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Title of Rule: Revision to the Medical Assistance Rule concerning Children with Autism - Rescind, Section 8.519
Rule Number: MSB 18-04-05-A
Division / Contact / Phone: Benefits and Services Management / Sheila Peil / 5156

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 18-04-05-A, Revision to the Medical Assistance Rule concerning Children with Autism - Rescind, Section 8.519
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) 10 CCR 2505-10-8.519, 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*

Remove the existing text at 8.519. The rule has been repealed. This rule is effective September 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).

   In September 2015 the Centers for Medicare and Medicaid rejected the Department's request to expand the Home and Community Based Services-Children with Autism (HCBS-CWA) waiver and required the Department to include Pediatric Behavioral Therapies as a benefit under Early and Periodic, Screening, Diagnostic and Treatment (EPSDT). With the addition of Pediatric Behavioral Therapies to EPSDT the CWA waiver will be closed. The only benefit this waiver offered was behavioral therapy.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   Social Security Act § 1902 / 42 U.S.C. § 1396a;

   Social Security Act § 1915(c) / 42 U.S.C. § 1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-6-804(8)(a), C.R.S. (2017)

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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.

   This rule change will impact approximately 54 children with Autism who are up to 6 years of age. An estimated 39 of these children are eligible for, and have transitioned to Health First Colorado, the Children's Extensive Support waiver or Medicaid Buy-In where they may access Pediatric Behavioral Therapies. Case management agencies are assisting the remaining 15 families to identify and access behavioral therapies outside of the CWA waiver.

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

   This rule will remove authorization for the Children with Autism Waiver. Through the addition of Pediatric Behavioral Therapies to Health First Colorado most of the children enrolled in the CWA will transition to Pediatric Behavioral Therapies, a few will access behavioral therapies through private insurance or other third-party sources.

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

   There is no anticipated cost with removal of the Children with Autism waiver. Costs associated with the increase to Health First Colorado Pediatric Behavioral Therapies have already been accounted for in previous system changes.

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

   There are no anticipated costs to the Department for removal of these rules and subsequent termination of the CWA waiver. The anticipated cost of not removing the CWA waiver could include sanctions against the Department by the Centers for Medicare and Medicaid Services.

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

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

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

   There are no alternative methods for rescinding the Children with Autism rules.

8.519 HOME AND COMMUNITY BASED SERVICES FOR CHILDREN WITH AUTISM WAIVER

8.519.1 DEFINITIONS

Assessment means a comprehensive and uniform process using the ULTC Instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, including ADLs and Instrumental Activities of Daily Living, health status and other factors relevant to determine the client's level of functioning. Assessment process includes collecting information from the client and appropriate collaterals pertaining to service needs, available resources, potential funding sources and includes supporting diagnostic information from a licensed medical professional.

Autism means the presence of markedly abnormal or impaired development in social interaction and communication and a markedly restricted repertoire of activity and interests as set forth in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000. No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, Washington, DC, American Psychiatric Association, 2000 is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

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

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

Case Management means the evaluation of functional eligibility and other activities which may include assessment, service plan development, service plan implementation and service monitoring, the evaluation of service effectiveness, and the periodic reassessment of such client's needs. Case Management activities may also include assistance in accessing waiver, State Plan, and other non-Medicaid services and resources and ensuring the right to a Fair Hearing.

Case Management Agency (CMA) means an agency contracted by the Department to furnish case management services to applicants and clients within a designated service area. CMAs may include Single Entry Point (SEP) agencies, Community Centered Boards (CCB), and private case management agencies.

Continued Stay Review (CSR) means a periodic face to face review of a client's condition and service needs performed in the client's residence, by a case manager to determine a client's continued eligibility for LTC services.

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

Department means the Department of Health Care Policy and Finacing.

Functional Eligibility means an applicant or client meets the criteria for LTC services as determined by the Department's ULTC instrument.

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

~~Intake/Screening/Referral means the initial contact with an individual by the CMA and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services, referral to other programs or services and the need for the Assessment.~~

~~Lead Therapist means a qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.~~

~~Line Staff means a qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.~~

~~Plan of Correction (POC) means a written plan submitted to and approved by the Department or the Department's designee includes the specific remediation and timeline that will correct identified deficiencies.~~

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

~~Senior Therapist means the qualified Medicaid provider according to criteria at 10 C.C.R. 2505-10, § 8.519.6.~~

~~Standardized, Norm-Referenced Assessment means the most current version of an assessment tool that measures a child's adaptive functioning, including but not limited to self-help skills, expressive and receptive communication, and adaptive and maladaptive behaviors. Examples of appropriate assessment tools include but are not limited to: the Vineland Adaptive Behavior Scales, Second Edition (Vineland-II), Scales of Independent Behavior, Revised (SIB-R), and Adaptive Behavior Assessment System, Second Edition (ABAS-II).~~

~~State Plan Benefit means the benefits the state covers in the operation of its Medicaid program. The State Plan is submitted to and approved by the Centers for Medicare and Medicaid acting on behalf of the Secretary for Health and Human Services.~~

~~Uniform Long Term Care (ULTC) Instrument means the Department prescribed form used to determine Functional Eligibility and medical verification for LTC services~~

~~Utilization Review (UR) means a system for prospective, concurrent, and retrospective review of the necessity and appropriateness of the allocation of supports and services to ensure the proper and efficient administration of Medicaid Long Term Care benefits. UR may use the ULTC Instrument and other assessment instruments as indicated by the Department and/or its designee.~~

~~8.519.2 BENEFITS~~

~~8.519.2.A. Home and Community Based Services for Children with Autism (HCBS-CWA) benefits shall be provided within Cost Containment.~~

~~8.519.2.B. Behavioral therapies shall be provided in a group or individual setting.~~

~~8.519.2.C. Behavioral therapies shall only be a benefit if they are not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means. Behavioral therapies may include:~~

~~1. Intensive developmental behavioral therapies specifically created to meet the client's needs including conditioning, biofeedback or reinforcement techniques.~~

2. Treatment goals that are consistent with building elementary verbal skills, teaching imitation, establishing appropriate toy play or interactive play with other children, teaching appropriate expression of emotions and behaviors, and where necessary, reducing self stimulation and aggressive behaviors.

3. One-on-one behavior therapy between a client and a therapist following a specific protocol established by the Lead Therapist. Therapy may be implemented by a Lead Therapist, Senior Therapist, or Line Staff.

4. Training or modeling for parents or a guardian so that the behavioral therapies can continue in the home. Training or modeling shall be:

a. Directed toward instruction on therapies and use of equipment specified in the Care Plan.

b. Carried out in the presence of and for the direct benefit of the client.

8.519.2.D. Benefits shall be limited to three years, either contiguous or intermittent with a one-year extension based on medical necessity as stated by the client's physician and upon approval by the Department.

8.519.2.E. The annual cost of benefits per client shall not exceed $25,000 or available funds whichever is less.

8.519.3 NON-BENEFIT

8.519.3.A. Case Management shall not be a benefit of the HCBS-CWA waiver but shall be provided as an administrative activity through the CMA.

8.519.3.B. Speech therapy shall not be a benefit under behavior therapies.

8.519.4 CLIENT ELIGIBILITY

8.519.4.A. An eligible client shall:

1. Be determined financially eligible by the financial eligibility site in the county where the applicant resides.

2. Be determined to meet the definition of disability as defined by the Federal Social Security Administration.

3. Be at risk of institutionalization into an ICF/MR as determined by the Case Manager using the ULTC Instrument.

4. Be safely served in the community within Cost Containment as determined by the Case Manager.

5. Meet the target population criteria as follows:

a. Has a diagnosis of Autism as certified by a physician.

b. Has not yet reached six years of age.

8.519.4.B. A client shall receive at least one HCBS-CWA waiver benefit per month to maintain enrollment in the waiver. Case Management itself is not a benefit for purposes of satisfying the requirement to receive at least one benefit per month on the HCBS-CWA waiver.

