DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Program Integrity, Section 8.000
Rule Number: MSB 19-01-30-A
Division / Contact / Phone: Audits and Compliance / Sarah Geduldig / 303-866-2341

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 19-01-30-A, Revision to the Medical Assistance Rule concerning Program Integrity, Section 8.000
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) 8.040, 8.050, 8.076, 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 8.040 with the proposed text at 8.040. Replace the current text at 8.050 with the proposed text beginning at 8.050.1 through the end of 8.050.7.B. Replace the current text at 8.076 with the proposed text beginning at 8.076.1 through the end of 8.076.7.B. This rule is effective August 30, 2019.

*to be completed by MSB Board Coordinator

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STATEMENT OF BASIS AND PURPOSE

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

   The Department is revising 10 CCR 2505-10, Section 8.040 Recovering from Providers, Section 8.050 Provider Appeals, and Section 8.076 Program Integrity. These sections outline the Department's program integrity efforts, including monitoring and ensuring compliance with federal and state statutes, rules and preventing provider fraud, waste, and abuse. The proposed revisions will provide additional guidance and outline processes for responding to a request for written response from the Department, provider self-disclosures, provider training on the False Claims Act and whistleblower protections, suspension of payments due to a credible allegation of fraud, and provider reinstatement after a for cause termination.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. Sec. 1320a-7k(d)(2); 42 C.F.R. § 455.23; 42 C.F.R. § 1002.215

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   25.5-4-301

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

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REGULATORY ANALYSIS

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

   The classes of persons who will be affected by the proposed rule are providers. This rule should not create any direct costs to providers.

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

   Providers will benefit from the revisions because the provider should gain a better understanding of the processes and guidance for preventing fraud, waste, and abuse.

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

   This rule should not create any additional costs to the Department, and could result in increased recoveries for overpayments made to providers.

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

   This rule should not result in additional costs to the Department. The rule outlines tools to prevent fraud, waste, and abuse and will likely increase the overpayment recoveries made by the Department, increase the amount of money self-disclosed to the Department, and prevent some future instances of fraud, waste, and abuse. There is also potential for cost avoidance by creating a process for ensuring previously terminated providers must be approved before enrolling again and clarifying some of the language around good cause to terminate a provider.

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

   This rule should not create any additional costs to the Department, so no less costly methods were available.

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

   No alternative methods were considered.

8.040 RECOVERIES FROM PROVIDERS

In the event that an audit or other competent evidence (e.g. information provided by another government agency) reveals that a Pprovider is indebted to the State for any reason, the Department shall recover this amount either through a repayment agreement with the Pprovider, ~~; or~~ by offsetting the amount owed against current and future claims of the Pprovider, ~~; or~~ through litigation, ~~;~~ or by any other appropriate action within its legal authority.

~~Providers shall will have the right to appeal pursuant to the provisions of Section 8.050.~~

8.050 PROVIDER APPEALS

8.050.1 DEFINITIONS

1. Adverse Action means:

   a. ~~An adverse action means a~~The Department or its designees makes a finding of fact or interpretation of rules that results in a determination that goods or services were not medically necessary; results in identification of o~~e~~verpayments; or results in a reduction in, or denial of, other specific payments under the Medical Assistance program.~~; or~~

   b. The denial, non-renewal or termination of a Provider agreement.~~; or~~

   c. The d~~D~~enial of, ~~the application~~ or request for additional information regarding an application for Medicaid Certification of a Nursing Facility pursuant to ~~10 C.C.R. 2505-10,~~ Section 8.430.~~; or~~

   d. The suspension of payments due to a determination of a credible allegation of fraud.

2. Mailed means caused to be directed, transmitted, or made available and includes, but ~~shall~~ is not ~~be~~ limited to:

   a. The use of the United States Postal Service~~, when requested by the provider~~;

   b. The use of electronic mail (e-mail);

   c. Making a notice available for retrieval through the Internet or an internet application, as long as notification of the availability is provided through e-mail;

   d. The use of private courier or delivery services; and

   e. The use of facsimile (fax) machines.

3. Medical assistance shall have the meaning defined in S~~s~~~~S~~ection 25.5-1-103(5), C.R.S.

4.

~~4.~~ Provider means any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods.

~~means any person, public or private institution, agency, or business concern that:~~

~~a. Provides medical or remedial care, services or goods authorized under the Medical Assistance program;~~

~~b. Holds, where applicable, a current valid license or certificate to provide such services or to dispense such goods; and~~

~~c. Is enrolled in the Medical Assistance program.~~

8.050.2 NOTICE OF ADVERSE ACTION

8.050.2.A. A notice of Adverse Action shall be in writing, ~~and shall be m~~Mailed to the Provider, and include the following: ~~.~~

1. A~~The notice shall include a~~ statement of what action the Department intends to take.

2. ~~The notice shall include t~~The reasons for the intended action and the applicable regulations in support of that action.

3. ~~The notice shall include t~~Information about appeal rights. ~~he right to appeal the action.~~

8.050.2.B. A notice of Adverse Action regarding a nursing facility's rate determination shall include a description of the method of rate calculation, the recommended or proposed audit adjustments with an explanation of adjustments and the final rate established.

8.050.2.C. A notice of Adverse Action regarding a determination of overpayment(s) following a review or an audit of a provider shall include the offer of an informal reconsideration of the review or audit findings and notice that no recovery of the overpayment will be implemented until such informal reconsideration, if requested, has been completed.

8.050.3 PROVIDER APPEALS

8.050.3.A. A Provider, other than a nursing facility whose notice of Adverse Action is regarding a rate determination, may appeal a notice of Adverse Action by filing a written appeal within thirty (30) calendar days from the date on the n~~N~~otice of Adverse Action. The appeal shall be filed with the Office of Administrative Courts, Department of Personnel and Administration 1525 Sherman Street, Fourth Floor, Denver, CO 80203.

8.050.3.B. The appeal shall specify the basis upon which the Provider appeals the Adverse Action.

8.050.3.C. The date of filing the appeal shall be the date the Office of Administrative Courts receives the appeal. Failure to file a timely appeal shall result in dismissal of the appeal.

8.050.3.D. No recovery of an overpayment shall be implemented until the appeal process has been completed.

8.050.4 NURSING FACILITY RATE DETERMINATION APPEALS

8.050.4.A. Mandatory Informal Reconsiderations

1. A nursing facility, whose notice of Adverse Action results from its rate determination, may file a written request for informal reconsideration with the Department within thirty (30) days of the date the rate determination letter is mailed or the date that the nursing facility is notified that an electronic copy of the rate determination letter is available for review, whichever is later. The request shall state, with specificity, the adjustments to the cost report the nursing facility wants reconsidered and the nursing facility's position as to each adjustment.

2. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.

3. When the first rate letter that incorporates a nursing facility's new appraised value is issued or made available electronically to the facility, the nursing facility may file a written request with the Department for informal reconsideration of the appraisal within thirty (30) days of the date on the rate letter or the date that the facility was notified that an electronic copy of the rate letter is available for review, whichever is later. Failure to file an informal reconsideration as set forth in this section shall cause any subsequent reconsideration or appeal of the appraisal at issue to be untimely and the reconsideration or appeal shall be dismissed.

4. Failure to file a written request for reconsideration as set forth in this section shall result in a waiver of the right to appeal the Adverse Action. Any issue not presented for informal reconsideration shall not be considered and shall not be appealable to the Office of Administrative Courts.

5. At informal reconsideration, the Provider shall not be allowed to present any information that was not submitted during the audit process prior to the issuance of the rate determination. The end of the audit process is defined as the expiration of the proposed adjustment review period as specified in ~~section 10 CCR 2505-10~~Sections ~~§§~~8.442.3.B and 8.442.3.C.

8.050.4.B. The nursing facility may file an appeal with the Office of Administrative Courts of the Department's written decision on the informal reconsideration within thirty (30) days of the date of the written decision. The appeal shall conform to the requirements of Section 8.050.3.

8.050.4.C. Should the Department not issue a written decision on the informal reconsideration within forty-five (45) days of the Department's receipt of the request for informal reconsideration, the nursing facility may file an appeal with the Office of Administrative Courts within thirty (30) days of the 45th day following receipt of the request for informal reconsideration.

8.050.4.D. Notwithstanding the position of the parties, their conduct or statements made during the ~~i~~informal ~~r~~Reconsideration process, any subsequent appeal initiated by the nursing facility shall be a de novo proceeding. ~~, and n~~Neither the Department nor the nursing facility shall be bound by their positions, conduct or statements made as part of the informal reconsideration process. The evidence submitted by the nursing facility and considered at the de novo proceeding~~,~~, shall be limited to that which was submitted during the audit process prior to the issuance of the rate determination being appealed. No new nursing facility information or documentary evidence shall be admissible at the de novo proceeding.

8.050.4.E. The administrative law judge (ALJ) may not under any circumstances alter the appraisal methodology used by the contract appraiser. The ALJ has no authority to consider appeals from providers requesting the use of any method for calculation of depreciation other than the cost valuation system used by the contract appraiser.

~~The administrative law judge (ALJ) shall not under any circumstances alter the appraisal methodology which is described in the most recent Request for Proposal (RFP). This limitation means the RFP~~

~~defines how the appraisal is to be conducted and the ALJ may not change the RFP's described method. In particular, where the RFP describes which variables or components from the Boeckh program are to be specifically calculated through Boeckh's built-in data, those requirements from the RFP cannot be altered by the ALJ. This limitation on the ALJ's scope of review also means that where the RFP requires physical depreciation to be calculated through the use of the tables published in the Boeckh manual, the ALJ has no authority to consider appeals from providers requesting the use of alternative tables or any other method of calculating depreciation.~~

8.050.4.F. The ALJ may alter the findings of fact, judgments and opinions contained in the appraisal report (e.g. measurements, decisions regarding the depreciation components of effective age and building condition) when supported by the evidence.

8.050.5 EXEMPTIONS FROM MANDATORY INFORMAL RECONSIDERATION IN NURSING FACILITY RATE DETERMINATION APPEALS

8.050.5.A. The following nursing facility rate issues are exempt from mandatory informal reconsideration.

1. In the case of Class I and Class II nursing facilities or private for-profit or non-profit nursing facility Class IV Providers, the nursing facility's right to appeal shall commence on the mailing date of the rate letter setting a rate based on the maximum reasonable cost calculation or on the date the facility array and other data used by the Department in its determination of the maximum reasonable rate is made available to Providers. This appeal period shall then expire thirty (30) days after the commencement date.

