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Title of Rule: Revision to the Medical Assistance Rule concerning Reimbursement of Nursing Facilities Serving Clients Who Meet the Hospital Back Up Level of Care, Section 8.740.7
Rule Number: MSB 18-02-12-C
Division / Contact / Phone: Payment Reform / Trevor Abeyta / 303-866-6192

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 18-02-12-C, Revision to the Medical Assistance Rule concerning Reimbursement of Nursing Facilities Serving Clients Who Meet the Hospital Back Up Level of Care, Section 8.740.7
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) 8.470.7, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.740.7 with the proposed text beginning at 8.740.7 through the end of 8.740.7.D. This rule is effective December 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Reimbursement of Nursing Facilities Serving Clients Who Meet the Hospital Back Up Level of Care, Section 8.740.7
Rule Number: MSB 18-02-12-C
Division / Contact / Phone: Payment Reform / Trevor Abeyta / 303-866-6192

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 is updating the Hospital Back Up reimbursement methodology from a cost based negotiated rate to a standardized rate based on clinical acuity. The new methodology will mirror the Medicare Part A Skilled Nursing facility reimbursement and utilize the federally mandated Minimum Data Set to determine reimbursement. This rule change is necessary because the current reimbursement methodology puts the Department and HBU providers at risk if the program is audited as the current methodology is not sound and rates are not supported by documentation. Currently non-clinical Department staff without a clinical background are negotiating the HBU rates with providers for patients based upon clinical information submitted by HBU providers. Additionally, individually negotiated rates are resource intensive for providers and the Department and result in significant delays in HBU admissions.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR part 483, subpart B

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-6-201 through 203, C.R.S. (2017)

Initial Review	**10/12/18**	Final Adoption	**11/09/18**
Proposed Effective Date	**12/30/18**	Emergency Adoption	

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Reimbursement of Nursing Facilities Serving Clients Who Meet the Hospital Back Up Level of Care, Section 8.740.7
Rule Number: MSB 18-02-12-C
Division / Contact / Phone: Payment Reform / Trevor Abeyta / 303-866-6192

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 will affect the 70 members per year who enter the HBU program as well as the 5 HBU providers. The people being served by the program will experience no costs or benefits. The providers will benefit from the proposed rule in that the new methodology will preempt any negative audit findings in the event of an audit. Providers also will save time since they are federally mandated to complete the MDS. Some providers may experience a drop-in reimbursement for their current patients if their patient's acuities do not match their Minimum Data Set Scoring.

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

   Expenditures for the HBU are expected to decrease $646,593 under the proposed methodology. Current analysis shows that some providers will see an increase in reimbursement while others will have a minimal drop.

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.

   Expenditures for the HBU are expected to decrease slightly under the proposed methodology. Current analysis shows that some providers will see an increase in reimbursement while others will have a minimal drop. Clients enrolled in the HBU program should experience quicker admission to HBU facility due to elimination of the rate negotiation process. No other impacts will occur for HBU clients.

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

   The proposed rule greatly outweighs the benefits of inaction. If no action is taken both the Department and providers are at financial risk for Federal Match if an audit occurs to the Hospital Back Up program as the methodology is not sound and there is no documentation associated with the cost-outs. Additionally, individually

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negotiated rates requires significant time to complete for the providers, as well as, the time to perform the review by Department staff. Although the cost-out is highly clinical, non-clinical staff review the rate. Finally, the negotiation process has resulted in rates exceeding $800.00 per day and delays admission to HBU when there cost-out issue preventing approval of the rate.

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.

   The Department has discussed about adding a clinical review component to the negotiated rate methodology, but this was rejected due to lack of availability with the Chief Nursing Officer.

8.470 HOSPITAL BACK UP LEVEL OF CARE

8.470.7 REIMBURSEMENT OF NURSING FACILITIES SERVING CLIENTS WHO MEET THE HOSPITAL BACK UP LEVEL OF CARE

8.470.7.A. The Medicaid reimbursement for services provided to a hospital -back up (HBU) level of care nursing facility client shall be negotiated between the Department and nursing facility in accordance with this subsection shall be based upon the Resource Utilization Group (RUG) classification determined through the client's minimum data set (MDS) resident assessment that has been transmitted to and accepted by the Centers for Medicare and Medicaid Services (CMS).

1. The Medicaid reimbursement for each client shall correspond to the negotiated cost of the services, durable medical equipment, and supplies as identified in the client's SURC approved care plan. RUG IV Case Mix Adjusted Federal RUG reimbursement rate prior to the application of any wage index component determined from a client's CMS accepted MDS resident assessment and related RUG classification.

2. All HBU facilities will receive an interim rate for 60 days post admission of the client to the facility.

   a. The interim rate will be the average RUG IV Case Mix Adjusted Federal RUG reimbursement rates for all clients enrolled in HBU, and will be recalculated annually. All claims billed during the interim rate payment period will be retroactively mass adjusted to reflect the permanent Medicaid reimbursement rate assigned to the client's RUG classification.

   b. No later than 60 days post-admission the HBU facility must complete an MDS resident assessment that has been accepted by CMS.

   c. No later than 60 days post-admission the provider must assign a RUG classification determined by the MDS resident assessment.

   d. If no MDS resident assessment has been accepted by CMS within 60 days post admission, the Department will withhold all future payments until the assessment has been accepted by CMS.

   a.

32. The Medicaid reimbursement for a client who meets the hospital back up HBU level of care shall not be based upon or related to the audited, cost-based reimbursement for a nursing facility's class I nursing facility residents. The appeal rights and procedures applicable to the Department's determination of a nursing facility's class I rate shall not apply to the reimbursement the offerDepartment offersed or paysid by the Department for a client who meets the hospital back up HBU level of care..

3. The Department and nursing facility shall negotiate the Medicaid reimbursement for an approved client who meets the hospital back up level of care, at the time of initial

placement in the nursing facility and whenever there is a significant change in the client's approved care plan or other relevant circumstances.

4. In the event that the Department and nursing facility are unable to reach agreement on an appropriate level of Medicaid reimbursement for a client who meets the hospital back up level of care, arrangements shall be made for the discharge of the client to another appropriate placement. The Department shall continue to reimburse the nursing facility for the client's care at the most recently agreed level of reimbursement until the nursing facility can provide appropriate placement, not to exceed 60 days.

5. Under no circumstances shall the payment for a client who meets the hospital back up level of care exceed 90 percent of the Medicaid payment to the discharging hospital.

4.6. If the Department determines that the client's third partythird-party coverage (private insurance or Medicare) will cover the cost of the client's care in either a hospital or nursing facility, Medicaid payment under this program shall be approved only after utilization of third--party benefits.

8.470.7.B. Providers shall bill for dDrugs and oxygen shall be billed directly to Medicaid by providers separately from the per diem rate as fee-for-service claims.