8.519.4.C. A client who has not received at least one benefit on the HCBS-CWA waiver for a period of one month shall be discontinued from the waiver.

8.519.5 WAIT LIST

8.519.5.A. The number of clients who may be served through the waiver at any one time during a year shall be limited by the Department.

8.519.5.B. Applicants who are determined eligible for benefits under the HCBS-CWA waiver, who cannot be served within the Department established limit, shall be eligible for placement on a wait list maintained by the Department.

8.519.5.C. The Case Manager shall ensure the applicant meets all criteria as set forth in Section 8.519.4 prior to notifying the Department to place the applicant on the wait list.

8.519.5.D The Case Manager shall enter the client's Assessment and Professional Medical Information Page data in the BUS and notify the Department by sending the client's enrollment information, utilizing the Department's approved form, to the Program Administrator

8.519.5.E. The score received from a standardized, norm-referenced assessment, shall be used to establish the order of an applicant's place on the wait list after November 1, 2013.

1. The case manager will confirm that the assessment score submitted by a client is from a standardized norm-referenced assessment tool.

2. If two clients have the same score, the date and time of the completed ULTC Instrument, as entered in the BUS, shall be used to establish the clients' order on the wait list.

8.519.5.F. Within five working days of notification from the Department that an opening for the HCBS-CWA waiver is available the CMA shall:

1. Reassess the applicant for functional level of care using the ULTC Instrument if more than 6 months has elapsed since the previous assessment.

2. Update the existing ULTC Instrument in the BUS if more than six months has elapsed since the date of the previous.

3. Reassess for the target population criteria.

4. Notify the Department of the applicant's eligibility status.

8.519.6 PROVIDER ELIGIBILITY

8.519.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CWA waiver, meet the responsibilities as set forth in Section 8.519.7 and enter into an agreement with the Department as set forth in 10 C.C.R. 2505-10, Section 8.130.

8.519.6.B. Providers shall enroll individually with the fiscal agent.

8.519.6.C. Providers shall be employed by a qualified Medicaid provider agency, clinic or hospital except for a Lead Therapist who may provide services independent from a Medicaid provider agency when the Lead Therapist employs the Senior Therapist and Line Staff.

8.519.6.D. Lead Therapists shall meet one of the following requirements:

1. Have a doctoral degree with a specialty in psychiatry, medicine or clinical psychology and be actively licensed by the state board of examiners. Have completed 400 hours of training and/or have direct supervised experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

2. Have a doctoral degree in one of the behavioral or health sciences and have completed 800 hours of specific training and/or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

3. Have a Master's degree, or higher, in behavioral sciences and be nationally certified as a "Board Certified Behavior Analyst" or certified Relationship Development Intervention (RDI) consultant or certified by a similar nationally recognized organization.

4. Have a Master's degree or higher in one of the behavior or health sciences and certification as a School Psychologist; or licensed teacher with an endorsement of special education or early childhood special education; or licensed psychotherapy provider; or credentialed as a related services provider (Physical Therapist, Occupational Therapist, or Speech Therapist) and have completed 1,000 hours of direct supervised training or experience in behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

8.519.6.E. The Lead Therapist shall assess the child and develop the treatment plan based on the child's individual needs. The Lead Therapist shall prescribe the amount, scope and duration of the therapy, make treatment adjustments and be responsible for treatment outcomes. The Lead Therapist shall be required to provide a written progress report for the case manager and the family every six months.

8.519.6.F. Senior Therapists shall meet one of the following requirements:

1. Have a Master's degree or higher in one of the behavior or health related sciences and have completed 1,000 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

2. Have a bachelor's degree or higher in a human services field and have completed at least 2,000 hours of direct supervised training in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

8.519.6.G. The senior therapist shall provide ongoing supervision and implementation of the treatment plan. This includes the supervision of line staff, training of the families and conducting team meetings with the family, line staff and other providers to review the child's progress. The senior therapist shall provide documentation of the location of the agency that is providing services, the time spent and the team members who participated in the delivery of services.

8.519.6.H. Line Staff shall meet all of the following requirements:

1. Be at least 18 years of age

2. Have graduated from high school or earned a high school equivalency degree.

3. Have or acquire 20 hours or more of direct supervised experience billable under the direction of a Lead or a Senior Therapist, in the use of behavioral therapies that are consistent with best practice and research on effectiveness for people with autism or other developmental disabilities.

4. Demonstrate understanding of the services and outcomes for children with Autism as attested to by the Lead Therapist or Senior Therapist.

5. Have cleared the provider's background check at the time he/she is hired.

8.519.6.I. The line staff shall be trained directly by the lead and/or senior therapist. The senior therapist is responsible for the line staff supervision and shall work with the line staff to implement the treatment plan. All services provided by the line staff shall be under the direction of the senior therapist and shall be documented.

8.519.7 PROVIDER RESPONSIBLITIES

8.519.7.A. HCBS-CWA Providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining and terminating employees.

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section 19-3-304 C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statues, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

   a. The Lead Therapist shall maintain a log of all complaints and critical incidents which shall include documentation of the resolution of the complaint or incident.

   b. The Lead Therapist shall communicate any critical incident via e-mail or fax to the Department within one business day.

8.519.7.B CWA Providers shall:

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

2. Ensure client records and documentation of services are made available at the request of the Case Manager.

3. Ensure that adequate records are maintained.

a. Client records shall contain:

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

ii. Name, address and phone number of the CMA and the Case Manager.

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

iv. Special health needs or conditions of the client.

v. Documentation of the specific services provided which includes:

1. Name of the individual provider.

2. The location for the delivery of services.

3. Units of service.

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

5. All Standardized norm-referenced assessments completed or obtained

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

7. Documentation regarding supervision of benefits.

8. Financial records for all claims, including documentation of services as set forth at 10 C.C. R. 2505-10, Section 8.040.02.

b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide behavioral therapies.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.519.7.B.

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

4. Conduct or obtain a recent norm-referenced assessment (no more than 30 days old) of each client upon entering the program, every six months while on the program, and upon exit of the program.

a. The provider shall provide a copy of the assessment results of each completed assessment to the case manager and the parents or guardian of the child.

b. The provider shall review the results of each assessment completed for a child and make necessary adjustments to the child's intervention plan accordingly.

8.519.8 CASE MANAGEMENT AGENCY ELIGIBILITY

8.519.8.A. In accordance with C.R.S. 25.5-6-804(5), A CMA shall enter into a contract with the Department to provide client Assessment, Case Management and Utilization Review.

8.519.8.B. The CMA shall have computer hardware and software, compatible with the Department's BUS, with capacity and capabilities as prescribed by the Department.

8.519.8.C. The CMA shall be certified annually in accordance with quality assurance standards and requirements set forth in 10 C.C.R. 2505-10, Section 8.079.2.

1. Certification of a CMA shall be based on a survey of each CMA's performance in the following areas:

a. Quality of the Case Management services provided by the CMA to the clients based on the client satisfaction survey.

b. Compliance with waiver requirements.

c. Performance of administrative functions, including Cost Containment, timely reporting, on-site visits to clients, community outreach and client monitoring.

d. Whether targeted populations are identified and served.

e. Financial accountability.

f. Retention of qualified personnel to perform the contracted duties.

2. The CMA shall receive denial, provisional approval or approval of certification based on the outcome of the certification survey.

3. In the event that the CMA does not meet the quality assurance standards, the CMA may receive provisional approval for certification for a period not to exceed 60 days provided the deficiencies do not constitute a threat to the health and safety of the clients.

a. The CMA shall submit a Corrective Action Plan to address any deficiencies. Upon receipt and review of the Corrective Action Plan, provisional certification may be approved at the Department's discretion for a single additional 60 day period.

b. If the Corrective Action Plan is not implemented successfully within the 60 day period, the service area will be assigned to another Department Approved CMA.

c. The CMA may receive technical assistance from the Department to facilitate corrective action.