2. In the case of state-administered Class IV intermediate ~~nursing~~ care facilities for ~~the~~ individuals with intellectual disabilities ~~mentally retarded w~~which are not subject to maximum reasonable cost calculations, the nursing facility's right to appeal shall commence on the mailing date of the nursing facility's rate letter setting the final rate based on the facility's actual allowable audited costs as reported on the form MED-13. Such appeal period shall then expire thirty (30) days after the commencement date. The Office of Administrative Courts shall not conduct the appeal hearing. The appeal process shall be resolved by both agencies presenting their position to the Governor's office. The Governor's decision shall be binding on both agencies.

3. An appeal of ~~from~~ the imposition of a civil money penalty or the denial of a Medicaid payment for a Medicaid-only certified nursing facility's failure to meet federal requirements for participation in Medicaid, shall follow the formal appeal process set forth in ~~10 C.C.R. 2505-10,~~ Section 8.050.3. The penalty shall not be enforced or collected until the Department sends a certified letter to the Provider explaining the penalty or the denial of payment. In cases where the Provider appeals the penalty, collection of the penalty shall be suspended until the ALJ~~administrative law judge~~ adjudicates the appeal.

8.050.6 INFORMAL RECONSIDERATIONS AND APPEALS OF OVERPAYMENTS RESULTING FROM REVIEW OR AUDIT FINDINGS

8.050.6.A. A Provider whose notice of Adverse Action results from a determination of overpayment(s), may file a written request for informal reconsideration with the Department within thirty (30) calendar days of the date of the notice of Adverse Action.

1. Requests made by telephone shall not be accepted.

2. The written request shall include ~~the following~~:

a. The specific overpayments the Provider wants reconsidered;

b. The Provider's position as to each overpayment; and

c. Documentation that has not already been provided to the Department that substantiates the Provider's position as to each overpayment.

3. If a Provider files a written request for informal reconsideration of an Adverse Action and an appeal of the same Adverse Action before a decision has been rendered on the informal reconsideration, the appeal shall control, and the request for an informal reconsideration shall not be acted upon.

8.050.6.B. Requests that do not comply with the requirements of this section shall be considered incomplete and shall be denied.

8.050.6.C. The Department shall issue a written decision on the informal reconsideration within forty-five (45) calendar days of the date on which the Department received the request for informal reconsideration. The Pprovider may file a written appeal of the informal reconsideration decision no later than thirty (30) calendar days from the date of the informal reconsideration decision pursuant to Section 8.050.3.

8.050.6.D. If the Department is unable to issue a written decision on the informal reconsideration decision within the time period described at Section 8.050.6.C., then the Department shall notify the Provider of its inability to complete the decision. The Provider may file a written appeal no later than 30 calendar days from the date of the notice stating that the Department is unable to render an informal reconsideration decision pursuant to Section 8.050.3.

8.050.6.E. Notwithstanding the position of the parties, their conduct or statements made during the ~~i~~nformal r~~R~~econsideration process, any subsequent appeal initiated by the Provider shall be a de novo proceeding, and neither the Department nor the Provider shall be bound by their prior positions, conduct or statements.

8.050.6.F. No recovery of an overpayment shall be implemented until the informal reconsideration and appeals process has been completed.

~~**8.050.7 STAY**~~

~~If an appeal is filed, upon motion of the Provider, the administrative law judge may stay the effective date of the adverse action until final agency action.~~

8.050.~~7~~8 CONDUCT OF HEARINGS

8.050.~~8~~7.A. Except as otherwise specifically provided in these rules, the provisions of Section 24-4-105, C.R.S., as amended, shall apply to the conduct of fair hearings.

8.050.~~8~~7.B. For nursing home appeals regarding appraisals, the ALJ~~administrative law judge~~ shall not, under any circumstance, alter the appraisal methodology from the most recent ~~RFP~~ Request for Proposal but may alter the finding of fact, judgments and opinions contained in the appraisal report if supported by the evidence.

8.076 PROGRAM INTEGRITY

8.076.1 DEFINITIONS

1. Abuse means Provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medical Assistance program, an Oeverpayment by the Medical Assistance program, or in reimbursement for goods or services that are not medically necessary, as defined at Section 8.076.1.8., or that fail to meet professionally recognized standards for health care. These practices may include, but are not limited to:

    a. Billing for goods or services without valid documentation to support the claims submitted for reimbursement.

    b. Unbundling charges on claims for goods or services by separating components of a group of procedures that are required to be billed together (or bundled), and billing each component separately.

    c. Submitting a fee-for-service claim or claims for goods or services before they have been provided.

    d. Signing prior authorizations or physician's orders for goods or services that are inappropriate or not medically necessary for the client.

    e. Presenting or causing to be presented for payment any false or fraudulent claim for goods or services.

    f. Submitting or causing to be submitted false information for the purpose of obtaining greater compensation than that to which the provider is legally entitled.

    g. Submitting or causing to be submitted false information for the purpose of meeting prior authorization requirements.

    h. Failing to retain or disclose or make available to the Department or its authorized agent(s) records of goods or services provided to eligible clients and related records of payments when requested.

    i. Engaging in a course of conduct or performing an act deemed improper or continuing such conduct following notification that said conduct should cease.

    j. Visiting a facility, such as a nursing home, and billing for individual visits without rendering any specific service to individual clients.

    k. Overutilizing by inducing, furnishing, or otherwise causing a client to receive goods or services not otherwise required or requested by the client or prescribing Ppprovider.

    l. Violating any applicable regulation listed at 10 C.C.R. 2505-10, Section 8.000, et. seq. or failing to comply with any guidance provided by the Department, including but not limited to provider bulletins and billing manuals.

    m. Submitting a false or fraudulent application for provider enrollmentstatus.

n. Violating any laws or regulations pertaining to federal or state health care programs or failing to meet professionally recognized standards for health care.

o. Conviction of a criminal offense relating to:

i) Performance of the Provider Agreement with the State;

ii) Negligent practice resulting in the death or injury to patients;

iii) Patient abuse;

iv) Fraudulent billing practices; ~~or~~

v) Misuse or misapplication of program funds; ~~.~~

vi) The unlawful manufacture, distribution, prescription or dispensing of controlled substances; or

vii) Actions that indicates a Provider may pose a risk to the health, safety, or well-being of a client.

p. Failure to meet standards required by state or federal law for participation such as licensure or certification requirements.

q. Failure to correct deficiencies in provider operations in accordance with an accepted plan of correction or written response after receiving written notice of these deficiencies from the Department, its designees, or other state agencies.

r. Formal reprimand or censure by an association of the P~~p~~rovider's peers or the appropriate state or federal regulatory or licensing body for unethical, illegal, or improper practices.

s. Suspension, exclusion, or termination from participation in another governmental medical program for fraudulent or abusive practices.

t. Failure to repay or make arrangements to repay O~~o~~verpayments or payments made in error.

u. Use of another P~~p~~rovider's provider identification number for the purpose of obtaining reimbursement.

v. Use of client identification numbers to submit claims for reimbursement for goods or services that were not rendered or delivered.

w. Alteration of any source documentation performed to support claims billed or creation of new source documentation to support claims billed when the alteration or creation occurs after a request for documentation is received by the P~~p~~rovider from the Department or its agent. Alteration does not include a late entry that is signed and dated when documented or transcriptions made to facilitate a Department review.

x. Upcoding services by submitting claims for a higher level of goods or services than what was provided or medically necessary.

2. Conviction or Convicted means that:

a. A judgment of conviction has been entered against an individual or an entity by a federal, state, or local court, regardless of whether there is a post-trial motion or an appeal pending;

b. A federal, state, or local court has made a finding of guilt against an individual or entity;

c. A federal, state, or local court has accepted a plea of guilty or *nolo contendere* by an individual or entity; or

d. An individual or entity has entered into participation in a first offender, deferred adjudication, or other program or arrangement where judgment of conviction has been withheld.

3. Excluded means a Provider that has been barred from participating in any health care program by the Office of Inspector General for the United States Department of Health and Human Services (OIG). ~~pursuant to 42 USC §1320a-7(a) or (b). 42 USC §1320a-7(a) and 42 USC §1320a-7(b) are incorporated herein by reference. No amendments or later editions are incorporated. Copies are available for inspections from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203-1818. Any material that has been incorporated by reference in this rule may be examined at any state publications repository library.~~

4. False Rr~~e~~presentation means an inaccurate statement that is relevant to a claim for reimbursement or Prior Authorization Request~~s~~ and is made by a Provider who has actual knowledge of the truth or false nature of the statement, or by a Provider acting in deliberate ignorance of or with reckless disregard for the truth of the statement. A Provider acts with deliberate ignorance of or with reckless disregard for the truth if the Provider fails to maintain records required by the Department or if the Provider fails to become familiar with rules, manuals, and bulletins issued by the Department, board or the Department's fiscal agent.

5. Fraud means an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to her/himself or some other person. It includes any act that constitutes fraud under ~~applicable~~ any federal or state law.

6. Furnished ~~refers to~~means goods ~~and~~ or services provided directly by, or under the direct supervision of, or ordered by, a practitioner or other individual (either as an employee or in his or her own capacity), a Provider, or other supplier of goods or services.

7. Good cause, for the purpose of withholding payments to a provider ~~,~~ or ~~or~~ denying, terminating, or not renewing a Provider agreement means:

a. The Provider has failed to comply substantially with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent.

b. The Provider has not complied with applicable federal and state statutes and regulations.

c. The Provider, either by omission or commission, is endangering or has endangered the health, safety, or well-being of a program services client or cients.