8.470.7.C. Twice yearly, the Department's contractor shall audit and validate MDS resident assessments and related RUG classifications that have been utilized to set Medicaid reimbursement rates for HBU clients.

1. The validation will review all client MDS resident's assessments scores.

2. Each June and December, the most recent MDS resident assessment score will be audited and validated.

3. The contractor shall report all invalid MDS resident assessment scores to the Department and the facility.

4. For any score identified as invalid, the Department will adjust the rate to reflect the validated MDS resident assessments and corresponding RUG IV reimbursement rate retroactively to the date of the previous validation. Claims will be reprocessed to reflect the corrected RUG IV reimbursement rate.

5. In the event the facility disputes the Contractor's determination of the RUG classification the facility can file an informal reconsideration related to the RUG classification in accordance with 10 CCR-25-5-10, Section 8.050.

    a. The Department must receive a request for informal reconsideration of a disputed RUG classification in writing within 30 days of the Contractor's notice of the disputed RUG classification. The request shall state, with specificity, each error in the disputed RUG classification. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.

    b. The Department will notify the facility of the final determination of the disputed RUG classification within 45 days of the receipt of the request for informal reconsideration.

c. The facility may file an appeal of the Department's final determination of the disputed RUG classification with the Office of Administrative Courts within 30 days from the date of the Department's notice.

8.470.7.D. Each month, the HBU facility must report the status of every HBU clients residing in the facility utilizing the Department's approved reporting form.

1. The HBU facility shall report all discharges, whether permanent or temporary, the death of a client, all changes in status, or no change in status.

2. Reports must be submitted by no later than 5:30 p.m. on the last day of the month. If no report is received by the deadline, then the Department will notify the facility that payment will be immediately suspended until the facility submits the required status report, and will immediately suspend all HBU payments to the facility.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adding Provider Types to FQHC Visit
Rule Number: MSB 18-06-15-A
Division / Contact / Phone: Benefits / Richard Delaney / 303 866-3436

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 18-06-15-A, Revision to the Medical Assistance Rule concerning Adding Provider Types to FQHC Visit
3. This action is an adoption of:	an amendment

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

   Sections(s) 8.700 - 8.700.3, 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 existing text at 8.700 with the proposed text beginning at 8.700.1 through the end of 8.700.5.A. This rule is effective December 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adding Provider Types to FQHC Visit
Rule Number: MSB 18-06-15-A
Division / Contact / Phone: Benefits / Richard Delaney / 303 866-3436

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 changes the definition of a payable encounter at Federally Qualified Health Centers. The amended rule adds the supervised mental health license candidates to the provider types that can generate a billable encounter.

   The rule is necessary to maintain access to mental health services at FQHCs. Without the rule, FQHCs will be unable to provide the services with the provider types that had been providing the services in the past. The change maintains care practices that were present prior to July 1, 2018.

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:

   The Medical Assistance Program changed coverage on July 1, 2018, to pay for short term behavioral health services without a specific diagnosis as a state plan benefit for all Medicaid clients enrolled in the Behavioral Health Managed Care program. Previously these services were only available through the Managed Care Entities (previously known as Behavioral Health Organizations) for clients enrolled in the behavioral health program and covered for specific diagnoses. Federally Qualified Health Centers (FQHCs) have been providing the services as contractors with the Managed Care Entities that cover behavioral health for Colorado Medicaid. When providing the services under the managed care program, visits with individuals supervised by licensed clinical social workers, licensed psychologists, licensed marriage and family therapists, and licensed professional counselors are paid as encounters to the FQHCs using the prospective payment system. With the change in coverage allowing HCPF to pay for those services as state plan benefits, an emergency rulemaking is necessary to comply with federal law or to preserve the public health, safety, and welfare, in accordance with C.R.S. § 24-4-103(6).

   1. To preserve public health, safety, and welfare.

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Several Federally Qualified Health Centers and their trade organization, Colorado Community Health Network have repeatedly affirmed to HCPF that failure to pay for the short term behavioral health services by individuals supervised as part of their training for a license by licensed psychotherapists will result in those services not being provided. The health, safety, and welfare of patients needing short term behavioral health services from FQHCs will be at risk without a timely change in rule, which can only be accomplished through an emergency rulemaking.

3. Federal authority for the Rule, if any:

   42 USC 1396a(bb)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   State authority for coverage of services is in C.R.S. 25.5-5-102(d) Physician services and 25.5-5-102(m) Federally qualified health centers. State authority for reimbursement is C.R.S. 25.5-4-401(1)(a).

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Title of Rule: Revision to the Medical Assistance Rule concerning Adding Provider Types to FQHC Visit
Rule Number: MSB 18-06-15-A
Division / Contact / Phone: Benefits / Richard Delaney / 303 866-3436

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.

   Medicaid clients that receive care at Federally Qualified Health Centers will be affected. This emergency rule will support access to care and continuity of care at FQHCs. No class of persons will bear any costs of the proposed rule. Medicaid clients will benefit from the proposed rule.

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

   The proposed impact is neutral to Medicaid clients. The services were available at FQHCs prior to July 1, 2018 through the behavioral health managed care program, Medicaid policy changed to allow these services through fee for service coverage and expand coverage to not require a specific diagnosis for the care. This rule makes payment as fee for service duplicate what was available prior to July 1, 2018 for clients with specific diagnoses.

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 costs probable with this rule change. It continues coverage of the services but changes payment mechanism. Overall the policy change is expected to save funds when implemented by all providers including FQHCs.

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

   There are no probable costs associated with the proposed rule. Probable benefits of action will align coverage of behavioral health services between FQHC providers and fee schedule providers. With inaction, there may be some probable cost savings due to FQHC providers being unable to be paid for a subset of behavioral health services. There are no foreseen probable benefits of inaction. Probable detriments are that many Medicaid clients will have their behavioral health treatment fragmented. FQHCs will not be able to provide the services as fee schedule services

so the clients will receive initial care from a non-integrated behavioral health entity then most likely integrate with the FQHCs services after their 6 sessions are complete.

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

   The changes are the most cost efficient approach to the new policy.

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 not changing the rule as an alternative method to achieve the integration of physical and mental health. That method would have been detrimental to the 6 sessions integration policy. There is no other way to pay for FQHC services except through the Prospective Payment System methodology under the Social Security Act (Title XIX, Section 1902(bb)). The 6 sessions policy was implemented to foster integration of physical and behavioral health from a single health care entity. To facilitate integration without this rule for FQHCs would be to abandon the 6 sessions policy for a large number of Medicaid clients because there would be no way to pay for services by licensure candidates at the FQHCs. The alternative methods would not achieve the purpose of the rule.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

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

Visit means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the services set forth in Section 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

a. A visit includes a one-on-one, face-to-face encounter between a center client and a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado providing services set forth in Section 8.700.3.A. The supervised person must hold a candidate permit as a licensed professional counselor or a candidate permit as a licensed marriage and family therapist, or a candidate permit as a psychologist, or a be a licensed social worker. Group sessions do not generate a billable encounter for any FQHC services.