8.519.8.D. The Department or its designee shall conduct reviews of the CMA agency.

8.519.9 CMA RESPONSIBILITIES

8.519.9.A. The CMA shall, in a format and manner specified by the Department, be responsible for the collection and reporting of summary and client specific data including, but not limited, to

information and referral services provided by the agency, waiver eligibility determination, financial eligibility determination, care planning, service authorization, fiscal accountability and utilization review.

8.519.9.B. The CMA shall maintain case records in accordance with Department requirements.

1. Case records shall be maintained for:

a. Individuals for whom the CMA completed an intake for HCBS-CWA.

b. Individuals who are HCBS-CWA clients.

2. Case records shall contain:

a. Identifying information, including the client's Medicaid identification number and social security number.

b. Identifying information referencing the client's parent(s) and/or legal guardian(s).

c. A copy of the ULTC Instrument and the Professional Medical Information Page (PMIP).

d. Documentation of the date on which the client referral was first received and dates of all actions taken thereafter by the CMA.

e. Documentation of all Assessment and target population criteria outcomes.

f. Documentation of all Case Management activities, the monitoring of service delivery, and service effectiveness.

g. Documentation that all Department required forms have the required signatures .

3. The CMA shall protect the confidentiality of all applicants and recipient records in accordance with section 26-1-114, C.R.S. (2005). No amendments or later editions are incorporated. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the Colorado Revised Statues, copyright 2005 by the committee on legal services for the State of Colorado, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

4. The CMA shall protect the confidentiality of all applicants and recipient records in accordance with and the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) at 45 C.F.R., Parts 160 and 164. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library. A copy of the federal privacy law, copyright 1996, is available for inspection from: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado, 80203-1714.

5. The CMA shall obtain release of information forms from the client's parent(s) and/or legal guardian(s) which shall be signed, dated and renewed at least annually or when there is a change in benefit provider.

8.519.9.C. The CMA shall assure that each client's parent(s) and/or legal guardian(s):

1. Is fully informed of his/her rights and responsibilities.

2. Participates in the development and approval of the Care Plan and is provided a completed copy.

3. Is given a choice of service providers from qualified providers in the CMA district of his/her residence.

4. Is fully informed of and given access to a uniform complaint system as defined by the Department.

8.519.9.D. At least annually, the CMA shall conduct a client satisfaction survey which consists of surveying a sample of clients selected by the Department to determine their level of satisfaction with services provided by the CMA.

1. The random sample of clients shall include ten clients or ten percent of the CMA's average monthly HCBS-CWA caseload, whichever is higher.

2. If the CMA's average monthly HCBS-CWA caseload is less than ten clients, all clients shall be included in the survey.

3. The client satisfaction survey shall be on a Department approved form.

4. The results of the client satisfaction survey shall be made available to the Department.

8.519.9.E. The CMA shall not require clients to come to the agency's office to receive Assessments, Utilization Review services or Case Management services.

8.519.9.F. The CMA shall provide adequate staff to meet all service and administrative functions including:

1. The CMA shall have a system for recruiting, hiring, evaluating, and terminating employees that complies with all federal and state affirmative action and civil rights requirements.

2. The CMA shall employ at least one full-time case manager.

3. The CMA shall have adequate support staff to maintain a computerized information system in accordance with the Department's requirements.

4. CMA staff shall attend training sessions as directed and/or provided by the Department at the Department's expense.

5. The CMA shall provide in-service and staff development training at the CMA's expense.

6. The supervisor and case manager shall meet minimum the following standards for education and/or experience:

a. The case manager shall have at least a bachelor's degree in one of the human behavioral science fields or nursing.

b. The supervisor shall meet all qualifications for a case manager and have a minimum of two years of experience in long term care.

c. The CMA may request a waiver of these requirements from the Department prior to employing an individual when the CMA has been unable to secure the

services of a qualified individual. The waiver shall be granted approval at the discretion of the Department.

8.519.10. CMA SERVICE FUNCTIONS

8.519.10.A. The CMA shall complete the following activities as a part of its Intake/Screening/Referral function:

1. Evaluate inquiries and address accordingly.

2. Determine the appropriateness of a referral for an Assessment.

3. Provide information and referral to other agencies as needed.

4. Obtain the applicant's parent(s)' and/or legal guardian(s)' signature on the ULTC Intake Form.

8.519.10.B. If a referral for HCBS-CWA waiver services is determined to be appropriate, the CMA shall complete the following activities as a part of its Assessment:

1. Initiate the ULTC Instrument within two working days of receiving a referral.

2. Identify potential payment source(s), including the availability of private funding resources.

3. Verify the applicant's financial eligibility status for Medicaid, or refer the applicant to the financial eligibility site in the applicant's county of residence to determine financial eligibility for Medicaid.

4. Notify the applicant's parent(s) and/or legal guardian(s) of his/her right to appeal adverse actions of the CMA, the Department, or contractors acting on behalf of the Department as set forth in 10 C.C.R. 2505-10, Section 8.057.

5. Obtain diagnostic information supplied from the Professional Medical Information Page from the applicant's medical provider, physician or nurse.

6. Determine the applicant's functional capacity during an Assessment through observation of the applicant and family in his/her residential setting.

7. Determine the applicant's service needs, taking into consideration services available or already being received from all funding sources.

8. Inform the applicant's parent(s) and/or legal guardian(s) of the right to choose enrollment in other HCBS waivers for which the applicant is qualified. Document on the Care Plan, the parent(s)' and/or legal guardian(s)' waiver selection preference.

9. Maintain appropriate documentation for certification of waiver eligibility.

10. Submit documentation, as determined by the Department, for authorization of services.

8.519.10.C. The CMA shall complete the following activities as a part of the Utilization Review function:

1. Log each ULTC form received and reviewed.

2. Score the client using the ULTC Instrument within one business day from the date of the Case Manager's Assessment.

3. Input an electronic copy of the Assessment on the BUS within 10 business days after completing the Assessment.

4. Notify the applicant's parent(s) and/or legal guardian(s) of the outcome of the Assessment with the Notice of Services Status (LTC 803) Form including:

a. The Assessment outcome shall be based upon waiver requirements and the ULTC Instrument score and shall determine if a client is approved or denied for enrollment or continued stay in the waiver.

b. When the Assessment outcome is a denial for enrollment in the waiver, the CMA shall notify the applicant's parent(s) and/or legal guarding in accordance with 10 C.C. R. 2505-10, Section 8.057.

5. The CMA shall develop the Care Plan upon completion of the Assessment and prior to authorizing services. The CMA shall complete the Care Plan and all required paperwork within 15 business days upon eligibility determination. Care planning shall include, but not be limited to:

a. Identifying and documenting Care Plan goals made with the participation of the client's parent(s) and/or legal guardian(s).

b. Identifying and documenting services needed including the type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but not available.

c. Documenting a client's parent(s)' and/or legal guardian(s)' selection of qualified providers.

8.519.10.D. The CMA shall complete a CSR of a client within 12 months of the initial Assessment or the previous CSR. The CSR shall be completed not more than three months before the end of the current certification period. A CSR shall be completed sooner if the client's condition changes.

1. A CSR shall include but not be limited to the following activities:

a. Obtain an update of the Professional Medical Information Page from the client's physician.

b. Assess a client's functional status face-to-face at the client's place of residence using the ULTC Instrument.

c. Update the Care Plan and provider contacts.

d. Evaluate service effectiveness, quality of care and appropriateness of services.

e. Verify continuing Medicaid financial and waiver eligibility.

f. Inform the client's Lead Therapist of any changes in the client's needs.

g. Refer the client to community resources as needed and develop resources for the client to the extent that the resource can be made available in the community.