~~beneficiary or beneficiaries.~~

d. The owner, operator, partner, or other participating employee of the Provider has previously owned, operated, or otherwise participated in and received direct or indirect payment from the Medical Assistance Program and has a documented pattern of program abuse, substandard care, endangerment of the health or well-being of clients, or non-compliance with program requirements.

e. The Provider's license or certification has expired, been revoked, ~~or~~ suspended, ~~or~~ surrendered while a formal disciplinary proceeding was pending before a state licensing authority, or for any other reason is invalid at the time goods are provided or services are rendered for which claims are submitted for reimbursement.

f. The Provider has been excluded, ~~or~~ suspended, or terminated from any~~the~~ Medical Assistance program of another state or has been excluded, ~~or~~ suspended, terminated or had had its billing privileges revoked ~~from reimbursement~~ under the Medicare program, or has been excluded by the OIG~~h~~ unless a waiver is granted by the ~~Department of Health and Human Services Office of Inspector General~~OIG.

g. The Provider has failed to fully and accurately make any disclosures required by federal and state statutes or regulations.

h. Any Provider, or person with an ownership or controlling interest in the Provider, or who is a Provider's agent or managing employee, ~~who~~ has been convicted of a criminal offense ~~related to that person's involvement in any program established under Medicare or Medicaid~~outlined in Section 8.076.1.1.o.

i. The Provider has demonstrated a pattern of A~~a~~buse.

j. The Provider has engaged in F~~f~~alse R~~r~~epresentation and/or F~~f~~raud in submitting Medical Assistance program claims.

k. The Provider has billed or sought collection through a third party from a client or the estate of a client~~solicited or accepted from an eligible client~~, his or her family, friend, ~~estate,~~ or other representative, for any amount ~~over and above the Medical Assistance program reimbursement amount~~ for covered goods or services, excluding any required copayment, coinsurance, or other client cost-sharing amounts, and failed, once notified by the Department, to correct the billing or collection action.~~.~~

l. The Provider has failed to return money paid by clients for covered goods or services rendered during any period of client eligibility. This includes failing to pay back clients for goods or services for which they were charged when their eligibility was determined retroactively and there is evidence of notification of retroactive eligibility for the client, regardless of whether payment for the covered goods or services were received.

m. The Provider owes the Department an outstanding balance and has failed to enter into a payment plan with the Department or the provider has failed to comply with a payment plan it had previously entered into.

n. The Provider has failed to provide a written response within thirty (30) days of the Department's request or the Provider has provided a written response but failed

to meet the requirements set out in the Department's request as described in Section 8.076.6.

o. The Provider has failed to provide information related to the False Claims Act and whistle-blower protections described in Section 8.076.7, within thirty (30) days of the Department's request.

8. Medical necessity means a Medical Assistance program good or service:

a. Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all;-

b. Is provided in accordance with generally accepted professional standards for health care in the United States;

c. Is clinically appropriate in terms of type, frequency, extent, site, and duration;

d. Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;

e. Is delivered in the most appropriate setting(s) required by the client's condition;

f. Is not experimental or investigational; and

g. Is not more costly than other equally effective treatment options.

~~8.1 For EPSDT-specific criteria, see 10 C.C.R. 2505-10, Section 8.280.4.E.~~

9. Overpayment means the amount paid to a Provider which is in excess of the amount that is allowable for goods or services furnished ~~under Section 1902 of the Social Security Act and~~ and which is required by Title XIX of the S~~s~~ocial S~~s~~ecurity A~~a~~ct to be refunded. An Overpayment may include, but is not limited to, improper payments made as the result of fraud, waste, and abuse.

~~to be refunded under Section 1903 of the Act.~~

10. Provider means any person, public or private institution, agency, or business concern enrolled under the state Medical Assistance program to provide medical care, services, or goods and holding, where applicable, -a current valid license or certificate to provide such services or to dispense such goods.~~Provider means any person, public or private institution, agency, or business concern providing medical or remedial care, services or goods authorized under the Medical Assistance program and holding, where applicable, a current valid license or certificate to provide such services or to dispense such goods, and enrolled in the Medical Assistance program~~

~~11. Suspension means that goods or services furnished by a specific Provider who has been convicted of a program-related offense in a federal, state or local court will not be reimbursed under the Medical Assistance program.~~

8.076.2 COMPLIANCE MONITORING

8.076.2.A. All Providers shall comply with the efforts of the Department, the U.S. Department of Health and Human Services (HHS)~~its designees~~, any investigative entity, ~~or~~ the Medicaid Fraud Control Unit (MFCU), or their designees to monitor Provider compliance with federal and state Medical Assistance program statutes, ~~and~~ regulations and guidance in order to detect and correct noncompliance and prevent fraud, waste and abuse.

8.076.2.B. Compliance monitoring includes, but is not limited to:

1. Conducting prospective, concurrent, and/or post-payment reviews of claims.

2. Verifying Provider adherence to professional licensing and certification requirements.

3. Reviewing goods provided and services rendered for fraud, waste and abuse.

4. Reviewing compliance with rules, manuals, and bulletins issued by the Department, board, or the Department's fiscal agent.

5. Reviewing compliance with nationally recognized billing standards and those established by professional organizations including, but not limited to, Current Procedural Terminology (CPT), ~~and~~ Current Dental Terminology (CDT), and Healthcare Common Procedure Coding System (HCPCS).

6. Reviewing adherence to the terms of the Provider Participation Agreement.

8.076.2.C. Compliance monitoring activities may include, but are not limited to:

1. Site reviews.

2. Desk audits.

3. Medical records reviews.

4. Claims reviews.

5. Data mining.

8.076.2.D. The ~~US Department of Health and Human Services, the~~ Department, HHS, investigative entities, the MFCU, or their designees ~~the Medicaid Fraud Control Unit, or their designees~~ has the right to audit and confirm any information submitted by the Provider to the Medical Assistance program. The Provider shall furnish information about submitted claims, claim documentation records, and original source documentation including, but not limited to, provider and patient signatures; medical, accounting, or financial records; or any other relevant information upon request.

8.076.2.E. ~~The Department or its designees shall provide a~~A written request to review records shall be provided to the Provider ~~to review records~~. This request shall include clearly defined due dates for submitting requested records, and the procedures for requesting an extension of time to submit the requested records~~, and the procedures for requesting an informal reconsideration or an appeal~~. This request shall include the option of providing paper copies of records, electronic copies of records in a format that is compatible with the Department's or its designee's systems, or an inspection or reproduction of the records by the Department or its designees at the Provider's site. Medical records requested for review shall be provided to the Department at the

expense of the Provider. The Provider shall submit or produce the requested materials within forty-five (45) calendar days unless:

1. The review is based on quality of care concerns, in which case the materials shall be submitted within fourteen (14) calendar days of the request; ~~or~~

2. The request is made during the course of a civil or criminal investigation, in which case the records shall be submitted immediately upon request; or~~.~~

3. The request is made during the course of an external audit with the state or federal government, in which case the records shall be submitted within the timeframe the external auditors request.

8.076.2.F. Records received by the Department after the forty-five (45) calendar day deadline may ~~shall not~~ be considered in the review at the Department's discretion.~~, unless the Department has granted a written extension.~~ The written request for an extension to submit records must be received by the Department within fifteen (15) calendar days from the date of the Department's request. Telephone requests shall not be accepted. The request shall specify the additional time requested and the circumstances present that require an extension of time.

8.076.2.G. Any claims submitted for which documentation is not received within the time limits specified in this section shall be considered an O~~o~~verpayment subject to recovery regardless of whether goods or services have been provided.

8.076.2.H. A Provider subject to a review or audit may request an interview in person or by telephone with the Department or its designees before the final written post-review correspondence is released. The request for an interview must be in writing, specify whether an in person or telephone interview is being requested, and must be received by the Department within ten (10) calendar days from the date of the Department's request for records. During this interview, the Provider may discuss the preliminary findings of the review or audit, what documentation the Provider may use to refute the findings, and the next steps in the review or audit process.

8.076.2.I. For ~~The Department's post-review formal correspondence shall indicate areas of strength, suggestions for improvement and required actions, unless the review is conducted for the purpose of post-payment review. For~~ all post~~-~~payment reviews, the Provider shall receive a letter identifying the O~~o~~verpayment demand or notice of no repayments. This notice shall include the procedures for requesting an informal reconsideration or an appeal.

8.076.2.J. ~~Duplication of Records —~~ The staff of the Department, HHS, investigative entities, the MFCU, or their designees ~~staff, its designees, or the Medicaid Fraud Control Unit~~ may photocopy or otherwise duplicate any paper or electronic document, chart, policy, or other record relating to medical care or services provided, charges to or payments made by clients, or goods or services provided for which a claim is submitted. The ~~Department or its designees and the Medicaid Fraud Control Unit shall be allowed to~~ use of duplicating equipment on the Provider's premises shall be allowed to the extent that such use results in minimal disruption of the Provider's business. If such use of duplicating equipment will~~shall~~ cause more than minimal disruption of business, the Provider shall notify the Department in writing or by telephone, and the Department shall attempt to resolve the issue with the Provider or make other arrangements.

8.076.2.K. Providers who maintain records to substantiate their claims for reimbursement in another entity's records including, but not limited to, a nursing facility, adult day care center, or hospital, ~~shall be~~are still subject to the requirements set forth at Section~~s~~ 8.076.2.E.

8.076.2.L. The Department may delegate compliance monitoring activities to its designees.

8.076.2.M. Nothing in Ssection 8.076 shall be construed as limiting the right of the Department to conduct quality improvement activities in accordance with the provisions of Ssection 8.079.

8.076.2.N. Nothing in Ssection 8.076 shall be construed as limiting the right of the Department to conduct emergency site visits when the Department has concerns about client safety, quality of care, fraud, abuse, or Provider financial failure.

8.076.3 RECOVERY OF OVERPAYMENTS

8.076.3.A. ~~A payment that meets the definition of an~~ Oo~~e~~verpayments are ~~is~~ subject to recovery by the Department or its designees. ~~P~~

8.076.3.B. Any identified Oo~~e~~verpayment ~~to a Provider~~ shall be recoverable from the Provider following exhaustion of any informal reconsideration and~~or~~ appeal pursuant to 8.050~~.6 and 8.050.3~~.

1. Overpayments and/or other indebtedness to the state are recoverable through a repayment agreement with the Provider, by offsetting the amount owed against current and future claims of the Provider, through litigation, or by any other appropriate action within the Department's legal authority.

2. The offset rate shall be 100% of the total amount owed to be withheld from subsequent payments until the entire amount owed is recovered. The Oo~~e~~verpayment offset rate may be reduced if the Provider shows good cause that withholding payment at the established rate will result in undue hardship.

3 In cases where sufficient records are not available to the reviewer or auditor~~multiple overpayments to the same Provider have been found~~, the recovery may be determined through ~~scientific statistical analysis and extrapolation of data from a statistically valid selected sample of the claims.~~a sampling of records so long as the sampling and any extrapolation ~~from is~~ are reasonably valid from a statistical standpoint and is in accordance with generally accepted auditing standards.

~~4. A provider shall have the right to request an informal reconsideration or an appeal of an identified overpayment. The regulations for reconsiderations are set forth at 8.050.6.A. The regulations for appeals are set forth at 8.050.3.A.~~

8.076.3.C. Self-Disclosure of Provider Identified Overpayments

1. If a Provider has received an Overpayment, the Provider is required to report and return the Overpayment within sixty (60) days of identification.