8.700.2 CLIENT CARE POLICIES

8.700.2.A The FQHCs health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the FQHC staff.

8.700.2.B The policies shall include:

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See Ssection 8.700.3.A.3.
2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the FQHC.
3. Rules for the storage, handling and administration of drugs and biologicals.

8.700.3 SERVICES

8.700.3.A The following services may be provided by a certified FQHC:

1. General services

    a. Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, ~~or~~ licensed addiction counselor or supervised person pursuing mental health licensure as defined in their respective practice acts.

        i. Outpatient primary care services that are furnished by a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado as defined in their respective practice acts.

    ~~b~~c. Part-time or intermittent visiting nurse care.

    ~~c~~d. Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under Section 8.700.3.A.1.a and b.

2. Emergency services. FQHCs furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

3. Services provided through agreements or arrangements. The FQHC has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the FQHC.

8.700.3.B A certified FQHC may also provide any service authorized for payment outside the per visit encounter rate by Section 8.700.6.B.

8.700.4 PHYSICIAN RESPONSIBILITIES

8.700.4.A A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on patient referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.700.5 ALLOWABLE COST

8.700.5.A The following types and items of cost for primary care services are included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor and licensed addiction counselor and licensure candidates for clinical psychologist, clinical social worker, licensed marriage and family therapist, and

licensed professional counselor who owns, is employed by, or furnishes services under contract to an FQHC.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies related to the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor or licensed addiction counselor.

4. Overhead cost, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

5. Costs of services purchased by the clinic or center.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Supportive Living Programs, Section 8.515.85
Rule Number: MSB 18-07-06-A
Division / Contact / Phone: Benefits and Services Management Division / Diane Byrne / 303-866-4030

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 18-07-06-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Supportive Living Programs, Section 8.515.85
3. This action is an adoption of:	an amendment

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

   Sections(s) 8.515.85, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.515.85 with the proposed text beginning at 8.515.85.A through the end of 8.515.85.O. This rule is effective December 30, 2018.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Supportive Living Programs, Section 8.515.85
Rule Number: MSB 18-07-06-A
Division / Contact / Phone: Benefits and Services Management Division / Diane Byrne / 303-866-4030

STATEMENT OF BASIS AND PURPOSE

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

   No substantive changes to the Supportive Living Program (SLP) regulations are being made. The intention of this rule is to correct citations to the recently updated Assisted Living Residence (ALR) rule within the SLP rule, as all SLP providers are required to be licensed as ALRs and are subject to the updated ALR regulations. The Department worked closely with the Department of Public Health and Environment (CDPHE), providers, participants, and other stakeholders during the revision of the ALR regulations, and was requested to make these updates to the SLP rule.

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:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   Section 25.5-6-704, C.R.S.

Initial Review	**10/12/18**	Final Adoption	**11/09/18**
Proposed Effective Date	**12/30/18**	Emergency Adoption	

DOCUMENT #05

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Supportive Living Programs, Section 8.515.85
Rule Number: MSB 18-07-06-A
Division / Contact / Phone: Benefits and Services Management Division / Diane Byrne / 303-866-4030

REGULATORY ANALYSIS

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

   Persons who utilize Supportive Living Program (SLP) services and providers of SLP services through the Brain Injury (BI) waiver will benefit from increased clarity and alignment of regulatory compliance requirements. The Department of Public Health and Environment (CDPHE) and Department staff will benefit from increased clarity on regulatory administration. There will be no cost to any classes from this rule change.

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

   Persons who utilize SLP services, providers, CDPHE, and the Department will benefit through increased clarity and alignment of regulatory compliance requirements through improved consistency of the licensing and survey process conducted by CDPHE.

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 or any other agency.

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

   This update is at the request of CDPHE, and benefits participants, providers, CDPHE, and the Department through increased clarity and regulatory alignment. There is no burden to the proposed rule as changes have already been made through the promulgation of the updated Assisted Living Residence (ALR) rule by CDPHE. Inaction has no benefit, and would lead to confusion and inconsistency for participants, providers, CDPHE, and the Department.

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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 is no cost or intrusion due to 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.

   No alternative methods were considered.

8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.A DEFINITIONS

Activities of Daily Living (ADLs) mean basic self-care activities, including mobility, bathing, toileting, dressing, eating, transferring, support for memory and cognition, and behavioral supervision.

Assistance means the use of manual methods to guide, assist, with the initiation or completion of voluntary movement or functioning of an individual's body through the use of physical contact by others, except for the purpose of providing physical restraint.

Assistive Technology Devices means any item, piece of equipment, or product system that is used to increase, maintain, or improve functional capabilities of individuals with disabilities.

Authorized Representative means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to assist the client in acquiring and utilizing supports and services.

Behavioral Management and Education means services as defined in 10 CCR 2505-10 § 8.516.40.A and inclusions as defined at § 8.516.40.B, as an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the client's ability to remain integrated in the community.

Case Management Agency (CMA) means an agency within a designated service area where an applicant or client can obtain Case Management services. CMAs include Single Entry Points (SEP), Community Centered Boards (CCB), and private case management agencies.

Case Manager means an individual employed by a CMA 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 – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and person-centered Service Plan for the client, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.

Critical Incident means an actual or alleged event or situation that creates a significant risk of substantial or serious harm to the health or welfare of a client that could have, or has had, a negative impact on the mental and/or physical well-being of a client in the short or long term. A critical incident includes accidents, suspicion of abuse, neglect, or exploitation, and criminal activity.

Department means the Department of Health Care Policy and Financing.

Health Maintenance Activities means those routine and repetitive health related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if he/she were physically able, or that would be carried out by family members or friends if they were available. These activities include, but are not limited to, catheter irrigation, administration of medication, enemas, suppositories, and wound care.

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

Instrumental Activities of Daily Living (IADLs) means activities related to independent living, including preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework and communication.

Interdisciplinary Team means a group of people responsible for the implementation of a client's individualized care plan, including the client receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by the client's needs and preferences, who are assembled in a cooperative manner to develop or review the person-centered care plan.

Personal Care Services includes providing assistance with eating, bathing, dressing, personal hygiene or other activities of daily living. When specified in the service plan, Personal Care Services may also include housekeeping chores such as bed making, dusting, and vacuuming. Housekeeping assistance must be incidental to the care furnished or essential to the health and welfare of the individual rather than for the benefit of the individual's family.

Person-Centered Care Plan is a service plan created by a process that is driven by the individual and can also include people chosen by the individual. It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the client needs to function safely in the community.

Protective Oversight is defined as monitoring and guidance of a client to assure his/her health, safety, and well-being. Protective oversight includes, but is not limited to: monitoring the client while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the client to carry out activities of daily living, and facilitating medical and other health appointments. Protective oversight includes the client's choice and ability to travel and engage independently in the wider community, and providing guidance on safe behavior while outside the Supportive Living Program.