~~8.519.10.E. The CMA shall authorize services~~

~~1. The CMA shall Submit the PAR to the Department or the Department's designees to approve the authorization of services and provider reimbursement.~~

~~2. The CMA shall be financially responsible for any services authorized which do not meet the requirements as set forth in Section 8.519 et. seq., or which are rendered by a provider due to the CMA's failure to timely notify the provider that the client is no longer eligible for services.~~

~~8.519.10.F The CMA shall provide on-going Case Management for a client as defined below:~~

~~1. On-going Case Management shall include, but not be limited to:~~

~~a. Review the Care Plan.~~

~~b. Contact the client's parent(s) and/or legal guardian(s) concerning the satisfaction with services provided.~~

~~c. Contact the service providers concerning their effectiveness and appropriateness regarding their service coordination.~~

~~d. Investigate complaints raised by the client's parent(s) and/or legal guardian(s) concerning the service providers.~~

~~e. Contact the appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client's parent(s) and/or legal guardian(s).~~

~~f. Resolve conflict or crisis related to the waiver benefit or Medicaid state plan service delivery, as needed.~~

~~g. Assess changes in the client's functioning, service effectiveness, service appropriateness and service cost-effectiveness.~~

~~h. Refer to community resources as needed.~~

~~2. The CMA shall contact the client's parent(s) and/or legal guardian(s) at least monthly or more frequently as determined by the client's needs.~~

~~3. The CMA shall review and update the ULTC Instrument and Care Plan, with the client's parent(s) and/or legal guardian(s) as required by a significant change in the client's condition. The review shall be conducted by telephone or at the client's place of residence, place of service or other appropriate setting as determined by the client's needs.~~

~~4. The CMA shall contact the service providers to monitor service delivery at least every three months, as required by the client's needs or the specific service requirements.~~

~~5. If the CMA suspects a client to be a victim of abuse, neglect or exploitation, the CMA shall immediately refer the client to the protective services section of the county department of social services in the client's county or residence and/or the local law enforcement agency.~~

6. The CMA shall immediately report any information that indicates an overpayment, incorrect payment or misuse of any public assistance benefit to the Department. The CMA and case manager shall cooperate with the appropriate agency in any subsequent recovery process in accordance with the 10 C.C.R. 2505-10, Section 8.076.

8.519.10.G. The CMA shall complete Denials and discontinuations.

1. The CMA shall notify the client's parent(s) and/or legal guardian(s) within one working day of determining the client no longer meets waiver requirements.

2. A client shall be notified of the denial/discontinuation by the CMA on the Department prescribed LTC 803 form if he/she is determined ineligible due to any of the following reasons:

a. The client no longer meets all of the criteria set forth at Sections 8.519.4.

b. The client exceeds the limitations set forth at Sections 8.519.2.E and 8.519.2.F.

c. The client's parent(s) and/or legal guardian(s) has twice in a 30 day consecutive period, refused to schedule an appointment for an Assessment or Case Management visit.

d. The client's parent(s) and/or legal guardian(s) has failed to keep three scheduled provider appointments in a 30 day period.

e. The client's parent(s) and/or legal guardian(s) fails to sign the Intake, Care Plan, Release of Information, or other forms as required.

3. The CMA shall notify a client's parent(s) and/or legal guardian(s) of the denial or discontinuation of services using the Department prescribed advisement letter for reasons not related to enrollment criteria:

a. A client who moves out of Colorado shall be discontinued effective upon the day after the date of the move.

b. A client whose parent(s) and/or legal guardian(s) voluntarily withdraws the client from the waiver shall be discontinued effective upon the day after the date on which the request is documented, or the date on which the client enters a long term care institution or another HCBS waiver.

4. The CMA shall not send notification when the denial or discontinuation is due to the death of the client. A client who dies shall be discontinued from the waiver, effective upon the day after the date of death.

5. The case manager shall provide the client with appropriate referrals to other community resources, as needed, within one working day of discontinuation.

6. The CMA shall notify all providers on the Care Plan within one working day of discontinuation.

7. The CMA shall notify the financial eligibility site within one working day after the denial or discontinuation.

8. If a case is discontinued before an approved HCBS prior authorization request (PAR) has expired, the case manager shall submit to the Department, within five working days of

discontinuation, a copy of the current PAR form on which the end date is adjusted and highlighted. The reason for discontinuation shall be noted on the form.

8.519.10.H. The CMA shall participate in the appeals process per 10 C.C.R. 2505-10, Section 8.057 et seq.

1. The CMA shall provide information to an applicant's parent(s) and/or legal guardian(s) regarding appeal rights when he/she applies for the waiver or whenever such information is requested, whether or not an adverse action has been taken by the CMA.

2. The CMA shall attend an appeals hearing to defend a determination of enrollment, denial or discontinuation.

3. The CMA shall not attend an appeal hearing for a denial or discontinuation based on financial eligibility unless subpoenaed or requested by the Department.

8.519.11 PRIOR AUTHORIZATION REQUESTS

8.519.11.A The CMA shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CWA waiver.

1. All units of service requested shall be listed on the Care Plan form.

2. The first date for which services can be authorized shall be the later of any of the following:

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

b. The assigned start date on the certification page of the ULTC Instrument.

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

3. The PAR shall not cover a period of time longer than that indicated on the ULTC Instrument.

4. The CMA shall submit a revised PAR if a change in the Care Plan results in a change in type or amount of services.

a. The revised Care Plan shall list the services being changed and state the reason for the change. Services on the revised Care Plan form, plus all services on the original Care Plan, shall be entered on the revised PAR.

b. Revisions to the Care Plan requested by providers after the end date on a PAR shall be disapproved.

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

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

8.519.11 REIMBURSEMENT

8.519.11.A. Reimbursement for CMA functions shall be determined by the number of clients served and the type of services provided and is subject to the availability of funds.

8.519.11.B. Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Home and Community Based Services for Elderly Blind and Disabled Rule Concerning Alternative Care Facilities Section 8.495
Rule Number: MSB 18-05-25-B
Division / Contact / Phone: Benefits and Services Division / Cassandra Keller / 866-5181

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 18-05-25-B, Revision to the Medical Assistance Home and Community Based Services for Elderly Blind and Disabled Rule Concerning Alternative Care Facilities Section 8.495
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) 8.495, 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 8.491 with the proposed text beginning at 8.491.1 through the end of 8.491. This rule is effective September 30, 2018.

*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 for Elderly Blind and Disabled Rule Concerning Alternative Care Facilities Section 8.495
Rule Number: MSB 18-05-25-B
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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 intention of this rule is to ensure providers meet both State and Federal guidelines for critical incident reporting, care planning, and the HCBS Final Settings Rule. The new regulations will make clear the new requirements for the providers. This will help to ensure the Department is in compliance with federal regulations, as well as better align regulations with our sister agencies. That collaboration will lead to improved oversight of Alternative Care Facilities as well as more comprehensive inspections by the Department of Public Health and Environment (DPHE).

   Additionally, the revised criteria for food safety regulations and and updated language and clarification throughout will provide more comprehensive regulations and safer settings for the HCBS waiver participants and clarity for providers.

   The Department has worked extensively with stakeholders throughout the revision process, including suggestions from them throughout. Stakeholders include LeadingAge, CALA, providers, case managers, participants, and DPHE. DPHE has done an extensive review of the revisions and made changes where necessary.

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);
   25.5-6-313(1) C.R.S.

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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.

   Individuals who will be affected by this rule are individuals who reside in Alternative Care Facilities on the EBD and CMHS waivers. They will benefit from this rule change due to improved critical incident reporting; care planning requirements; HCBS Final Settings Rule requirements; food safety regulations; and updated language and clarification throughout. They will not bear any cost from this rule change. Alternative Care Facilities may have a slight additional administrative burden, but the Department does not anticipate the providers bearing any additional costs.

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

   All EBD and CMHS waiver clients who reside in Alternative Care Facilities will benefit from the new requirements and additional oversight it will bring to the program.

