearing dentures must be prior authorized by the Department as defined in 10 CCR 2505-10 section 8.200 et seq.

3. Hearing Aid Instructions

a. All referrals for hearing aids must be certified by the attending physician, and must include an evaluation for suitability and specifications of the appropriate appliance, in accordance with 10 CCR 2505-10 section 8.287.02.

~~b. Purchase of new hearing aids to replace pre-existing hearing aids must include documentation of necessity of replacement of the pre-existing hearing aid. The documentation shall also describe the trade-in value given for the pre-existing aid, if appropriate.~~

~~4. Corrective Lenses Instructions~~

~~a. The evaluation of the need for corrective eyeglasses (lenses) must be a part of a comprehensive general visual examination conducted by a licensed ophthalmologist or optometrist.~~

~~b. The medical necessity for prescribed corrective lenses should not be based on the determination of the refractive state of the visual system alone, but should be identified by the current procedural terminology in the Physician Current Procedures Terminology (CPT) Code as established by the American Medical Association. This document is available through the American Medical Association, 515 North State Street, Chicago, Illinois 60610 or http://www.ama-assn.org/catalog. The document referred to does not include later amendments to or editions of the CPT4. Copies are available for inspection and available at cost at the following address: Director, Office of Medical Assistance, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203-1714; or may be examined at any State Publications Depository Library.~~

~~D. Prior Authorization Request Process:~~

~~For allowable PETI expenses that exceed $400 per client in a calendar year, costs must be prior authorized by the Department or its designee. The process is as follows:~~

~~1. Prior authorization requests must be submitted to the Department or its designee on the form prescribed by the State. In addition to the information requested on the form, the following attachments must be included:~~

~~a. A description of the service or supply, and the estimated cost.~~

~~b. A physician's statement indicating the medical necessity of the service or supply.~~

~~2. Prior authorizations will be certified based on the following criteria:~~

~~a. The request is not a benefit of the Medicaid program.~~

~~b. The cost of the request does not exceed the basic Medicaid rate for such services or supply.~~

~~c. The special medical service or supply is medically necessary.~~

3. ~~The Department or its designee shall review and approve/deny the Prior Authorization Request within ten working days of receipt~~

4. ~~Upon receipt of the approved Prior Authorization Request (PAR), the nursing facility shall adjust the patient payment by the amount authorized on the following month's Medicaid billing or on the nursing facility's next billing cycle.~~

5. ~~All documentation of the incurred expenses must be available in the client's financial and medical record for audit purposes. Lack of documentation shall cause the patient payment deduction to be disallowed causing the provider to be overpaid by the Medicaid program.~~