Room and Board is defined as a comprehensive set of services that include lodging, routine or basic supplies for comfortable living, and nutritional and healthy meals and food for the client, all of which are provided by the Supportive Living Program provider, and are not included in the per diem.

SLP certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to HCPF after the Supportive Living Program (SLP) provider has met all licensing requirements as an Assisted Living Residence (ALR), in addition to all requirements in these regulations at 10 CCR 2505-10, § 8.515.85.

8.515.85.B CLIENT ELIGIBILITY

1. Supportive Living Program services are available to individuals who meet all of the following requirements:

   a. Clients are determined functionally eligible for Home and Community Based Services Brain Injury waiver by a certified case management agency;

   b. Clients are enrolled in the Home and Community Based Services Brain Injury waiver; and

   c. Clients require the specialized services provided under the Supportive Living Program as determined by assessed need.

8.515.85.C SUPPORTIVE LIVING PROGRAM INCLUSIONS

1. Supportive Living Program services consist of structured services designed to provide:

   a. Assessment;

   b. Protective Oversight and supervision;

c. Behavioral Management and Education;

d. Independent Living Skills Training in a group or individualized setting to support:

i. Interpersonal and social skill development;

ii. Improved household management skills; and

iii. Other skills necessary to support maximum independence, such as financial management, household maintenance, recreational activities and outings, and other skills related to fostering independence;

e. Community Participation;

f. Transportation between therapeutic activities in the community;

g. Activities of Daily Living (ADLs);

h. Personal Care and Homemaker services; and

i. Health Maintenance Activities.

2. Person-Centered Care Planning

Supportive Living Program providers must abide by the Person-Centered Care Planning process. Providers will work with Case Management Agencies to ensure coordination of a client's Person-Centered Care Plan. Additionally, Supportive Living Program providers must provide the following actionable plans for all HCBS-BI waiver clients updated every six (6) months:

a. Transition Planning; and

b. Goal Planning.

These elements of a Person-Centered Care Plan are intended to ensure the client actively engages in his or her care and activities as well as ensure he or she is able to transition to any other type of setting or service at any given time.

3. Exclusions

The following are not included as components of the Supportive Living Program:

a. Room and board; and

b. Additional services which are available as a State Plan benefit or other HCBS-BI waiver service. Examples include, but are not limited to: physician visits, mental health counseling, substance abuse counseling, specialized medical equipment and supplies, physical therapy, occupational therapy, long term home health, and private duty nursing.

8.515.85.D PROVIDER LICENSING AND CERTIFICATION REQUIREMENTS

1. Supportive Living Program providers shall be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. 7.

a. Providers that provided and billed SLP services prior to December 31, 2014, either licensed by CDPHE as an ALR pursuant to 6 CCR 1011-1, Ch. 7, as a Home Care Agency Class A (HCA) pursuant to 6 CCR 1011-1, Ch. 26, or under another certification approved by the Department shall be considered existing providers.

b. Existing providers not fully in compliance with the requirements of § 8.515.85.D or § 8.515.85.I may continue to provide services under a request for exception and plan for compliance approved by the Department until they become fully compliant. Existing providers shall submit a renewal request for exception and plan of compliance to the Department each year for review and approval.

i. Existing providers must show coordination with CDPHE and the Colorado Division of Fire Prevention & Control (DFPC) and their approval of progress with a plan of compliance with this request. The Department shall coordinate with CDPHE and DFPC in the application of regulatory requirements of both license and certification requirements.

2. In addition to the requirements of § 8.515.85.D.1, Supportive Living Program providers must also receive SLP Certification by CDPHE. CDPHE issues or renews a Certification when the provider is in full compliance with the requirements set out in these regulations. Certification is valid for three years from the date of issuance unless voluntarily relinquished by the provider, revoked, suspended, or otherwise sanctioned pursuant to these regulations.

3. No Certification shall be issued or renewed by CDPHE if the owner, applicant, or administrator of the Supportive Living Program has been convicted of a felony or of a misdemeanor involving moral turpitude as defined by law or involving conduct that CDPHE determines could pose a risk to the health, safety, and welfare of clients.

4. In addition to meeting the requirements of this section, Supportive Living Program providers shall be licensed in accordance with C.R.S. §§ 25-1.5-103 (2013) and 25-3-101, et seq. (2013). Supportive Living Program providers who are Assisted Living Residences shall be licensed in accordance with C.R.S. § 25-27-101, et seq. (Jul. 1, 2013).These statutes are hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

5. CDPHE may deny, suspend, revoke, or not renew the Certification of any Supportive Living Program provider who is out of compliance with the requirements of these regulations. Providers may appeal this process pursuant to the State Administrative Procedure Act, C.R.S. § 24-4-101, et seq. (2013).

8.515.85.E PROVIDER RESPONSIBILITIES

Supportive Living Program providers must follow all person-centered planning initiatives undertaken by the State to ensure client choice.

8.515.85.F HCBS PROGRAM CRITERIA

1. All HCBS Program Criteria must be fully implemented in accordance with the final Department transition plan for compliance with federal Home and Community-Based Settings requirements. The federal regulations can be found at 42 C.F.R., Chapter IV, Parts 430, 431, 435, 436, 440, 441, and 447 (Mar. 17, 2014), which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

   The following will be used to establish program criteria for Supportive Living Program providers in establishing a home-like environment pursuant to 42 C.F.R. § 440.180. In accordance with 42 C.F.R. § 441.301, the setting must:

   a. Be integrated in and support full access to the greater community;

   b. Be selected by the client from among setting options;

   c. Ensure client rights of privacy, dignity, and respect, and freedom from coercion and restraint;

   d. Optimize individual initiative, autonomy, and independence in making life choices;

   e. Facilitate client choice regarding services and supports, and who provides them;

   f. Put in place a lease or other written agreement providing similar protections for the client that addresses eviction processes and appeals;

   g. Ensure privacy in the client’s unit including lockable doors, choice of roommates, and freedom to furnish or decorate the unit;

   h. Ensure that clients have the freedom and support to control their own schedules and activities, and have access to food at any time;

   i. Each client shall have the right to receive and send packages. No client’s outgoing packages shall be opened, delayed, held, or censored by any person;

   j. Each client has the right to receive and send sealed, unopened correspondence. No client’s incoming or outgoing correspondence shall be opened, delayed, held, or censored by any person;

   k. Enable clients to have visitors of their choosing at any time; and

   l. Be physically accessible.