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

   There will not be a cost increase to the Department.

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

   The clarification to the Alternative Care Facility rule will significantly benefit participants, which outweighs any additional administrative burdens on the part of the Facilities.

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

The additional requirements in the proposed regulations are required by CMS and must be implemented. The additional regulations and clarifications will require minimal additional output from the Department.

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

   No alternative methods were considered.

8.495 ALTERNATIVE CARE FACILITIES ~~[Eff. 03/30/2009]~~

8.495.1 DEFINITIONS

Alternative Care Facility (ACF) ~~as defined~~ authorized in ~~C.R.S. section~~ 25.5-6-303(3), C.R.S., ~~-~~means an Assisted Living Residence as defined at 6 CCR 1011-1, Chapter VII, Section ~~21.102~~, which has been licensed by the Colorado Department of Public Health and Environment (CDPHE)~~, pursuant to certification~~ and has been certified by the Department to provide Alternative Care Services and Protective Oversight to Medicaid~~-~~ participants~~clients~~.

Alternative Care Services as described ~~defined~~ in ~~C.R.S. section~~ 25.5-6-303(4), C.R.S., means, but is not limited to, a package of personal care and homemaker services provided in a state licensed and ~~-~~certified alternative care facility including: assistance with bathing, skin, hair, nail and mouth care, shaving, dressing, feeding, ambulation, transfers, ~~and~~ positioning, bladder & bowel care, medication reminding and monitoring, accompanying, routine housecleaning, meal preparation, bed making, laundry, and shopping. Alternative Care Services also includes Medication Administration.

Care Plan means the individualized goal-oriented plan of services, supports, and preferences developed collaboratively with the participant and/or the designated or legal representative and the service provider, as outlined in 6 CCR 1011-1, Chapter VII, Section 2 and 10 CCR 2505-10, Section 8.495.6.F.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 6 CCR 1011-1, Chapter VII, Section 7.9 and 6 CCR 1011-1, Chapter VII, Section 7.16.

~~Life Skills Training means services designed and directed at the development and maintenance of the resident's ability to independently sustain himself/herself physically, emotionally, and economically in the community.~~

Medication Administration as ~~defined~~ described in ~~C.R.S. section~~ 25-1.5-301, C.R.S., means assisting a participant with taking medications~~person in the ingestion, application, inhalation, or, using universal precautions, rectal or vaginal insertion of medication, including prescription drugs,~~ while using standard healthcare precautions, according to the legibly written or printed ~~directions of the~~ order of an attending physician or other authorized practitioner. Medication administration may include assistance with ingestion, application, inhalation, and rectal or vaginal insertion of medication, including prescription drugs. Provider must document and keep record of ~~or as written on the prescription label and making a written record thereof with regard to~~ each medication administered, including the time and the amount taken.~~, but~~ "Aadministration" does not include judgment, evaluation, assessment, or the injections of medication, the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by the participant. ~~evaluation, or assessments or the injections of medication,~~

~~the monitoring of medication, or the self-administration of medication, including prescription drugs and including the self-injection of medication by the participantresident.~~

Non-Medical Leave Days mean days of leave from the ACF by the participant~~client~~ for non-medical reasons such as family visits. ~~or field trips.~~

Programmatic Leave Days mean days of leave from the ACF prescribed for a ~~Medicaid client~~participant by a physician for therapeutic and/or rehabilitative purposes.

Protective Oversight means ~~guidance to a resident~~care and service as defined at 6 CCR 1011-1, Chapter VII, Section 2 ~~1.102.(32)~~ and 10 CCR 2505-10, Section 8.489.31.S.,~~-~~ which includes ~~It is~~ the monitoring and guidance of a ~~resident~~ participant to assure their~~his/her~~ health, safety, and well-being, and a general awareness of a participant's whereabouts. Protective oversight also includes, but is not limited to: monitoring the participant~~resident~~ while on the premises, ~~ensuring the participant's health, safety, and well-being; and~~ monitoring the participant's needs, and ensuring that the participant receives the services and care necessary to protect the participant's health and welfare. ~~monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the resident to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the resident choice and~~

~~ability to travel and engage independently in the wider community, and guidance on safe behavior while outside the ACF.~~

Provider means the entity that holds the Assisted Living Residence ~~/~~ Facility license and certification and ~~that~~ shall be responsible or delegate responsibility to appropriate staff for the delivery of Alternative Care Services.

Resident Agreement means a written agreement specifying at a minimum the services to be provided, charges and refund policies, written disclosures of information, discharge procedures, and management of participant funds/property, which shall be signed by the participant and/or participant's guardian or other legal representative as outlined in 6 CCR 1011-1, Chapter VII, Section 11.3-6.

Secured Environment means an ACF that operates as defined in 6 CCR 1011-1, Chapter VII~~,~~ Section 2 ~~Section 1.108~~.

8.495.2 PARTICIPANT~~CLIENT~~ ELIGIBILITY

~~8.495.2.~~A. ~~Clients~~ Participants ~~who are participating~~ in the Home and Community Based Services (HCBS) Elderly, Blind and Disabled waiver pursuant to 10 CCR 2505-10, S~~s~~ection 8.485 and~~or~~ the HCBS ~~Mental Illness~~Community Mental Health Supports waiver pursuant to 10 CCR 2505-10, S~~s~~ection 8.509 are eligible to receive services in an Alternative Care ~~Services~~Facility.

~~8.495.2.~~B. Potential participants~~clients~~ shall be assessed, at a minimum, by a team that~~which~~ includes the ~~client~~ participant ~~and his/her family and/o~~ and/or~~r~~ guardian or other legal representative, the ACF administrator or appointed representative, and ~~Single Entry Point (SEP)~~Case Management Agency (CMA) case manager. If one of the parties listed above is not available, input or information must be obtained from each party prior to making an admission determination. It may also include family members, ~~as appropriate~~ Accountable Care Collaborative~~,~~ or Mental Health Center case managers, and any other interested parties as approved by the participant~~care givers~~, to determine that the ACF is an appropriate community setting that will meet the individual's choice and need for independence and community integration.

1. An~~The~~ assessment will be conducted prior to admission, annually, and whenever there is a significant change in physical, cognitive, or behavioral needs, or as requested by the participant. The annual assessment must be completed by the team outlined in 10 CCR 2505-10, Sections 8.495.2.B. ~~medical or mental condition or behavior.~~
2. The assessment will document that the facility is able to support the ~~client~~ participant and their needs. The assessment will also document the participant's physical, behavioral and social needs, so that supports can be identified to enable them to lead as independent a life as possible. The assessment will be used to develop the participant's Care Plan.

~~2. The assessment will document physical, cognitive, behavioral and social care needs.~~

8.495.3 ~~CLIENT~~ PARTICIPANT BENEFITS

~~8.495.3.~~A. Alternative Care Services which include, but are not limited to, personal care and homemaker services pursuant to 10 CCR 2505-10, S~~s~~ections 8.489 and 8.490, are benefits to ~~clients~~ participants residing in an ACF.

1. Medication Administration is ~~an Alternative Care Service~~ included in the reimbursement rate for Alternative Care Services and shall not be additionally reimbursed or billed in any other manner.

~~8.495.3.~~B. Room and board shall not be a benefit of Alternative ~~CF services~~Care Services. ~~Clients~~ Participants shall be responsible for room and board in an amount not to exceed the Department's ~~annually~~ established rate.

C. Participant engagement opportunities shall be provided by the ACF, as outlined in 6 CCR 1011-1, Chapter VII, Section 12.19-26.

8.495.4 ~~CLIENT~~ PARTICIPANT RIGHTS

~~8.495.4.~~A. An ACF must~~shall~~ be integrated in the community and foster the independence of the participant~~client~~ while promoting each participant's~~client's~~ individuality, choice of care, and lifestyle.