2. Identification of an Overpayment occurs when the Provider has ~~through the exercise of due diligence,~~ determined that it ~~the Provider~~ has received an Overpayment and quantified the amount of the Overpayment.

3. Reporting an Overpayment must be made in writing and at a

minimum contain the following information:

a) Provider National Provider Identification (NPI);

b) Provider Medicaid Identification Number;

c) Provider contact information (name, phone number, address and email address);

d) Claims affected for each service location; and

e) Basis for the Overpayment determination.

4. Failure to report and return the Overpayment within ~~the~~ sixty (60) days of identification shall result in the Department recovering the Overpayment plus statutory interest in accordance with Section 8.076.3.C.

5. Self-disclosure of P~~p~~rovider ~~-~~-identified Overpayments are not an ~~does not meet the definition of~~ Adverse Action as defined in Section 8.050, and are not ~~therefore is not~~ subject to an appeal.

8.076.4 ~~WITHHOLDING OF PAYMENT DURING INVESTIGATION FOR~~ SUSPENSION OF PAYMENTS IN CASES OF A CREDIBLE ALLEGATION OF FRAUD ~~AND/OR WILLFUL MISREPRESENTATION~~

8.076.4.A. Payments to a P~~p~~rovider ~~may~~ will be ~~withheld~~suspended, in whole or in part, upon a determination of a credible allegation of fraud for which an investigation is pending~~.~~ unless there is good cause to not suspend payments or to suspend payment only in part. ~~receipt of reliable evidence that the circumstances giving rise to the need for a withholding of payments involve fraud or willful misrepresentation under the Medical Assistance program. Payments may be withheld without first notifying the Provider of the intention to withhold such payments. A Provider shall be granted appeal rights upon request.~~

1. An allegation of fraud is considered credible if the allegation has evidence of reliability after a review of the allegation, facts and evidence.

2. A determination that there is good cause to not suspend payments or to suspend payment only in part will be made in accordance with the provisions in 42 C.F.R. § 455.23(e)-(f).

8.076.4.B. A Pprovider shall be notified of a suspension of payments, in whole or in part, by a notice of Adverse Action.

8.076.4.C. A Provider shall be granted appeal rights in accordance with Section 8.050.

8.076.4.D. Payments may be suspended without first notifying the Provider of the intention to withhold such payments. Notice of suspension of payments shall be sent to the Provider within the following timeframes:

1. Within five (5) calendar days of taking such action.

2. Within thirty (30) days if requested by law enforcement in writing to delay sending the notice. Requests for delay notice may be renewed in writing twice, ~~two more times,~~not to exceed ninety (90) days.

8.076.4.EB. ~~Notice of withholding shall be sent to the Provider within five (5) calendar days of taking such action.~~ The notice shall include:

1. A s~~S~~tatement that payments are being ~~withheld in~~suspended in accordance with this provision and 42 C.F.R. § 455.23;

2. The general allegations as to the nature of the suspension of payments action;

32. A s~~S~~tatement that the ~~withholding~~ suspension of payments is for a temporary period, ~~as stated in 8.076.4.C and cite~~ and the circumstances under which ~~withholding~~ suspension of payments will be terminated;

43. ~~Specify, when appropriate, to~~ W~~w~~hich type or types of claims are subject to the suspension of payments, when appropriate~~withholding is effective~~; ~~and~~

54. A statement that the Provider may submit written evidence showing why the suspension of payments should not be implemented ~~Inform the Provider of the right to submit written evidence~~ for consideration by the Department; and~~.~~

6. The right to appeal as described in Section 8.050.~~(appeal rights)~~

8.076.4.FC. A ~~withholding~~ suspension of payment action under Section 8.076.4 shall cease if the Department or prosecuting authorities determine that there is insufficient evidence of fraud or false representation by the Provider or if legal proceedings related to the alleged fraud are complete. ~~and did not result in a conviction.~~

8.076.5 DENIAL, TERMINATION AND/OR NONRENEWAL OF PROVIDER AGREEMENTS

8.076.5.A. The Department may deny an application for a Provider agreement, terminate or not renew a Provider agreement for Ggood Cc~~c~~ause, as defined at Section 8.076.1.7.

8.076.5.B. A potential Provider shall be notified of the Department's decision to deny an application for a Provider agreement by a notice of Adverse Action.

8.076.5.C. A Provider shall be notified of the Department's decision to terminate or not renew a Provider agreement by a notice of Adverse Action. Termination and/or nonrenewal shall not be effective sooner than thirty (30) calendar days from the date of the notice except as provided at Section 8.076.5.D, where notice will be provided within five (5) calendar days of taking such action.~~.~~

8.076.5.D. Provider agreements may be terminated without prior notice if:

1. The Provider has been ~~found guilty~~convicted of fraud or convicted of a crime related to the Provider's involvement in Medicare, Medicaid, or any other federally funded program;

2. The Provider has been found to have made a false representation; ~~or~~

3. The termination is imperatively necessary for the preservation of the public health, safety, or welfare and observance of the requirements of notice would be contrary to the public interest. Within five (5) business days of the emergency termination, the ~~p~~Provider shall receive a notice of Adverse Action;~~.~~

4. The Provider has been excluded by the OIG, or Medicare has terminated its Provider agreement or revoked the Provider's billing privileges.~~;~~

8.076.5.E. Providers who had their Provider agreement terminated for G~~g~~ood C~~c~~ause under this Section must apply for reinstatement in the Medical Assistance program prior to filing an application for enrollment. In order to apply for reinstatement, the P~~p~~rovider-applicant must send a written request to the Department that includes information that provides reasonable assurances that the actions that were the basis for termination have not reoccurred and will not recur in the future. After reviewing the written request, the Department will notify the provider of whether the provider is eligible for reinstatement or if the reinstatement has been denied, If the reinstatement has been denied the provider has the right to appeal in accordance with Section 8.050.

8.076.6 REQUEST FOR WRITTEN RESPONSE

8.076.6.A. The Department may request a written response from any ~~p~~Provider who fails to comply with the rules, manuals, bulletins, other guidance issued by the Department, state board or the Department's fiscal agent, or from any Provider~~, or~~ whose activities endanger the health, safety, or welfare of clients.

1 The r~~R~~equest by the Department will be made in writing and contain specific information on the P~~p~~rovider's failed compliance.~~.~~

2 The Provider must provide a written response within thirty (30)~~ten (10)~~ C~~c~~alendar days of the request addressing each identified area of failed compliance and either describe how the P~~p~~rovider will come into and ensure future compliance, or provide an explanation and specific reason why the P~~p~~rovider disagrees with the Department's finding of failed compliance.

3. The Department will review the written response to determine if it addresses the identified areas of failed compliance or provides an acceptable explanation of why the Department's findings were incorrect. The Department will notify the P~~p~~rovider of its determination within thirty (30) c~~C~~alendar days of the ~~request.~~receipt of the response.

8.076.6.B Once the Department has requested a written response, the Department may take the following actions until it determines that the P~~p~~rovider has come into compliance:

1. Conduct a prospective review to ensure compliance with rules in accordance with Section 8.076.2.

2. Prohibit the provider from accepting new referrals or receiving reimbursement for services provided under new referrals for Medicaid services.

8.076.7 FALSE CLAIMS ACT AND WHISTLEBLOWER PROTECTIONS COMPLIANCE

8.076.7.A. If an entity is reimbursed at least $5,000,000 per year, as a condition of reimbursement the entity must maintain documentation:

1. Establishing written policies for all employees of the entity (including management), and of any contractor or agent of the entity, that provide ~~must include provide~~ detailed information about the False Claims Act established 31 U.S.C. §§ ~~under sections~~ 3729~~through~~ 3733; ~~of title 31,~~~~a description of~~ administrative remedies for false claims and statements as provided in 31 U.S.C. §§ 3801-3812; ~~established under chapter 38 of title 31;~~ state laws pertaining to civil or criminal penalties for false claims and statements; ~~,~~ and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse;

2. Detailing provisions reagarding the entity's ~~Detailed provisions regarding the entity's p~~Ppolicies and procedures for detecting and preventing fraud, waste, and abuse; and

3. Of the employee handbook for the entity, including a specific discussion of the la~~Copies or written summaries of the A specific discussion of the~~ws described in subparagraph (1), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste and abuse. ~~written notice to employees about their~~

8.076.7.B. In order to ensure compliance with the provisions of Section 8.076.7.A, the entity must comply with written requests for this information within thirty (30) calendar days.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules concerning Case Management and Quality Performance, Sections 8.393, 8.500, 8.600 & 8.700
Rule Number: MSB 19-04-16-A
Division / Contact / Phone: DIDD/Case Management Unit / Heather Fladmark / 5187

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 19-04-16-A, Revision to the Medical Assistance Rules concerning Case Management and Quality Performance, Sections 8.393, 8.500, 8.600 & 8.700
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.500, 8.600 and 8.700, 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 8.500 with the proposed text beginning at 8.500.1 through the end of 8.500.16.E. Replace the current text beginning at 8.500.90 with the proposed text beginning at 8.500.90 through the end of 8.500.90 unnumbered paragraph 57. Replace the current text at 8.500.95 with the proposed text beginning at 8.500.95 through the end of 8.500.95. Replace the current text at 8.500.101 with the propose text beginning at 8.500.101 through the end of 8.500.101. Replace the current text at 8.500.106 with the proposed text beginning at 8.500.106 through the end of 8.500.106. Replace the current text at 8.503 with the propose text beginning at 8.503 through the end of 8.503 unnumbered paragraph 50. Replace the current text at 8.503.50 with the proposed text beginning at 8.503.50 through the end of 8.503.50.