2. The provider must ensure adherence to all state assurances set forth at 42 C.F.R. § 441.302 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this

incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

3. Exceptions

Exceptions exist to the aforementioned HCBS Program Criteria listed in Section 8.515.85.F.1 of this rule when clear rationale and reasoning exist and is supported by appropriate documentation. These exceptions are for the corresponding sections in Section 8.515.85.F.1 of this rule, and are as follows:

a. HCBS Program Criteria under 8.515.85.F.1, a through k:

Requirements of program criteria may be modified if supported by a specific assessed need and justified and agreed to in the person-centered care plan pursuant to 42 C.F.R. § 441.302 (Jan. 16, 2014). The following requirements must be documented in the person-centered care plan:

i. Identify a specific and individualized assessed need.

ii. Document the positive interventions and supports used prior to any modifications to the person-centered care plan.

iii. Document less intrusive methods of meeting the need that have been tried but did not work.

iv. Include a clear description of the modification that is directly proportionate to the specific assessed need.

v. Include regular collection and review of data to measure the ongoing effectiveness of the modification.

vi. Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

vii. Include the informed consent of the individual.

viii. Include an assurance that interventions and supports will cause no harm to the individual.

b. HCBS Program Criteria under 8.515.85.F.1.b and e:

i. When a client chooses to receive Home and Community-Based Services in a provider-owned or controlled setting where the provider is paid a single rate to provide a bundle of services, the client cannot choose an alternative provider to deliver services that are included in the bundled rate.

ii. For any services that are not included in the bundled rate, the client may choose any qualified provider, including the provider who controls or owns the setting if the provider offers the service separate from the bundle.

iii. To illustrate these HCBS Program Criteria b and e requirements by way of example, if a program provides habilitation connected with daily living and on-site supervision under a bundled rate, an individual is choosing the residential provider for those two services when he or she chooses the residence. The individual has free choice of providers for any other services in his or her service plan, such as therapies, home health or counseling.

c. HCBS Program Criteria under 8.515.85.F.1.c:

When a client needs assistance with challenging behavior, including a client whose behavior is dangerous to himself, herself, or others, or when the client engages in behavior that results in significant property destruction, the Supportive Living Program must properly create service and support plans detailing plans to appropriately address these behaviors.

d. HCBS Program Criteria under 8.515.85.F.1.g:

Requirements for a lockable entrance door may be modified if supported by a specific assessed need and justified and agreed to in the person-centered service plan pursuant to 42 C.F.R. § 441.302 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.515.85.G STAFFING

1. The Supportive Living Program provider shall ensure sufficient staffing levels to meet the needs of clients~~, and shall meet all other staffing requirements pursuant to 6 CCR 1011-1, Ch. 7, § 1.104(4)(a)~~.

~~, which states the following:~~

~~a. The owner shall employ sufficient staff to ensure the provision of services necessary to meet the needs of the residents; and~~

~~b. In determining staffing, the facility shall give consideration to factors including but not limited to:~~

~~i. Services to meet the residents' needs,~~

~~ii. Services to be provided under the care plan, and~~

~~iii. Services to be provided under the resident agreement.~~

~~c. Each facility shall ensure that at least one staff member who has the qualifications and training listed under Sections 1.104(3)(e) and (f), and who shall be at least 18 years of age, is present in the facility when one or more residents is present. These regulations are hereby incorporated by reference. The incorporation of these regulations exclude later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in~~

~~its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.~~

In addition to these regulations, staff should be trained in how to work with an individual or individuals in difficult situations that may arise in the course of their work.

2. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in relevant precautions and emergency procedures, including first aid, to ensure the safety of the clientele. The SLP provider shall adhere to all other regulations pursuant to 6 CCR 1011-1, Ch. 7, §§ 3.3, ~~1.103(8)~~ 6, 7, and 8 ~~§ 1.104(1)-(2) (Aug. 14, 2013)~~, which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

3. Within one month of the date of hire, the Supportive Living Program provider shall provide adequate training for staff on each of the following topics:

    a. Crisis prevention;

    b. Identifying and dealing with difficult situations;

    c. Cultural competency;

    d. Infection control; and

    e. Grievance and complaint procedures.

4. Prior to providing direct care, the Supportive Living Program provider shall provide to the operator, staff, and volunteers an orientation of the location in which the program operates and adequate training on person-centered care planning.

5. All staff training shall be documented. Copies of person-centered care plan training and related documentation must be submitted to the Department. Copies must also be submitted for inspection and approval upon changing the training curriculum.

6. In addition to the relevant requirements imposed by CDPHE in 6 CCR 1011-1 Ch. 7 on Assisted Living Residence, the Department requires that the program director shall have an advanced degree in a health or human service related profession plus two years of experience providing direct services to persons with a brain injury. A bachelor's or nursing degree with three years of similar experience or a combination of education and experience shall be an acceptable substitute.

7. The provider shall employ or contract for behavioral services and skill training services according to client needs.

8. The Supportive Living Program provider shall employ staff qualified by education, training, and experience according to orientation and training requirements indicated within 10 CCR 2505-10, § 8.525.85.G. The Supportive Living Program shall have staff on duty as necessary to meet the needs of clients at all times, so that provision of services is not dependent upon the use of clients to perform staff functions. Volunteers may be

utilized in the home but shall not be included in the provider's staffing plan in lieu of employees.

9. The Supportive Living Program provider shall have written personnel policies. Each staff member shall be provided a copy upon employment and the administrator or designee shall explain such policies during the initial staff orientation period.

10. All Supportive Living Program provider staff, prospective staff, and volunteers shall undergo a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider.

8.515.85.H CLIENT RIGHTS AND PROPERTY

1. Clients shall have all rights stated in 10 CCR 2505-10 § 8.515.85.F.1, (HCBS Program Criteria) and in accordance with 42 C.F.R. § 441.301 (Jan. 16, 2014), which is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

2. The provider shall have policies on management of client funds and property consistent with those at 6 CCR 1011-1 Ch. 7, §§ 11.9 and 11.10~~1.105(3)~~.
~~, which states the following:~~
~~a. A facility may enter into a written agreement with the resident or resident's legal representative for the management of a resident's funds or property. However, there shall be no requirement for the facility to handle resident funds or property.~~
~~i. Written Agreement. A resident or the resident's legal representative may authorize the owner to handle the resident's personal funds or property. Such authorization shall be in writing and witnessed and shall specify the financial management services to be performed.~~
~~ii. Fiduciary Responsibility. In the event that a written agreement for financial management services is entered into, the facility shall exercise fiduciary responsibility for these funds and property, including, but not limited to, maintaining any funds over the amount of five hundred dollars ($500) in an interest bearing account, separate from the general operating fund of the facility, which interest shall accrue to the resident.~~
~~iii. Surety Bond. Facilities which accept responsibility for residents' personal funds shall post a surety bond in an amount sufficient to protect the residents' personal funds.~~
~~iv. Accounting.~~
~~1) A running account, dated and in ink, shall be maintained of all financial transactions. There shall be at least a quarterly accounting provided to the resident or legal representative itemizing in writing all transactions including at least the following: the date on which any money was received from or disbursed to the resident; any and all deductions for room and board and other expenses; any advancements to the resident; and the balance.~~
~~2) An account shall begin with the date of the first handling of the personal funds of the resident and shall be kept on file for at least three years following termination of the resident's stay in the facility. Such record shall be available for inspection by the Department.~~
~~v. Receipts. Residents shall receive a receipt for and sign to acknowledge disbursed funds.~~