1. The ~~client's~~participant's choice to live in an ACF shall afford the ~~client~~ participant the opportunity to responsibly contribute to the home in meaningful ways and shall avoid reducing personal choice and initiative. The participant's~~client's~~ individual behaviors shall not negatively impact the harmony of the ACF.

B. The facility must ensure that a lease, residency agreement, or other form of a written agreement will be in place for each HCBS participant and provides protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord tenant law.

1. A violation of a lease or resident agreement that leads to a discharge must include at least 30 days' notice to the participant and/or their guardian or other legal representative, and a copy of the written notice shall be sent to the state or local ombudsman within five calendar days of the date that it was provided to the participant.

C. ~~Clients~~ Participants shall be informed of their rights, according to 6 CCR 1011-1, Chapter VII, Section 13. Pursuant to 6 CCR 1011-1, Chapter VII, Section 13.1, ~~Section 104 (5) (e) (ii),~~ the policy on resident rights shall be ~~posted in a conspicuous place.~~in a visible location so that they are always available to participants and visitors.

1. These rights include but are not limited to:

a. Participants have the choice in selecting the ACF in which they reside;

b. Participants are afforded the right and opportunity to responsibly contribute to the home in meaningful ways, engage in community life, and express personal choice;

c. Participants have the right to dignity and privacy, including in their living/sleeping units;

d. Participants shall have choice in a roommate, with the provider accommodating roommate choices. If the facility only has one bed in a two-bed room available, the new individual and the current occupant must at least have a chance to meet and determine whether they are willing to share a room; and

e. Communication with staff that is respectful and in a dignified manner.

2. The following rights may be modified when supported by a specific and assessed need, as determined by the provider, participant, and case manager:

a. Participants have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment;

b. Participants shall have access to food at all times, choose when and what to eat, and shall have access to food preparation areas if they can appropriately handle kitchen equipment as documented in the Care Plan;

c. Participants and their roommates shall have personal quarters with entrance doors lockable by the individual and shall control access to their quarters, unless otherwise specified in their Care Plan. Only appropriate staff shall have keys to private quarter doors, as specified in the Care Plan;

d. Participants shall have the freedom and support to determine their own schedules and activities, including methods of accessing the greater community;

e. Participants shall have the right to possess and self-administer medications with a physician's written order and approval of the self-administration of medications, (along with a copy of the physician's written order supporting self-administration) which shall be documented in the Care Plan;

f. The right to have visitors at any time;

g. The right to control his/her personal resources;

h. The right to have access to the entire facility; and

i. The right to receive unopened mail.

3. The Care Plan must include proper documentation supporting the modification, which includes but is not limited to:

a. Identification of a specific and individualized assessed need;
b. Documentation of the positive interventions and less intrusive methods that have been used to support the well-being and needs of the participant;
c. Informed consent of the participant or their guardian/other legal representative;
d. Documentation of the participant's ~~SEP~~ case manager involvement of any rights modification; and
e. Modifications to the Care Plan and supporting documentation must be reviewed, at a minimum, on an annual basis.

D~~8.495.4.C~~. ~~Clients~~ Participants shall be informed of all ACF ~~rules and/or~~ policies upon admission to the facility, and when changes to policies are made,. r. ~~R~~ules and/or policies shall apply consistently to the administrator, staff, volunteers, ~~and as appropriate, to clients~~and participants residing in the facility and their family or friends who visit. Participant acknowledgement of rules and policies must be documented in the Care Plan or a participant agreement.

E~~8.495.4.D~~. ~~Clients~~ Participants shall be informed of the facility's policies and procedures~~policy regarding the~~ for implementation of an individual's advance directives, should the need arise.

~~8.495.4.E. Clients shall be allowed to decorate and use personal furnishings in their bedrooms in accordance with house rules while maintaining a safe and sanitary environment at all times.~~

F. If requested by the participant~~client~~, the ACF shall provide bedroom furnishings, including but not limited to a bed, bed and bath linens, a lamp, chair and dresser and a way to secure personal ~~articles~~possessions.

~~8.495.4.F. As documented in the admission assessment (10 CCR 2505 10 section 8.495.2.B), the provider will accommodate roommate choices within reason.~~

~~8.495.4.G. Clients and their roommates determined capable to control access to private personal quarters, shall be allowed to lock their doors and control access to their quarters.~~

~~8.495.4.H. Clients shall have~~ and what~~unscheduled access to food and food preparation areas if determined capable to appropriately handle cooking activities.~~

~~8.495.4.I~~G. Providers shall not require a Medicaid participant~~client~~ to ~~participate~~ take part in performing household or other related tasks. ~~unless such tasks have been outlined in the client's individual care plan as necessary Life Skills Training.~~

~~8.495.4.J. Clients shall have the right to possess and self-administer medications with a physician's written order, and approval of (along with a copy of the physician's written order supporting self-administration)as appropriate.~~

8.495.5 PROVIDER ELIGIBILITY

~~8.495.5.~~A. The Provider shall be licensed in accordance with 6 CCR 1011-1, Chapters II and VII.

~~8.495.5.~~B. Certification Standards ~~for ACFs~~

1. The Provider shall be Medicaid certified by the Department as an ACF in accordance with 10 CCR, ~~Volume 8~~ 2505-10, Section 8.487.20.
2. Certification shall be denied, revoked, terminated or suspended when a Provider is unable to meet, or adequately correct deficiencies relating to, licensure and/or certification standards as defined at 6 CCR 1011-1, Chapter VII and 10 CCR 2505-10, Section 8.495.

~~Administrators shall be qualified as defined at 6 CCR 1011-1, Chapter VII, Section 1.102 shall satisfactorily complete the Department authorized training on ACF rules and regulations prior to Medicaid certification.~~

3. ACF Providers shall maintain a copy of any license, ~~permit,~~ ACF certification, proof of insurance or bond, W-9, and any other documentation as required by state or local authority. Providers shall submit to the Department a copy of the assisted living residence license upon renewal or change of ownership.
4. Administrators shall be qualified as defined at 6 CCR 1011-1, Chapter VII, Section 6, prior to Medicaid certification.

~~4. Provisional certification may be granted at the discretion of the Department for up to 60 days.~~

~~5. Certification shall be denied when a Provider is unable to meet, or adequately correct licensure and/or certification standards as defined at 6 CCR 1011-1, Chapter VII, Section 1.102 and detailed at 6 CCR 1011-1, Chapter VII, Section 1.103.; 10 CCR 2505-10 section 8.495.~~

~~8.495.5.~~C. The Provider shall enter into a Provider Agreement with the Department upon the completion of the provider application and ACF certification.

D. The Provider Agreement shall be denied, revoked, suspended, or terminated if an ACF provider does not operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation, and other standards prescribed in law or regulations.

~~8.495.5.~~E~~D~~. Notification to the Department of Significant ACF Change

1. Suspension, Revocation or Termination
   a. ACF Providers shall notify the Department within five working days when any required license, ~~permit,~~ certification, insurance or bond has a change in status, including any suspension, revocation or termination.
2. Change of Ownership~~.~~
   a. Providers shall provide written notice to the Department of intent to change ownership no later than 30 days before the sale of the facility.
      i.~~)~~ The new owner shall not automatically become a Medicaid provider without meeting licensing, certification, and approval process standards. ~~The new owner shall meet all licensing, certification or approval processes and shall not automatically become a Medicaid Provider.~~
      ~~3.~~ ~~The Department may terminate or not renew the Provider Agreement if a Provider is in violation of any applicable standards or regulations.~~

8.495.6 PROVIDER ROLES AND RESPONSIBILITIES

~~8.495.6.~~A. All documentation, including but not limited to, individual resident agreements and C~~c~~are ~~p~~Plans, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to 10 CCR 2505-10, S~~s~~ection 8.130 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) ~~auditors(s)~~ upon request.