*to be completed by MSB Board Coordinator

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Replace the current text at 8.503.120 with the proposed text beginning at 8.503.120 through the end of 8.503.120. Replace the current text at 8.503.160 with the proposed text beginning at 8.503.160 through the end of 8.503.160. Insert the newly proposed text beginning at 8.519 through the end of 8.519.23.D. Replace the current text at 8.600 with the proposed text beginning at 8.600.2 through the end of 8.600.2. Replace the current text at 8.600.4 with the proposed text beginning at 8.600.4 through the end of 8.600.4 unnumbered paragraph 66. Replace the current text at 8.607 with the proposed text beginning at 8.607 through the end of 8.607.1 Replace the current text at 8.607.6 with the proposed text beginning at 8.607.6 through the end of 8.607.8. Replace the current text 8.608 with the proposed text beginning at 8.608.4 through the end of 8.608.4. Replace the current text at 8.608.8 with the proposed text beginning at 8.608.8 through the end of 8.608.8. Replace the current text at 8.609 with the proposed text beginning at 8.609.2 through the end of 8.609.2. Replace the current text at 8.609.5 with the proposed text beginning at 8.609.5 through the end of 8.609.5. Replace the current text at 8.611 with the proposed text beginning at 8.611 paragraph E through the end of 8.611 paragraph E. Replace the current text at 8.612 with the proposed text beginning at 8.612.1 through the end of 8.612.3.H. Replace the current text at 8.760 with the proposed text beginning at 8.760.1 through the end of 8.760.1. Replace the current text at 8.761 with the proposed text beginning at 8.761.14 through the end of 8.761.4.46. This rule is effective August 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rules concerning Case Management and Quality Performance, Sections 8.393, 8.500, 8.600 & 8.700
Rule Number: MSB 19-04-16-A
Division / Contact / Phone: DIDD/Case Management Unit / Heather Fladmark / 5187

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).

   HB 17-1343, requires the Department to implement Conflict Free Case Management (CFCM) for individuals with intellectual and developmental disabilities (I/DD). HB 17-1343 requires the Department to create a third-party entity to assist with the choice of case management agencies. The Department has completed 10 stakeholder engagements to gather feedback and recommendations. The Department along with stakeholders and expert recommendations developed qualifications for Case Management Agency and Case Manager qualifications. The Department has worked closely with stakeholders in the development of the qualifications which included 12 stakeholder meetings in various locations across the State of Colorado and in informal public comment period. This rule further defines the case management agency and case manager role, separate and distinct from eligibility and case management.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   25.5-10-211.5

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Rules concerning Case Management and Quality Performance, Sections 8.393, 8.500, 8.600 & 8.700
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REGULATORY ANALYSIS

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

   Individuals with Intellectual and developmental disabilities (I/DD) receiving HCBS waiver services and case management services will be affected by this 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.

   This regulation requires the department to implement a third-party entity per statute. The budget request has been approved to implement the third-party entity this next upcoming fiscal year.

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

   This rule will impact current Community Centered Boards (CCB). The Department has intended costs and have budget approval.

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

   The Department is required to complete this work pursuant to 25.5-10-211.5. The Department has predicted costs for the implementation of the third-party entity and has received a budget approval for the implementation of the third party entity.

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

   The Department believes that this is the most cost-effective way and less intrusive method to move into compliance with statute. The Department has done significant stakeholder engagement to develop a way that will be less intrusive to our clients yet provide the clients with choice and to comply with statute.

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

   Alternative methods were considered as the statute requires the Department to define Case Management Agency, Case manager qualifications and to create a third-party entity to assist with case management agency selection. The Department has presented alternative methods to stakeholders to gather ideas of the best route to take that makes sense, least intrusive and person centered.

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.A Administration of a Single Entry Point

1. The SEP agency shall be required by federal or state statute, mission statement, by-laws, articles of incorporation, contracts, or rules and regulations which govern the agency, to comply with the following standards:

   a. The SEP agency shall serve persons in need of LTSS programs defined in Section 8.390.3;

   b. The SEP agency shall have the capacity to accept multiple funding source public dollars;

   c. The SEP agency may contract with individuals, for-profit entities and not-for-profit entities to provide some or all SEP functions;

   d. The SEP agency may receive funds from public or private foundations and corporations; and

   e. The SEP agency shall be required to publicly disclose all sources and amounts of revenue.

2. For individuals with intellectual or developmental disabilities seeking or receiving services, the SEP will refer to the appropriate Community Center Board (CCB) for programs that serve this population. In the event that the individual is eligible for both a program administered by the SEP and by the CCB, the individual will have the right to choose in which program that he or she will participate.

8.500 HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD) WAIVER

8.500.1 This Ssection hereby incorporates the terms and provisions of the federally-approved Home and Community Based Services for Persons with Developmentally Disabilities waiver (HCBS-DD) CO.0007.R06.00. To the extent that the terms of that federally-approved waiver are inconsistent with the provisions of this sSection, the waiver will control.

8.500.1 DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD Wwaiver or a HCBS Wwaiver service.

APPLICANT means an individual who is seeking a long term care services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

AUDITABLE : means the information represented on the wavier cost report can be verified by reference to adequate documentation as required by generally accepted auditing standards.

Authorized Representative means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at 8.510.1.

CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to Sections 25.5-10-209.5, C.R.S. and CRS 25.5-6-106, C.R.S. and pursuant to a provider participation agreement with the state department.

CLIENT means an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to for an agreed to receive Home and Community Based Services (HCBS).

CLIENT means an individual who has met long term care (LTC) eligibility requirements, is enrolled in and chooses to receive LTC services, and receives LTC services.

CLIENT REPRESENTATIVE means a person who is designated by the Cclient to act on the Cclient's behalf. A client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Cclient to speak for or act on the Cclient's behalf.

Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 27-10.5-105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-101, C.R.S. *et seq*, and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.

COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing home and community based services and Medicaid state plan benefits including long term home health services and targeted case management.

COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Cclient.

DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

DEVELOPMENTAL DELAY means as defined in Ssection 8.600.4.

DEVELOPMENTAL DISABILITY means as defined in Ssection 8.600.4.~~a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation~~ interlllectual and developmental ~~or~~disability ~~or related conditions which include Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation~~ intellectual and developmental disability~~. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. § 600015002~~, *et seq.*, shall not apply.~~

~~"Impairment of General Intellectual Functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (seventy (70) or less assuming a scale with a mean of 100 and a standard deviation of fifteen (15)), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. When an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.~~

~~"Adaptive Behavior Similar to That of a Person With Mental Retardation~~intellectual and developmental disability~~" means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.~~

~~"Substantial Intellectual Deficits" means an intellectual quotient that is between seventy-one (71) and seventy-five (75) assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.~~

~~DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services for persons with Developmental Disabilities (HCBS-DD) within the Colorado Department of Human Services.~~

EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means as defined in 8.280.1. ~~the child health component of Medicaid State Plan for Medicaid eligible children up to the age of twenty-one (21).~~

FAMILY means a relationship as it pertains to the ~~c~~Client and is defined as:

A mother, father, brother, sister; or, ~~any combination,~~

Extended blood relatives such as grandparent, aunt, uncle, ~~cousin;or~~cousin; or~~,~~

An adoptive parent; or,

One or more individuals to whom legal custody of a C~~c~~lient with a developmental disability has been given by a court; or,

A spouse; or,

The C~~c~~lient's children.

FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for long term ~~care~~ services and supports as determined by the Department's prescribed instrument.

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long Term Care instrument and medical verification on the Professional Medical Information Page to determine if the Cclient meets the institutional Llevel of Ccare (LOC).

GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation provided in group living environments of four (4) to eight (8) Cclients receiving services who live in a single residential setting, which is licensed by the Colorado Department of Public Health and Environment as a residential care facility or residential community home for persons with developmental disabilities. ~~and certified by the Operating Agency.~~

GUARDIAN means a person who has qualified as a guardian of a minor or incapacitated person pursuant to testamentary or court appointment but excludes ~~one who is merely as~~ a Guardian Ad Litem (C.R.S. 15-10-201).

~~GUARDIAN means an individual at least twenty-one years (21) of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Guardianship may include limited, emergency or temporary substitute court appointed guardian but not a guardian ad litem.~~

~~Home And Community Based Services (HCBS) Waiver~~HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVER ~~-~~means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Cclient who requires a level of institutional care that would otherwise be provided in a hospital or~~,~~ nursing facility for individuals with intellectual disabilities (ICF-IDD) ~~or intermediate care facility for the mentally retarded (ICF-MR).~~

INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation services provided to three (3) or fewer Cclients in a single residential setting or in a host home setting that does not require licensure by the Colorado Department of Public Health and Environment. ~~IRSS settings are certified by the Operating Agency.~~

~~LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the client's spouse.~~

INSTITUTION means a hospital, nursing facility~~, or Intermediate Care Facility for the Mentally Retarded (ICF-MR)~~ or intermediate care facility for individuals with intellectual disabilities (ICF-IDD) for which the Department makes Medicaid payment under the Medicaid State Plan.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECXTUAL DISABILITIES (ICF-IID) ~~THE MENTALLY RETARDED (ICF-MR)~~ means a publicly or privately operated facility that provides health and habilitation services to a Cclient with ~~mental retardation~~an intellectual or developmental disability or related conditions.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.

LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Cclient must require in order to receive services in an institutional setting under the Medicaid State Plan.

LONG TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities. ~~such as bathing, dressing, preparing meals and administering medications.~~

~~LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services or the program of all-inclusive care for the elderly (PACE), swing bed and hospital back up program (HBU).~~

MEDICAID ELIGIBILE means an applicant or Cc~~l~~ient meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a Cc~~l~~ient in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in the Cc~~l~~ient's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

~~OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.~~

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services-for Pp~~p~~ersons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

~~POST ELIGIBILITY TREATMENT OF INCOME (PETI) means the determination of the financial liability of an HCBS Waiver client as defined in 42 CFR § 435.217.~~

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department~~, the Operating Agency~~, a State ~~F~~fiscal ~~A~~agent or the Case Management Agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information document signed by a licensed medical professional used as a component of the LOC ~~level of care~~ evaluation to determine a~~t~~he Client's need for LTSS ~~program~~.

~~PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional level of care.~~

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined Section ~~in 10 CCR 503~~2505~~-10~~ 16.200~~8.600.4~~ *et seq.*, that has received program approval to provide HCBS-DD ~~W~~waiver services.

PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use, including vehicles for hire.

RELATIVE means a person related to the Cc~~l~~ient by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department or the Department's contractor's ~~or the Operating Agency's~~ review after services and supports are provided to ensure the C~~c~~lient received services according to the ~~service~~ support plan ~~and standards of economy, efficiency and quality of service.~~and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

SERVICE PLAN means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a C~~c~~lient to remain safely in the community and developed in accordance with the Department's ~~and the Operating Agency's~~ rules.

~~. set forth in 10 CCR 2505-10 Section 8.400.~~

STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER~~:~~ means the state owned and operated agency providing ~~home and community based services (~~HCBS waiver services~~)~~ to C~~c~~lients enrolled in the HCBS waiver for Persons with Developmental Disabilities.

SUPPORT is any task performed for the C~~c~~lient where learning is secondary or incidental to the task itself or an adaptation is provided.

SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the ~~c~~Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

Targeted Case Management (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

~~TARGETED CASE MANAGEMENT (TCM) means a Medicaid State Plan benefit for a target population which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure nonduplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources.~~

THIRD PARTY RESOURCES means services and supports that a C~~c~~lient may receive from a variety of programs and funding sources beyond natural supports or Medicaid. That ~~They~~ may include, but ~~are~~are not limited to, community resources, services provided through private insurance, non-profit services and other government programs.

WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.500.6 SERVICE PLAN

8.500.6.A The Case Management Agency shall complete a Service Plan for each C~~c~~lient enrolled in the HCBS-DD ~~W~~waiver in accordance with ~~10 CCR 2505-10~~ Section 8.519.11.B.2~~400~~.

~~8.500.6.B The Service Plan shall:~~

~~1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver services or through other means,~~

~~2. Be in accordance with the Department's rules, policies and procedures, and~~

~~3. Include updates and revisions at least annually or when warranted by changes in the client's needs.~~

~~8.500.6.C The Service Plan shall document that the client has been offered a choice:~~

~~1. Between waiver services and institutional care,~~

~~2. Among waiver services, and~~

~~3. Among qualified providers.~~

8.500.12 PRIOR AUTHORIZATION REQUESTS

8.500.12.A Prior Authorization Requests (PAR) shall be in accordance with ~~10 CCR 2505-10,~~ Section 8.519.14~~058~~.

~~8.500.12.B A PAR shall be submitted to the Operating Agency through the Department's designated information management system.~~

~~8.500.12.C The Case Management Agency shall comply with the policies and procedures for the PAR review process as set forth by the Department and the Operating Agency.~~

~~8.500.12.D The Case Management Agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:~~

~~1. Consistent with the client's documented medical condition and functional capacity as indicated in the functional needs assessment,~~

~~2. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved waiver, and~~

~~3. Not duplicative of another authorized service, including services provided through:~~

~~a. Medicaid State Plan benefits,~~

~~b. Third party resources,~~

~~c. Natural supports,~~

~~d. Charitable organizations, or~~

~~e. Other public assistance programs.~~

~~4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10, Section 8.058.4.~~

8.500.16 APPEAL RIGHTS

The Case Mmanagement Aagency shall meet the requirements set forth at Section 8.519.22.

8.500.16.A The CCB shall provide the long term care notice of action form to applicants and Cclients within teneleven (1011) business days regarding their appeal rights in accordance with 10 CCR 2505-10, Section 8.057 *et seq.* When:

1. The Cclient or applicant is determined to not have a developmental disability,

2. The Cclient or applicant is found eligible or ineligible for LTSSLTC services,

3. The cClient or applicant is determined eligible or ineligible for placement on a waiting list for Medicaid LTC servicesLTSS,

4. An adverse action occurs that affects the Cclient's or applicant's waiver enrollment status,

5. An adverse action occurs that affects the provision of the client's waiver services, or

6. The applicant or client requests such information.

8.500.16.B The CCB shall appear and defend represent itstheir decision at the Office of Administrative Courts as described in 10 CCR 2505-10,Section 8.057 et seq. when the CCB has made a denial or adverse action against a cClient.

8.500.16.C The CCB shall notify all providersthe Case Management Agency in the client's service plan within oneten (10) business day of the adverse action.

8.500.16.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.16.E The applicant or Cclient shall be informed of an adverse action if the Cclient or applicant is determined ineligible as set forth in client eligibility and the following:

1. The client cannot be served safely within the cost containment as identified in the HCBS-DD Waiver,

2. The client is placed in an institution for treatment with a duration that continues for more than thirty (30) days,

13. The Cclient or applicant is detained or resides in a correctional facility, or

24. The Cclient or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

8.500.16.F The client shall be notified, pursuant to 10 CCR 2502-10 Section 8.057.2.A, when the following results in an adverse action that does not relate to HCBS-DD Waiver client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the functional needs assessment,

2. A waiver service is terminated or denied because is not available through the current federally-approved waiver,

3. A service plan or waiver service exceeds the limits as set forth in the in the federally-approved waiver,

4. The client or client representative has failed to schedule an appointment for the functional needs assessment, service plan, or six (6) month visit with the case manager two (2) times in a thirty (30) day consecutive period,

5. The client or client representative has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,

6. The client enrolls in a different long term care program, or

7. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.

a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to Income Maintenance Staff Manual at 9 CCR 2503-1, Section 3.140.2,, shall not be terminated unless one or more of the other client eligibility criteria are no longer met.

8. The client voluntarily withdraws from the waiver program. The client shall be terminated from the waiver effective upon the day after the date on which the client's request is documented.

8.500.16.G The CCB shall not send the LTC notice of action form when the basis for termination is death of the client, but shall document the event in the client record. The date of action shall be the day after the date of death.

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

The section hereby incorporates the terms and provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Wwaiver, CO.0293. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

HCBS-SLS services and supports which are available to assist persons with intellectual or developmental disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an HCBS-SLS setting. HCBS-SLS waiver services are not intended to provide twenty four (24) hours of paid support or meet all identified Cclient needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) means basic self--care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation,,ambulation, and needing supervision to support behavior, medical needs and memory/cognition.

ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-SLS waiver or a specific HCBS-SLS waiver service(s).

APPLICANT means an individual who is seeking a ~~Long Term Care~~ long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in ~~a~~an assessment.

Authorized Representative means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at 8.510.1.

CASE MANAGEMENT AGENCY(CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to Section 25.5-10-209.5 ~~and CRS 25.5-6-106,~~ C.R.S. and pursuant to a provider participation agreement with the state department.

CLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community Based Services (HCBS).

~~CLIENT means an individual who has met Long Term Care (LTC) eligibility requirements, is enrolled in and chooses to receive LTC services, and subsequently receives LTC services.~~

CLIENT REPRESENTATIVE means a person who is designated by the C~~c~~lient to act on the C~~c~~lient's behalf. A C~~c~~lient representative may be: (A~~a~~) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or, (B~~b~~) an individual, family member or friend selected by the ~~c~~Client to speak for and/or act on the C~~c~~lient's behalf.

Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

~~C.R.S.~~

~~COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 27-10.5105, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-105, C.R.S. *et seq*, and provides authorized services and supports to such persons either directly or by purchasing such services and supports from service agencies.~~

CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

~~means the service delivery option set forth at section 8.510. et. seq~~

COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services, and Medicaid State Plan Benefits including long-term home health services~~Long Term Home Health services~~, and targeted case management.

COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Cclient.

DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

DEVELOPMENTAL DELAY means as defined in Ssection 8.600.4.

DEVELOPMENTAL DISABILITY means as defined in Ssection 8.600.4.~~DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to an intellectual and developmental disability or related conditions which includes Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. § 15002, et seq., shall not apply.~~means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation. Unless otherwise specifically stated, the federal definition of "Developmental Disability" found in 42 U.S.C., Section 6000, *et seq.*, shall not apply.

~~Impairment of general intellectual functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (Seventy (70) or less assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (15)), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. When an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.~~

~~Adaptive behavior similar to that of a person with intellectual and developmental disability mental retardation means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. These adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.~~

~~Substantial intellectual deficits means an intellectual quotient that is between seventy one (71) and seventy five (75) assuming a scale with a mean of one hundred100 and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. The standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.~~

~~DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services-Supported Living Services (HCBS-SLS) to persons with developmental disabilities within the Colorado Department of Human Services.~~

EARLY AND PERIODIC SCREENING ~~AND~~ DIAGNOSIS AND TREATMENT (EPSDT) means as defined in 8.280.1. ~~the child health component of the Medicaid State Plan for Medicaid eligible children up to age 21.~~

FAMILY means a relationship as it pertains to the C~~c~~lient and includes the following:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, ~~or~~ uncle, cousin; or

~~Cousins or,~~

An adoptive parent; or,

One or more individuals to whom legal custody of a ~~c~~Client with a developmental disability has been given by a court; or,

A spouse; or

The ~~c~~Client's children.

FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for long-term services and supports ~~Long Term Care services~~ as determined by the Department' s prescribed instrument.

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the ~~u~~Uniform L~~l~~ong T~~t~~erm C~~c~~are instrument and medical verification on the professional medical information page to determine if the applicant or ~~c~~Client meets the institutional ~~l~~Level of ~~c~~Care (LOC).

GUARDIAN means a person who has qualified as a guardian of a minor or incapacitated person pursuant to testamentary or court appointment but excludes ~~one who is merely~~ a Guardian Ad Litem (C.R.S. 15-10-201). ~~an individual at least twenty-one (21) years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated client pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute guardian but not a guardian ad litem.~~

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the S~~s~~ocial ~~s~~Security ~~a~~Act and provided in community settings to a ~~C~~client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or I~~i~~ntermediate C~~c~~are ~~f~~Facility for Individuals with Intellectual Disabilities (ICF-IID)~~the mentally retarded (ICF-MR).~~

INSTITUTION means a hospital, nursing facility, or I~~i~~ntermediate ~~c~~Care ~~f~~Facility for Individuals with Intellectual Disabilities (ICF-IID) ~~the mentally retarded (ICF-MR)~~ for which the Department makes Medicaid payment under the Medicaid State ~~p~~Plan.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) ~~THE MENTALLY RETARDED (ICF-MR)~~ means a public or private facility that provides health and habilitation services to a C~~c~~lient with intellectual or developmental disabilities or related conditions.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the C~~c~~lient's spouse.

LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a C~~c~~lient must require in order to receive services in an institutional setting under the state plan.

LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional ~~limitations~~limitations and chronic illness who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

~~LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services, swing bed and hospital back up program (HBU).~~

MEDICAID ELIGIBLE means an applicant or C~~c~~lient meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the State covers, and how the State addresses additional Federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a C~~c~~lient in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in a ~~c~~Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

~~OPERATING AGENCY means the Department of HEALTH CARE POLICY AND FINANCING, IN THE DIVISION FOR INTELLECTUAL AND DEVELOPMENTAL DISABILITIES, which manages the operations of the Home and Community Based Services for persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.~~

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services for Persons with Developmental Disabilities ~~the Developmentally Disabled~~ (HCBS-DD), Home and Community Based Services Supported Living Services (HCBS-SLS) and Home and Community Based Services Children's Extensive Support (HCBS-CES) waivers.