3. Upon client request, a client shall be entitled to receive available money or funds held in trust.

8.515.85.I FIRE SAFETY AND EMERGENCY PROCEDURES

1. Applicants for initial provider Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by DFPC, in accordance with 8 CCR 1507-31 (Aug. 26, 2013), which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

2. Existing SLP providers as defined at 10 CCR 2505-10, § 8.515.85.D.1 may continue, through the use of a Department-approved exception as defined in 10 CCR 2505-10, § 8.515.85.D.1.b, to utilize existing fire safety systems approved by the local fire authority having jurisdiction until they demonstrate compliance with 8 CCR 1507-31 provided they remain in compliance with the following:

    a. There is no change in evacuation status of a client,

    b. nor a client admission or discharge that alters the residence overall fire safety rating, and

    c. no renovation of 25 percent or greater to the total interior of the physical plant is performed.

    d. If such a change, admission, discharge or renovation occurs, the home shall be required to meet the applicable standards referenced in 10 CCR 2505-10 § 8.515.85.I.1.

3. Providers shall develop written emergency plans and procedures for fire, serious illness, severe weather, disruption of essential utility services, and missing persons for each client. Emergency and evacuation procedures shall be consistent with any relevant local and state fire and life safety codes and the provisions set forth in 6 CCR 1011-1 Ch. 7, §10.~~1.104(5)(b) and (c),which state the following:~~

    ~~a. Emergency plan. The emergency plan shall include planned responses to fire, gas explosion, bomb threat, power outages, and tornadoes. Such plan shall include provisions for alternate housing in the event evacuation is necessary.~~

    ~~b. Disclosure to residents. Within three (3) days of admission, the plan shall be explained to each resident or legal representative, as appropriate.~~

    ~~c. The policy shall describe the procedures to be followed by the facility in the event of serious illness, serious injury, or death of a resident.~~

    ~~d. The policy shall include a requirement that the facility notify an emergency contact when the resident's injury or illness warrants medical treatment or face-to-face medical evaluation. In the case of an emergency room visit or unscheduled hospitalization, a facility must notify an emergency contact immediately, or as soon as practicable.~~

4. Within three (3) days of scheduled work or commencement of volunteer service, the program shall provide adequate training for staff in emergency and fire escape plan procedures.

5. Staff and clients shall have training on, and practices of, emergency plans and procedures, in addition to fire drills, at intervals throughout the year. There shall be at least two fire drills conducted annually during the evening and overnight hours while clients are sleeping. All such practices and training shall be documented and reviewed every six (6) months. Such documentation shall include any difficulties encountered and any needed adaptations to the plan. Such adaptations shall be implemented immediately upon identification.

8.515.85.J ENVIRONMENTAL AND MAINTENANCE REQUIREMENTS

1. A Supportive Living Program residence shall be designed, constructed, equipped, and maintained to ensure the physical safety of clients, personnel, and visitors as required by 6 CCR 1011-1, Ch. 7, §§ ~~1.111~~20, 21, 22, 23, and 24, regarding the interior and exterior environment.~~:~~

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

~~i. Potential Safety Hazards include:~~

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

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

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

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

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

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

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

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

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

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

~~a) Such appliances are not used for cooking;~~

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

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

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

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

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

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

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

~~9) Fire resistant wastebaskets. Enclosed areas on the premises where smoking is allowed shall be equipped with fire resistant wastebaskets. In addition, resident rooms~~

~~occupied by smokers, even when house rules prohibit smoking in resident rooms, shall have fire resistant wastebaskets.~~

~~ii. Potential Infection/Injury Hazards~~

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

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

~~iii. Heating, Lighting, and Ventilation~~

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

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

~~iv. Water~~

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

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

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

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

~~b. Exterior Environment~~

~~i. Potential Safety Hazards~~

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

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

2. The Supportive Living Program provider shall comply with all State and Local Laws/Codes regarding furnishings, equipment and supplies pursuant to 6 CCR 1011-1, Ch. 7, § 20.1~~1.112 (Aug. 14, 2013)~~, which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

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

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

    a. Handling of soiled linen and clothing;

    b. Storing personal care items;

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

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

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

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

7. The Supportive Living Program provider shall comply with all bathroom requirements regarding handrails, handholds, and other needs of clients pursuant to 6 CCR 1101-1 Ch. 7, § ~~1.112(4)~~22.
~~a. A full bathroom shall consist of at least the following fixtures: toilet, hand washing sink, toilet paper dispenser, mirror, tub or shower, and towel rack.~~
~~b. There shall be a bathroom on each floor having resident bedrooms which is accessible without requiring access through an adjacent bedroom.~~
~~c. In any facility which is occupied by one or more residents utilizing an auxiliary aid, the facility shall provide at least one full bathroom as defined herein with fixtures positioned so as to be fully accessible to any resident utilizing an auxiliary aid.~~
~~d. Bathtubs and shower floors shall have non-skid surfaces.~~
~~e. Grab bars shall be properly installed at each tub and shower, and adjacent to each toilet in any facility which is occupied by one or more residents utilizing an auxiliary aid or as otherwise indicated by the needs of the resident population.~~
~~f. Toilet seats shall be constructed of non-absorbent material and free of cracks.~~
~~g. The use of common personal care articles, including soap and towels, is prohibited.~~
~~h. Toilet paper in a dispenser shall be available at all times in each bathroom of the facility.~~
~~i. Liquid soap and paper towels shall be available at all times in the common bathrooms of the facility.~~

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

9. The Supportive Living Staff shall maintain a clean, safe, and healthy environment, including appropriate cleaning techniques and sanitary meal preparation and delivery according to 6 CCR 1011-1, Ch. 7, §~~ ~~ 17.~~1.109, which requires the following:~~

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

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

~~c. Facilities with twenty (20) beds or more shall comply with CDPHE's March 1, 2013 regulations on Colorado Retail Food Establishments at 6 CCR 1010-2, which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.~~

8.515.85.K COMPLAINTS AND GRIEVANCES

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

8.515.85.M RECORDS

1. Supportive Living Providers shall develop policies and procedures to secure client information against potential identity theft. Confidentiality of medical records shall be maintained in compliance with 45 C.F.R. §§ 160.101, et seq. and 164.102, et seq. (2014), which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

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

8.515.85.N REIMBURSEMENT

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

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

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

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

8.515.85.O CALCULATION OF CLIENT PAYMENT (PETI)

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

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

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

      ii. For an individual with financial responsibility for others:

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

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

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

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

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

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

4) Medications, with the following limitations:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adding Community or Facility Based care to CLLI Respite Services, Section 8.504
Rule Number: MSB 18-08-08-A
Division / Contact / Phone: Office of Community Living / Kathleen Homan / 303-866-5749

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 18-08-08-A, Revision to the Medical Assistance Rule concerning Adding Community or Facility Based care to CLLI Respite Services, Section 8.504
3. This action is an adoption of:	an amendment

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

   Sections(s) 10 CCR 2505 - §8.504.1.N (p. 88) and §8.504.2.F , 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 8.504 with the proposed text beginning at 8.3504 through the end of 8.504.9. This rule is effective December 30, 2018

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Adding Community or Facility Based care to CLLI Respite Services, Section 8.504
Rule Number: MSB 18-08-08-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 Community Options Benefits Section would like to amend the current Children with Life Limiting Illness (CLLI) Waiver rule to add community and facility-based options as a billable location for Respite benefits. Current rule only allows respite in the family's home or in the home of an approved care provider. Community and Facility based respite was previously in the CLLI waiver but had been removed due to zero utilization. The Department recently received stakeholder feedback from family members, providers and agency advocates that this service is needed. A rule change is necessary in order to increase access to care and support families. The Department intends for this service to be effective on January 1, 2019.

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:

   The Home and Community Based Services for Children with Life Limiting Illness program (HCBS-CLLI) in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2017);
   25.5-5-305 and 10 CCR 2505 - 10.8.504.1.N and 10.8.504.2.F

Initial Review	**10/12/18**	Final Adoption	**11/09/18**
Proposed Effective Date	**12/30/18**	Emergency Adoption	

DOCUMENT #04

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Title of Rule: Revision to the Medical Assistance Rule concerning Adding Community or Facility Based care to CLLI Respite Services, Section 8.504
Rule Number: MSB 18-08-08-A
Division / Contact / Phone: Office of Community Living / Kathleen Homan / 303-866-5749

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.

   Only eligible and enrolled Members of the CLLI waiver and their families will be affected by this change. Only eligible and enrolled Members of the CLLI waiver and their families will benefit from this proposed rule. The proposed rule does not increase 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.

   Current rule only allows for this service to be offered in the home. The qualitative impact of the rule change would be increased access to the community and increased socialization for the Member. This may be positive or negative depending on the individual. Respite is intended to provide short-term relief for the caregiver. Respite, outside of the home, may improve the caregiver's feelings of relief and comfort from the service. They may derive additional comfort having a community location for respite instead of having a caregiver welcomed into the family home. Facility based care may increase the caregiver's sense that an agency can adequately care for their family member instead of just one person in the family home. This service was previously in the waiver but eliminated due to low utilization and zero providers. The Department received assurances from the provider community that this service would be offered if approved.

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 further costs to the Department from this proposed rule. The potential increase of service utilization is unknown at this time. Agencies must follow appropriate licensing, credentialing and enrollment procedures through CDPHE and the Department. This may increase an agency's administrative costs if they are not currently a provider.

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

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The benefits of this rule include: increased community inclusion to Waiver Members, increased service providers in the community, increased access to services and increased choices of providers for Members and their families. There are no benefits for inaction but the probable costs of inaction include: ongoing service limitations for families, ongoing lack of choice in services for families and less community inclusion for Waiver Members. There are zero to minimal additional costs from this proposed rule. All potential benefits outweigh inaction as increasing access to care and access to services is invaluable.

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

   None.

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.

   None were proposed or rejected.

8.504 HOME AND COMMUNITY BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESS WAIVER

8.504.05 Legal Basis

The Home and Community Based Services for Children with Life Limiting Illness program (HCBS-CLLI) in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CLLI program is also authorized under state law at C.R.S. § 25.5-5-305 et seq. – as amended.

8.504.1 DEFINITIONS

A. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved assessment tool to complete assessments.

B. Bereavement Counseling means counseling provided to the client and/or family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a child with a life-threatening condition. Enabling the client and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.

C. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs.

D. Continued Stay Review (CSR) means a reassessment by the Single Entry Point case manager to determine the client's continued eligibility and functional level of care.

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

F. Curative Treatment means medical care or active treatment of a medical condition seeking to affect a cure.

G. Expressive Therapy means creative art, music or play therapy which provides children the ability to creatively and kinesthetically express their medical situation for the purpose of allowing the client to express feelings of isolation, to improve communication skills, to decrease emotional suffering due to health status, and to develop coping skills.

H. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

I. Life Limiting Illness means a medical condition that, in the opinion of the medical specialist involved, has a prognosis of death that is highly probable before the child reaches adulthood at age 19.

J. Massage Therapy means the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.

K. Palliative/Supportive Care is a specific program offered by a licensed health care facility or provider that is specifically focused on the provision of organized palliative care services. Palliative care is specialized medical care for people with life limiting illnesses. This type of care is focused on providing clients with relief from the symptoms, pain, and stress of serious illness, whatever the diagnosis. The goal is to improve the quality of life for both the client and the family. Palliative care is appropriate at any age (18 and under for this waiver) and at any stage in a life limiting illness and can be provided together with curative treatment. The services are provided by a Hospice or Home Care Agency who have received additional training in palliative care concepts such as adjustment to illness, advance care planning, symptom management, and grief/loss. For the purpose of this waiver, Palliative Care includes Care Coordination and Pain and Symptom Management.

1. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will allow for a seamless system of care. Care Coordination does not include utilization management, that is review and authorization of service requests, level of care determinations, and waiver enrollment, provided by the case manager at the Single Entry Point.

2. Pain and Symptom Management means nursing care in the home by a registered nurse to manage the client's symptoms and pain. Management includes regular, ongoing pain and symptom assessments to determine efficacy of the current regimen and available options for optimal relief of symptoms. Management also includes as needed visits to provide relief of suffering, during which, nurses assess the efficacy of current pain management and modify the regimen if needed to alleviate distressing symptoms and side effects using pharmacological, non-pharmacological and complementary/supportive therapies.

L. Prior Authorization Request (PAR) means the Department's prescribed form to authorize services.

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

N. Respite Care means services provided to an eligible client who is unable to care for himself/herself on a short-term basis because of the absence or the need for relief of those persons normally providing care. Respite Care ~~is provided in the client's residence and~~ may be provided through ~~by~~ different levels of care ~~providers~~ depending upon the needs of the client. Respite care may be provided in the client's residence, in the community, or in an approved respite center location.

O. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking or receiving services of his or her rights and responsibilities.

P. Therapeutic Life Limiting Illness Support means grief/loss or anticipatory grief counseling that assist the client and family to decrease emotional suffering due to the client's health status, to decrease feelings of isolation or to cope with the client's life limiting diagnosis. Support is intended to help the child and family in the disease process. Support is provided to the client to decrease emotional suffering due to health status and develop coping skills. Support is provided to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis for limited lifespan, surrounding the failing health status of the client, and impending death of a child. Support is provided to the client and/or family members in order to guide and help them cope with the client's illness and the related stress that accompanies the continuous, daily care required by a terminally ill child. Support will include but is not limited to counseling, attending physician visits, providing emotional support to the family/caregiver if the child is admitted to the hospital or having stressful procedures, and connecting the family with community resources such as funding or transportation.