B. Participant Engagement

1. Providers shall, in consultation with the participant's, provide social and recreational engagement opportunities both within and outside the facility.

a. Opportunities for social and recreational engagement shall take into consideration the individual interests and wishes of the participants.

b. In determining the types of opportunities and activities offered, the provider shall consider the physical, social, and mental stimulation needs of the participants.

C. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:
   a. Death;
   b. Abuse/neglect/exploitation;
   c. Injury to participant or illness of participant;
   c. Damage or theft of participant's property;
   d. Medication mismanagement;
   e. lost or missing person; and
   f. criminal activity.

2. A provider must submit a written or verbal report of a Critical Incident to the participant's ~~Single Entry Point (SEP)~~ case manager within 24 hours of discovery of the actual or alleged incident. The report must include:
   a. Participant name;
   b. Participant identification number;
   c. Waiver;
   d. Incident type;
   e. Date and time of incident;
   f. Location of incident;
   g. Persons involved;
   h. Description of incident; and
   i. Resolution, if applicable.

3. If any of the above information is not available within 24 hours of incident and not reported to the case manager, a follow-up to the initial report must be completed. Failure to report incidents may result in corrective action by the Department. ~~8.495.6.B. Using the State approved Critical Incident Reporting Form, Providers shall notify the client's Single Entry Point (SEP) case manager within 24 hours of any incident or situation that would be communicated to other interested parties.~~

D~~8.495.6.C~~. Participant Leave

1. Providers shall notify the ~~client's~~ participant's ~~SEP~~ case manager of any ~~client~~ participant planned or unplanned non-medical and/or programmatic leave for greater than 24 hours.

2~~1~~. The therapeutic and/or rehabilitative purpose of leave shall be documented ~~as part of~~in the participant's ~~client's~~ C~~c~~are P~~p~~lan.

E~~8.495.6.D~~. Additional Charges

1. Any additional monies assessed to the participant~~client~~ or ~~his/her~~their family and/or guardian:

~~1~~ a. Shall not be for Medicaid services~~.~~;

b~~2~~. Shall be clearly delineated in the ~~participantclient~~resident agreement~~.~~; and

c~~3~~. Shall be fully refunded except for withholdings which are in accordance with the resident agreement and are clearly defined on the day of discharge.

F. Care Plan

1. The following information must be documented in the Care Plan:

a. Medical Information:

i. If the participant is taking any medications and how they are administered, with reference to the Medication Administration Record (MAR);

ii. Special dietary needs, if any; and

iii. Reference to any documented physician orders.

b. Social and recreational engagement:

i. The participant's preferences and current relationships; and

ii. Any restrictions on social and/or recreational activities identified by a physician.

c. Any other special health or behavioral management needs that supports the participant's individual needs.

d. Additional Care Planning Documentation:

i. Documentation from the admission process which demonstrates that the facility was selected by the participant;

ii. Identification of the Individual's goals, choices, preferences, and needs and incorporation of these elements into the supports and services outlined in the Care Plan;

iii. Any modifications to the participants rights, with the required supporting documentation; and

iv. Evidence the participant and/or their guardian, designated representative, or legal representative has had the opportunity to participate in the development of the Care Plan, has reviewed it, and has signed in agreement with the plan.

~~8.495.6.E~~G. Environmental Standards

1. The Alternative Care Facility is an environment that supports individual comfort, independence and preference, maintains a home-like quality and feel for participants at all times, and provides participants with unrestricted access to the facility in accordance with the residency agreement or modifications as agreed to and documented in the participant's Care Plan. ~~Alternative Care Facilities are responsible and shall maintain a home-like quality and feel for all residents at all times.~~

2. Facilities shall provide an outdoor area accessible to participants without staff assistance that is well maintained, facilitates community gatherings, and is appropriately equipped for the population served.

3. Facilities shall provide access for participants to make private phone calls at their preference and convenience.~~an accessible private telephone with toll free local calls.~~

4~~3~~. Facilities shall provide comfortable places for~~a~~ private visits with family, friends and other visitors. ~~area where clients in shared bedrooms may have visitors.~~

5~~4~~. Facilities shall provide easily accessible ~~access to~~ common areas and a physical environment that meets the needs of any participant needing support. ~~is not through another resident's bedroom.~~

6~~5~~. Facilities shall maintain a comfortable temperature throughout the facility and participant rooms, sufficient to accommodate the use and needs of the participants, never to exceed

80 degrees. ~~be heated to at least 70 degrees during the day and 65 degrees at night. Bedroom temperatures shall not exceed 85 degrees. During the summer months the facility shall provide at least one common area that can accommodate all residents where the temperature is no more than 76 degrees.~~

7~~6~~. The facility shall develop and follow written policies and procedures to ensure the continuation of necessary care to all residents for at least 72 hours immediately following any emergency including, but not limited to, a long-term power failure. ~~Facilities shall have a battery or generator-powered alternative lighting system available in the event of power failure.~~

8~~7~~. The monthly schedule of daily recreational and social engagement ~~activities~~ opportunities shall ~~be posted in a conspicuous place at all times~~be in a visible location so that they are always available to participants and visitors, and developed in accordance with 6 CCR 1011-1, Chapter VII, Section 12.26, ~~Section 1.107.2~~pertaining to Resident Engagement~~Social and Recreation Activities~~.

a. Staff shall be responsible for ensuring that the daily schedule of recreational and social engagement opportunities is implemented and offered to all participants.~~The daily schedule of recreational and social activities shall be implemented by staff and offered to all clients.~~

9~~8~~. ~~Appropriate r~~Reading material ~~should~~shall be available in the common areas at all times, reflecting the interests, hobbies, and requests of the participants.~~that reflects the residents' interests and hobbies shall be made available in the common area(s).~~

10~~9~~. Facilities shall provide nutritious food and beverages that participants~~clients~~ have access to at all times. Access to food and cooking of food shall be in accordance with 6 CCR 1011-1, Chapter VII, Section 17.1-3.~~, Section 1.105(4) House Rules and Section 1.111 (1) Interior Environment~~. The access to food shall be provided in at least one of the following ways:

a. Access to the ACF kitchen.

b. Access to an area separate from the ACF kitchen stocked with nutritious food and beverages.

c. A kitchenette with a refrigerator, sink, and stove or microwave, separate from the ~~client's~~participant's bedroom.

d. A safe, sanitary way to store food in the ~~client's~~participant's room.

11~~0~~. ~~The~~ Each participant's cooking capacity ~~of residents~~ shall be assessed ~~in the~~as part of the ~~original~~ pre-admission process ~~team evaluation~~ and updated in the Care Plan as necessary.~~on-going care plans.~~

~~a. Cooking may be limited to supervised access, if necessary for the client's safety and well-being.~~

H~~8.495.6.F~~. ~~Service~~ Provider Service Requirements~~Standards~~

1. The facility shall provide Protective Oversight and Alternative Care services to ~~clients~~ participants every day of the year, 24 hours per day.

2. Alternative Care ~~Service~~ Facility Providers shall maintain and follow written policies and procedures for the administration of medication in accordance with 6 CCR 1011-1, Chapter VII and XXIV, Medication Administration Regulations.~~, if the facility administers medication to clients.~~

3. Providers shall not discontinue ~~nor refuse~~ services to a ~~client~~ participant unless documented efforts have been ineffective to resolve the conflict leading to the discontinuance ~~or refusal~~ of services.

4. The facility shall develop emergency policies that address, at a minimum, a plan that ensures the availability of, or access to, emergency power for essential functions and all resident-required medical devices or auxiliary aids.