~~POST ELIGIBILITY TREATMENT OF INCOME (PETI) means the determination of the financial liability of an HCBS waiver client as defined in 42 C.F.R 435.217.~~

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department~~, the Operating Agency~~, a State fiscal agent or the case management agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information document signed by a licensed medical professional used as a component of the Level of Care evaluation to determine the Clients need for LTSS program.

~~PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client needs institutional level of care.~~

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in ~~2 CCR 503-1,~~ Section ~~16.200~~ 8.600.4 *et ~~seq.~~,,seq.,* that has received program approval to provide HCBS-SLS services.

PUBLIC CONVEYANCE means public passenger transportation services that are available for use by the general public as opposed to modes for private use including vehicles for hire.

REIMBURSMENT RATES ~~Reimbursement rates~~ means the maximum allowable Medicaid reimbursement to a provider for each unit of service.

RELATIVE means a person related to the C~~c~~lient by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department or the Department's contractor ~~or the Operating Agency's~~ review after services and supports are provided to ensure the C~~c~~lient received services according to the service plan ~~and standards of economy, efficiency and quality of service~~and that the Case Management Agency complied with requirements set forth in statute, waiver and regulation.

SERVICE DELIVERY OPTION means the method by which direct services are provided for a C~~c~~lient and ~~participant. those options include:~~include a) by an agency and ~~.~~b) ~~c~~C~~C~~lient~~participant~~ directed.

SERVICE PLAN means the written document that specifies identified and needed services to include Medicaid eligible and non-Medicaid eligible services, regardless of funding source, to assist a C~~c~~lient to remain safely in the community and developed in accordance with the Department's rules. ~~and the Operating Agency's rules set forth in 10 CCR 2505-10, Section 8.400.~~

SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not subject to the SPAL are set forth at S~~s~~ection 8.500.102.B ~~(10 C.C.R. 2505-10)~~. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

~~SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs. Each SPAL is determined by the Department and Operating Agency based on the annual appropriation for the HCBS-SLS waiver, the number of clients in each level, and projected utilization.~~

SUPPORT is any task performed for the C~~c~~lient where learning is secondary or incidental to the task itself or an adaptation is provided.

SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi- structured interview of respondents who know the C~~c~~lient well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

"SUPPORT LEVEL" means a numeric value determined using an algorithm that places C~~c~~lients into groups with other ~~c~~Clients who have similar overall support needs.

Targeted Case Management (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

~~TARGETED CASE MANAGEMENT (TCM) means a Medicaid State plan benefit for a target population which includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources such as medical , social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources.~~

THIRD PARTY RESOURCES means services and supports that a Cclient may receive from a variety of programs and funding sources beyond natural supports or Medicaid that may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

WAIVER SERVICE means optional services defined in the current federally approved HCBS waiver documents and do not include Medicaid State plan benefits.

8.500.95 SERVICE PLAN:

The Ccase Mmanagement Aagency shall complete a service plan for each Client enrolled in the HCBS-SLS waiver in accordance with Section 8.519.11.B.2

~~8.500.95.A The case management agency shall complete a service plan for each client enrolled in the HCBS Waiver in accordance with 10 CCR 2505-10, Section 8.400.~~

~~8.500.95.B The service plan shall:~~

~~1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver services or through other means,~~

~~2. Be in accordance with the Department's rules, policies and procedures, and~~

~~3. Include updates and revisions at least annually or when warranted by changes in the client's needs.~~

~~8.500.95.C The service plan shall document that the client has been offered a choice:~~

~~1. Between waiver services and institutional care,~~

~~2. Among waiver services, and~~

~~3. Among qualified providers.~~

8.500.101 PRIOR AUTHORIZATION REQUESTS

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14

~~8.500.101.A Prior authorization requests (PAR) shall be in accordance with 10 C.C.R. 2505-10, Section 8.058.~~

8.500.101.B A prior authorization request shall be submitted to the Operating Agency through the Department's designated information management system.

8.500.101.C The case management agency shall comply with the policies and procedures for the PAR review process as set forth by the Department or the Operating Agency.

8.500.101.D The case management agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:

1. Consistent with the client's documented medical condition and functional capacity as indicated in the functional needs assessment,

2. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved waiver, and

3. Not duplicative of another authorized service, including services provided through:

   a. Medicaid State plan benefits,

   b. Third party resources,

   c. Natural supports,

   d. Charitable organizations, or

   e. Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10 § 8.058.4.

8.500.106 APPEAL RIGHTS

Case ~~m~~Management ~~a~~Agency~~ies~~ shall meet the requirements set forth at Section 8.519.22

8.500.106.A The CCB shall provide the long term care notice of action form to applicants and ~~c~~Clients within eleven ~~ten~~ (1~~0~~) business days regarding their appeal rights in accordance with ~~10 CCR 2505-10,~~ Section 8.057 *et seq.* w~~W~~hen:

1. The C~~c~~lient or applicant is determined to not have a developmental disability,

2. The C~~c~~lient or applicant is found eligible or ineligible for ~~LTC services~~LTSS,

3. The C~~c~~lient or applicant is determined eligible or ineligible for placement on a ~~wait~~waiting list for ~~Medicaid LTC services~~LTSS,

4. An adverse action occurs that affects the C~~c~~lient's or applicant's waiver enrollment status; or,~~,~~

5. An adverse action occurs that affects the provision of the client's waiver services, or

6. The applicant or client requests such information.

8.500.106.B The CCB shall appear and defend ~~represent~~ its ~~their~~ decision at the O~~o~~ffice of A~~a~~dministrative C~~c~~ourts as described in ~~10 CCR 2505-10,~~ Section 8.057 *et seq.* when the CCB has made a denial or other adverse action against a C~~c~~lient or applicant.

8.500.106.C The CCB shall notify the Case Management Agency in the client's service plan within one (1) business day of the adverse action.

~~8.500.106.C The CCB shall notify all providers in the client's service plan within ten (10) business day of the adverse action.~~

8.500.106.D The CCB shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

8.500.106.E The applicant or C~~c~~lient shall be informed of an adverse action if the C~~c~~lient is determined ineligible ~~as set forth in client eligibility~~ and the following:

~~1. The client cannot be served safely within the cost containment as identified in the HCBS-SLS Waiver,~~

~~2. The client is placed in an institution for treatment with a duration that continues for more than thirty (30) days,~~

1~~3~~. The C~~c~~lient or applicant is detained or resides in a correctional facility, or

2~~4~~. The ~~c~~Client or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

~~8.500.106.F The client shall be notified, pursuant to 10 CCR 2505-10, Section 8.057.2.A, when the following results in an adverse action that does not relate to HCBS-SLS waiver client eligibility requirements:~~

~~1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the functional needs assessment,~~

~~2. A waiver service is terminated or denied because is not available through the current federally approved waiver,~~

~~3. A service plan or waiver service exceeds the limits as set forth in the in the federally approved waiver,~~

~~4. The client or client representative has failed to schedule an appointment for the functional needs assessment, service plan, or six (6) month visit with the case manager two (2) times in a thirty (30) day consecutive period,~~

~~5. The client or client representative has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,~~

~~6. The client enrolls in a different long term care program, or~~

~~7. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.~~

a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual 9 CCR 2503-1, Section 3.140.2,, shall not be terminated unless one or more of the other client eligibility criteria are no longer met.

8. The client voluntarily withdraws from the waiver. The client shall be terminated from the waiver effective upon the day after the date on which the client's request is documented.

8.500.106.G The CCB shall not send the LTC notice of action form when the basis for termination is death of the client, but shall document the event in the client record. The date of action shall be the day after the date of death.

8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (HCBS-CES)

8.503 DEFINITIONS

ACTIVITIES OF DAILY LIVING (ADL) means basic self--care activities including bathing, bowel and bladder control, dressing, eating, independent ambulation, transferring, and needing supervision to support behavior, medical needs and memory cognition.

ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-CES waiver or a HCBS waiver service.

APPLICANT means an individual who is seeking a long-term services and supports Long Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

Authorized Representative means an individual designated by a Client, or by the parent or guardian of the Client receiving services, if appropriate, to assist the Client receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined at 8.510.1.

AUTHORIZED REPRESENTATIVE (AR) means an individual designated by the client, parent or legal guardian of a minor, if appropriate, who has the judgment and ability to direct CDASS on the client's behalf and meets the qualifications as defined at 10 CCR 2505-10 Sections 8.510.6 and 8.510.7

.CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Ddepartment to provide case management services for Home and Community Based Services waivers pursuant to Sections 25.5-10-209.5 and CRS 25.5-6-106, C.R.S. and pursuant to a provider participation agreement with the state Ddepartment.

CLIENT means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community Based Services (HCBS).

CLIENT means an individual who has met Long Term client representative may be (A) a legal representative including but not limited to a court appointed guardian, a parent of a minor child, or a spouse, or (B) an individual, family member or friend selected by the parent or guardian of the client to speak for or act on the clients' behalf.

CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the Client's behalf. A Client representative may be: (A) a legal representative including, but not limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual, family member or friend selected by the Client ~~client~~ to speak for or act on the Client's behalf.

Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

~~COMMUNITY CENTERED BOARD (CCB) means a private corporation, for profit or not for profit, which, when designated pursuant to Section 27-10.5-101, C.R.S., provides case management services to clients with developmental disabilities, is authorized to determine eligibility of such clients within a specified geographical area, serves as the single point of entry for clients to receive services and supports under Section 27-10.5-101, C.R.S. et seq., and provides authorized services and supports to such clients either directly or by purchasing such services and supports from service agencies.~~

COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services, and Medicaid State Plan benefits including long term home health services and targeted case management ~~services~~.

COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the ~~c~~Client.

CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option for services that assist an individual in accomplishing activities of daily living when included as a waiver benefit that may include health maintenance, personal care and homemaker activities.

DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single state Medicaid agency.

DEVELOPMENTAL DELAY means as defined in S~~s~~ection 8.600.4.

DEVELOPMENTAL DISABILITY means as defined in S~~s~~ection 8.600.4.~~DEVELOPMENTAL DELAY means a child who is:~~

~~Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:~~

~~Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age,~~

~~Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development,~~

~~Has an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or~~

~~Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a Community Centered Board.~~

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to an intellectual and developmental disability or related conditions which include Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found in found in 42 U.S.C. § 15002, et seq., shall not apply.

DEVELOPMENTAL DISABILITY means a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include Cerebral palsy, Epilepsy, Autism or other neurological conditions when such condition result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, unless otherwise specifically stated, the federal definition "Developmental Disability" found in 42 U.S.C. Section 6000 *et seq.*

"Impairment of general intellectual functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (seventy (70) or less assuming a scale with a mean of 100 and a standard deviation of fifteen (15)), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. Tthe standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. wWhen an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.