Q. Utilization Review means approving or denying admission or continued stay in the waiver based on level of care needs, clinical necessity, amount and scope, appropriateness, efficacy or efficiency of health care services, procedures or settings.

8.504.2 BENEFITS

8.504.2.A. Home and Community Based Services under the Children with Life Limiting Illness Waiver (HCBS-CLLI) benefits shall be provided within Cost Containment.

8.504.2.B. Therapeutic Life Limiting Illness Support may be provided in individual or group setting.

1. Therapeutic Life Limiting Illness Support shall only be a benefit if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

2. Therapeutic Life Limiting Illness Support is limited to the client's assessed need up to a maximum of 98 hours per annual certification period.

8.504.2.C. Bereavement Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

1. Bereavement Counseling is limited to the client's assessed need and is only billable one time.

2. Bereavement Counseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

8.504.2.D. Expressive Therapy may be provided in an individual or group setting.

1. Expressive Therapy is limited to the client's assessed need up to a maximum of 39 hours per annual certification period.

8.504.2.E. Massage Therapy shall be provided in an individual setting.

1. Massage Therapy shall only be used for the treatment of conditions or symptoms related to the client's illness.

2. Massage Therapy shall be limited to the client's assessed need up to a maximum of 24 hours per annual certification period.

8.504.2.F. Respite Care shall be provided in the home, in the community, or in an approved respite center location of an eligible client on a short term basis, not to exceed 30 days per annual certification as determined by the Department approved Assessment. Respite Care shall not be provided at the same time as state plan Home Health or Palliative/Supportive Care services.

1. Respite Care services include any of the following in any combination necessary according to the Support Planning services:

   a. Skilled nursing services;

   b. Home health aide services; or

   c. Personal care services

8.504.2.G. Palliative/Supportive Care shall not require a nine month terminal prognosis for the client and includes:

1. Pain and Symptom Management; and

2. Care Coordination

8.504.2.H. HCBS-CLLI clients are eligible for all other Medicaid state plan benefits, including Hospice and Home Health.

8.504.3 NON-BENEFIT

8.504.3.A. Case Management is not a benefit of the HCBS-CLLI waiver. The Single Entry Point (SEP) provides case management services as an administrative activity.

8.504.4 CLIENT ELIGIBILITY

8.504.4.A. An eligible client shall:

1. Be financially eligible.

2. Be at risk of institutionalization into a hospital as determined by the SEP case manager using the Department approved assessment tool.

3. Meet the target population criteria as follows:

   a. Have a life-limiting diagnosis, as certified by a physician on the Department prescribed form, and

   b. Have not yet reached 19 years of age.

8.504.4.B A client shall receive at least one HCBS-CLLI waiver benefit per month to maintain enrollment in the waiver.

1. A client who has not received at least one HCBS-CLLI waiver benefit during a month shall be discontinued from the waiver.

2. Case Management does not satisfy the requirement to receive at least one benefit per month on the HCBS-CLLI waiver.

8.504.5 WAIT LIST

8.504.5.A. The number of clients who may be served through the waiver at any one time during a year shall be limited by the federally approved HCBS-CLLI waiver document.

8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-CLLI waiver, who cannot be served within the capacity limits of the federally approved waiver, shall be eligible for placement on a wait list maintained by the Department.

8.504.5.C. The SEP case manager shall ensure the applicant meets all criteria as set forth in Section 8.504.4.A prior to notifying the Department to place the applicant on the wait list.

8.504.5.D. The SEP case manager shall enter the client's Assessment and Professional Medical Information Page data in the Benefits Utilization System (BUS) and notify the Department by sending the client's enrollment information, utilizing the Department's approved form, to the program administrator.

8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish the order of an applicant's place on the wait list.

8.504.5.F. Within five working days of notification from the Department that an opening for the HCBS-CLLI waiver is available, the SEP case manager shall:

1. Reassess the applicant for functional level of care using the Department approved assessment tool if the date of the last Assessment is more than six months old.

2. Update the existing Department approved assessment tool data if the date is less than six months old.

3. Reassess for the target population criteria.

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

8.504.6 PROVIDER ELIGIBILITY

8.504.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CLLI waiver, enter into an agreement with the Department. Providers must comply with the requirements of 10 CCR 2505-10, Section 8.130.

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

8.504.6.C. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

8.504.6.D. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall be one of the following:

1. Licensed Clinical Social Worker (LCSW)

2. Licensed Professional Counselor (LPC)

3. Licensed Social Worker (LSW)

4. Licensed Independent Social Worker (LISW)

5. Licensed Psychologist; or

6. Non-denominational spiritual counselor, if employed by a qualified Medicaid home health or hospice agency.

8.504.6.E. Individuals providing Expressive Therapy shall enroll with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

1. Individuals providing Expressive Therapy delivering art or play therapy services shall meet the requirements for individuals providing Therapeutic Life Limiting Illness Support services and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent clients.

2. Individuals providing Expressive Therapy delivering music therapy services shall hold a Bachelor's, Master's or Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists, and have at least one year of experience in the provision of music therapy to pediatric/adolescent clients.

8.504.6.F. Massage Therapy providers shall have an approved registration and be in good standing with the Colorado Office of Massage Therapy Registration.

8.504.6.G. Individuals providing Palliative/Supportive Care services shall be employed by or working under a formal contract with a qualified Medicaid hospice or home health agency.

8.504.6.H. Individuals providing Respite services shall be employed by a qualified Medicaid home health, hospice or personal care agency.

8.504.7 PROVIDER RESPONSIBILITIES

8.504.7.A. HCBS-CLLI 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 19-3-307 C.R.S. (2016).

8.504.7.B. HCBS-CLLI 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 SEP 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 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. Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.

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

7. Documentation of communication with the client's SEP case manager.

8. Documentation of communication/coordination with other providers.

b. Personnel records for each employee shall contain:

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

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 8.504.7.A.

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

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

8.504.8 PRIOR AUTHORIZATION REQUESTS

8.504.8.A. The SEP case manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CLLI waiver.

8.504.8.B. All units of service requested shall be listed on the Support Planning form.

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

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

2. The assigned start date on the certification page of the Department approved assessment tool.

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

8.504.8.D. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Department approved assessment tool.

8.504.8.E. The SEP case manager shall submit a revised PAR if a change in the Support Planning results in a change in services.

8.504.8.F. The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.

8.504.8.G. Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.

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

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

8.504.9 REIMBURSEMENT

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

1. Submitted charges; or

2. A fee schedule as determined by the Department.