5. Providers shall have written policies and procedures for employment practices.

~~5~~6. Providers shall maintain the following records/files:

a. Personnel files for all staff and volunteers shall include:

i.) Name, home address, phone number and date of hire.
ii.) The job description, chain of supervision and performance evaluation(s).

b. It shall be the responsibility of the Administrator to establish written policies concerning employee health, as outlined in 6 CCR 1011-1, Chapter VII, Section 7.6.
recommendations/standards/whatever of the iii) For staff with direct resident contact, including food handlers, evidence of pre-hire and annual tuberculin (TB) testing or chest x-ray, where appropriate.

cb. Client Participant files shall be kept confidential and shall include:
i.) The participant's team assessment outlined in 10 CCR 2505-10, Ssections 8.495.2. B. and Ccare Pplan per 68.495.6.F. CCR 1011-1, Chapter VII, section 1.107(3).

6. The facility shall ensure that its staff has a clear understanding of all regulations pertaining to the facility's licensure and certification by the State of Colorado.

77. The facility shall encourage and assist client's participant's' participation in engagement opportunities and activities within the ACF community and the wider community, when appropriate.

8.495.6.GI. Staffing StandardsRequirements

1. Each facility will divide and document the 24-hour day into two 12--hour blocks which will be considered daytime and nighttime. The designation of daytime and nighttime hours shall be permanently documented in facility policy and disclosed in the written resident agreements. In determining appropriate staffing levels, the facility shall adjust staffing ratios based on the individual acuity and needs of the participants in the facility. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition Direct Care Staff defined at 10 CCR 2505-10, Sections 8.495.1. The facility shall comply with Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

2. Staffing at a facility shall be no less than the following staffing standards:
a. A minimum of 1 staff to -10 residents participants during the daytime.
b. A minimum of 1 staff to 16 residents participants during the nighttime.
c. A minimum of 1 staff to 6 residents participants in a Secured Environment at all times.
i.) There shall be a minimum of one awake staff member that is on duty during all hours of operation in a Secured Environment.

23. Staffing Ratio Waiver

a. Staffing waiver requests shall be submitted to the Department's ACF Benefit Administrator. They will be evaluated and granted based on several criteria. This includes, but is not limited to:

i. Years facility has been in operation;

ii. Past critical incidents at the facility;

iii. The Provider has adequately documented how a staffing waiver would not jeopardize the health, safety or quality of life of the participants;

iv. Provider availability and client access; and
v. Free of deficiencies impacting participant health and safety in both the CDPHE and Life Safety Code survey and inspections. Prior to receiving

consideration for a staffing waiver, the facility shall be free of deficiencies for both fire safety and patient care issues in Life Safety and Health surveys.

b.3. Subject to Departmental approval, the Department may grant staffing waiversAn approved staffing waiver is only applicable for nighttime hours, only except in awith the exception for Secured Environments.

a. The Provider shall adequately document that a staffing waiver would not jeopardize the health, safety or quality of life of the residents.

c. A staffing waiver expires five years from the date of approval. Continuance of staffing waiver requires Department approval.

db. Any existing staffing waiver may be subject to revocation if a facility is does not comply with Departmentany applicable regulations, is cited with fire safety or patient care deficiencies impacting participant health and safety by CDPHE or the Division of Fire Protection Control, has or substantiated patient care complaints, or the staffing waiver has jeopardized the health, safety or quality of life of the participants.

ic. In the event of a staffing waiver denial or revocation, a facility may reapply for a staffing waiver only after the facility receives an annuala CDPHE and Life Safety survey with no deficiencies impacting participant health and safety in either fire safety or patient care.

bii. Existing staffing waivers shall be null and void upon a change in the total number of licensed beds or a change of ownership in a facility.

4. The facility shall ensure that all staff and volunteer training be completed within the first 30 days of employment. Training shall include, but is not limited to, the training topics outlined in 6 CCR 1011-1, Chapter VII, Section 7.9.

5. The Provider shall ensure the Administrator and all staff meet the qualifications and employment standards set forth in 6 CCR 1011-1, Chapter VII, Section 7.4-7.

8.495.6.JH. Standards for Secured Environment ACFs

1. Facilities providing a secured environment may be licensed for a maximum of 30 secured beds.
   a. A waiver may be granted by the Department when adequate documentation of the need for additional beds has been proven and the number of beds would not jeopardize the health, safety and quality of care of residentsparticipants.
2. The facilities shall establish an environment that promotes independence and minimizes agitation and unsafe wandering through the use of visual cues and signs.
3. Doors to bedrooms shall not be locked unless the resident is able to manage the key independently.
34. Provide a secured outdoor area accessible without staff assistance, which shall be level, well maintained, and appropriately equipped for the population served.

8.495.6.KI. Appropriateness of Medicaid ParticipantClient Placement

1. An ACF shall not admit, or shall discharge within 30 days, any participantclient, who:
   a. Needs skilled services on more than an intermittent basis. Skilled services shall only be provided on an intermittent basis by a Medicaid certified home health provider.
   b. Is incapable of self-administration of medication, and the facility does not administer medications.
   c. Is consistently unwilling to take medication prescribed by a physician.
   bd. Is diagnosed with a substance abuse issue and refuses treatment by the appropriate mental health and/or /medical professionals, and cannot be safely served by the facility.
   ce. Has an acute physical illness which cannot be managed through medications or prescribed therapy.

~~f. Has a seizure disorder which is not adequately controlled.~~

~~e~~g. Exhibits behavior that:

i.~~)~~ Disrupts the safety, health and social needs of the home.

ii.~~)~~ Poses a physical threat to self or others, including but not limited to, violent and disruptive behavior and/or any behavior which involves physical, sexual, or psychological force or intimidation and fails to respond to interventions, as outlined in the ~~client's~~ participant's C~~c~~are P~~p~~lan.

iii.~~)~~ ~~Indicates~~ Demonstrates an unwillingness or inability to maintain appropriate personal hygiene under supervision or with assistance.

iv.~~)~~ Is consistently disorientated to time, person and place to such a degree ~~he/she~~they pose~~s~~ a danger to self or others and the ACF does not provide a Secured Environment.

h. Has physical limitations that:

i.~~)~~ Limit ambulation, unless compensated for by assistive device(s) or with assistance from staff.

~~ii) Require tray food services on a continuous basis.~~

2. All discharges, including emergency discharges, shall be in accordance to 6 CCR 1011-1, Chapter VII, Section 11.11.

3. ~~Clients~~ Participants admitted for R~~r~~espite ~~c~~Care to the ACF must meet the same criteria as other ~~clients~~ participants for appropriate placement.

8.495.7 REIMBURSEMENT

~~8.495.7.~~A. Effective January 1 of each year, the Department shall establish a uniform room and board payment for all Medicaid ~~clients~~ participants in ACFs. The standard room and board payment shall be permitted to rise in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises its grant amounts.

1. Providers shall not charge a Medicaid participant more than the Department's annually established room and board rate. The room and board rate shall include but is not limited to: basic furniture, linens, utilities, and basic toiletries to include: toilet paper, soap, tissues, shampoo, toothpaste, and toothbrush.

~~8.495.7.~~B. ACFs must bill for reimbursement in accordance with the Department rules, policies and procedures.~~Facilities shall bill for reimbursement according to 10 CCR 2505-10 section 8.040.~~

1. Reimbursement shall be per unit, with one unit equaling one day of care, as ~~estimated~~ outlined on the Prior Authorization (PAR) form.

2. When a participant~~client~~ is determined eligible for HCBS services under the 300% income standard pursuant to 10 CCR 2505-10, S~~s~~ection 8.100, Medicaid reimbursement shall be determined for Alternative Care Services according to 10 CCR 2505-10, S~~s~~ection 8.486.60.

~~8.495.7.~~C. Reimbursement shall be the lower of:

1. The Medicaid unit rate; or
2. The rate the ACF charges its private-pay residents for similar services.

~~8.495.7.~~D. Non-Medical/Programmatic Leave Reimbursement

1. The ACF may receive reimbursement for a maximum of 42 days in a calendar year for Non-Medical/Programmatic Leave Days combined.
2. The ACF cannot bill for services during Leave Days if participant is receiving Medicaid services over 24 hours in another approved Medicaid Facility, such as a nursing facility or hospital.