"Adaptive behavior similar to that of a person with with intellectual and developmental disabilitymental retardation" means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. tThese adaptive behavior limitations are a direct result of, or are significantly influenced by, the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.

"Substantial intellectual deficits" means an intellectual quotient that is between seventy-one (71) and seventy-five (75) assuming a scale with a mean of one hundred (100) and a standard deviation of fifteen (15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services- Children's Extensive Support (HCBS-CES) to persons with developmental delays or disabilities within the Colorado Department of Human Services.

EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in 8.280.1. the child health component of the Medicaid State Plan for a Medicaid eligible client up to 21 years of age.

FAMILY means a relationship as it pertains to the cClient and is defined as:

A mother, father, brother, sister or any combination,

Extended blood relatives such as grandparent, aunt, uncle, cousin,

An adoptive parent,

One or more individuals to whom legal custody of a person with a developmental disability has been given by a court,

A spouse or,

The ~~c~~Client's child.

FISCAL MANAGEMENT SERVICE (FMS) ~~ORGANIZATION~~ means the entity contracted with the Department ~~as the employer of record for attendants, to provide personnel management services, fiscal management services and skills training to a parent or guardian or authorized representative of a client receiving CDASS.~~to complete employment related functions for CDASS attendants and track and report on individual Client allocations for CDASS.

FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for ~~Long Term Care services~~long-term services and supports as determined by the Department

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long Term Care instrument and medical verification on the Professional Medical Information Page to determine if the applicant or ~~c~~Client meets the institutional Level of~~O~~f Care (LOC).

GUARDIAN means a person who has qualified as a guardian of a minor or incapacitated person pursuant to testamentary or court appointment but excludes a Guardian Ad Litem (C.R.S. 15-10-201). ~~an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not a guardian ad litem.~~

Guardian ad litem" or "GAL" means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963", set forth in article 33 of title 22, C.R.S., and who, if appointed to represent a child in a dependency or neglect proceeding pursuant to article 3 of title 19, C.R.S., shall be an attorney-at-law licensed to practice in Colorado (C.R.S. 13-91-103)

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a C~~c~~lient who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or i~~I~~ntermediate c~~C~~are ~~F~~facility for individuals with intellectual disabilities (ICF-IID).~~the Mentally Retarded (ICF/MR).~~

INSTITUTION means a hospital, nursing facility, facility or ICF-IID~~/MR~~ for which the Department makes Medicaid payments under the state plan.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID)~~THE MENTALLY RETARDED (ICF/MR)~~ means a publicly or privately operated facility that provides health and habilitation services to a C~~c~~lient with developmental disabilities or related conditions.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the C~~c~~lient's ~~guardianlientth~~spouse~~e.~~

LEVEL OF CARE (LOC) means the specified minimum amount of assistance a C~~c~~lient must require in order to receive services in an institutional setting under the Medicaid State Plan.

LICENSED MEDICAL PROFESSIONAL means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses: ; physician, physician assistant and nurse governed by the Colorado Medical License Act and the Colorado Nurse Practice Act.

LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities. such as bathing, dressing, preparing meals, and administering medications.

LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), or Home and Community Based Services (HCBS), Long Term Home Health Services, the program of All-Inclusive Care for the Elderly, Swing Bed and Hospital Back Up program (HBU).

MEDICAID ELIGIBLE means the applicant or eClient meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a eClient in the ingestion, application or inhalation of medication, including prescription and non-prescription drugs, according to the directions of the attending physician or other licensed health practitioner and making a written record thereof.

NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in the Cclient's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the HCBS-DD, HCBS-SLS and HBCS-CES waivers.

PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, the Operating Agency, a state fiscal agent or the Case Management Agency.

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the eClient needs institutional Level oOf Care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in 10.2 CCR 503-12505-10,Section Section 16.200 8.600.4 *et seq.*, that has received program approval to provide HCBS-CES waiver services.

RELATIVE means a person related to the eClient by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department or the Department's contractor or the Operating Agency's review after services and supports are provided to ensure the eClient received services

according to the service plan ~~and standards of economy, efficiency and quality of service.~~and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

SERVICE PLAN means the written document that specifies identified and needed services, regardless of funding source, to assist a ~~c~~Client to remain safely in the community and developed in accordance with the Department's ~~and the Operating Agency's~~ rules ~~set forth in 10 CCR 2505-10, Section 8.400.~~

SUPPORT is any task performed for the ~~c~~Client where learning is secondary or incidental to the task itself or an adaptation is provided.

Targeted Case Management (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

~~TARGETED CASE MANAGEMENT SERVICES (TCM) means a Medicaid State Plan benefit for a target population which includes: facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources including but not limited to medical, social, educational and other resources to ensure non-duplication of HCBS waiver services and the monitoring of the effective and efficient provision of HCBS waiver services across multiple funding sources.~~

THIRD PARTY RESOURCES means services and supports that a C~~c~~lient may receive from a variety of programs and funding sources beyond natural supports or Medicaid. They may include, but are not limited to community resources, services provided through private insurance, non-profit services and other government programs.

UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the Department ~~of Health Care Policy and Financing~~ to review the HCBS-CES waiver applications for determination of eligibility based on the additional targeting criteria.

WAIVER SERVICE means optional services defined in the current federally approved waiver~~s documents~~ and do not include Medicaid State Plan benefits.

8.503.50 SERVICE PLAN

The C~~c~~ase M~~m~~anagement ~~agenca~~Agency shall complete a service support plan for each Client enrolled in the HCBS-CES waiver in accordance with Section 8.519.11.B.2

~~8.503.50.A The case management agency shall complete a service plan for each client enrolled in the HCBS-CES waiver in accordance with 10 CCR 2505-10 Section 8.400.~~

~~1. The service plan shall:~~

a. Address the client's assessed needs and personal goals, including health and safety risk factors either by HCBS-CES waiver services or any other means,

b. Be in accordance with the Department's and the Operating Agency's rules, policies and procedures,

c. Be entered and verified in the Department prescribed system within ten (10) business days,

d. Describe the types of services to be provided, the amount, frequency and duration of each service and the type of provider for each service,

e. Include a statement of agreement, and.

f. Be updated or revised at least annually or when warranted by changes in the HCBS-CES waiver client's needs,

2. The Service Plan shall document that the client has been offered a choice:

a. Between HCBS-CES waiver services and institutional care,

b. Among HCBS-CES waiver services, and

c. Among qualified providers.

8.503.120 PRIOR AUTHORIZATION REQUESTS

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14

8.503.120.A Prior Authorization Requests (PAR) shall be in accordance with 10 CCR 2505-10, Section 8.058.

1. A Prior Authorization Request shall be submitted to the Operating Agency through the Department's designated information management system.

2. The case management agency shall comply with the policies and procedures for the PAR review process as set forth by the Department and the Operating Agency.

3. The case management agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:

a. Consistent with the client's documented medical condition and functional capacity as indicated in the Functional Needs Assessment,

b. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved HCBS-CES waiver, and

c. Not duplicative of another authorized service, including services provided through:

i.) Medicaid State Plan benefits,

ii.) Third party resources,

iii.) Natural supports,

iv.) Charitable organizations, or

v.) Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10, Section 8.058.4.

8.503.160 APPEAL RIGHTS

Case Mmanagement aAgencyies shall meet the requirements set forth at Section 8.519.22

8.503.160.A The CCB shall provide the long-term careLong Term Care noticecare notice of action form (LTC 803) to the applicant and Cclient's parent or legal guardian within teneleven (101) business days regarding the Cclient's appeal rights in accordance with 10 CCR 2505-10, Section 8.057 *et seq.* when:

1. The Cclient or aApplicant is determined not to have a developmental delay or developmental disability,

2. The cClient or aApplicant is determined eligible or ineligible for Medicaid -LTSSLTC services,

3. The cClient or aApplicant is determined eligible or ineligible for placement on a waiting list for Medicaid LTC servicesLTSS,

4. An Adverse Action occurs that affects the Cclient's or applicant's HCBS-CES waiver enrollment status through termination or suspension,

5. An Adverse Action occurs that affects the provision of HCBS-CES waiver services or,

56. The Applicant or client requests such information.

8.503.160.B The CCB shall appear and defend its represent their decision at the Office of Administrative Courts as described in 10 CCR 2505-10, Section 8.057 *et seq.* when the CCB has made a denial or adverse action against a Cclient or applicant. 8.500.16.C

8.503.160.C The CCB shall notify the Case Management Agency in the client's service plan within one (1) business day of the adverse action.

8.503.160.C The CCB shall notify all providers in the client's service plan within one (1) working day of the adverse action.

8.503.160.D The CCB shall notify the County Department of Human Services income maintenance technician within one (1) business day of an Adverse Action that affects Medicaid financial eligibility.

8.503.160.E The CCB shall inform the applicant's or ~~c~~Client's ~~-~~parent or legal guardian ~~shall be informed~~ of an adverse action if the applicant or ~~c~~Client is determined ineligble ~~ineligible as set forth in client eligibility~~ and the following:

1. The ~~c~~Client or applicant, parent or legal guardian fails to submit the Medicaid financial application for LTC to the financial eligibility site within thirty (30) days of LTC referral,

2. A C~~c~~lient, parent or legal guardian fails to submit financial information for re-determination for LTC to the financial eligibility site within the required re-determination timeframe,

3. The County Income Maintenance Technician has determined the C~~c~~lient no longer meets financial eligibility criteria as set forth in ~~10 CCR 2505-10,~~ Section 8.100,

4. The C~~c~~lient cannot be served safely within the cost containment as identified in the HCBS-CES waiver,

5. The ~~c~~Client requires twenty~~-~~four (24) hour supports provided through Medicaid state plan,

6. The resulting total cost of services provided to the ~~c~~Client, including Targeted Case Management, home health and HCBS-CES waiver services, exceeds the cost containment as identified in the HCBS-CES waiver,

7. The C~~c~~lient enters an institution for treatment with duration that continues for more than thirty (30) days,

8. The ~~c~~Client is detained or resides in a correctional facility, and

9. The C~~c~~lient enters an institute for mental illness with a duration that continues for more than thirty (30) days.

~~8.503.160.F The client and parent or legal guardian shall be notified, pursuant to 10 CCR 2505-10, Section 8.057, when the following results in an adverse action that does not relate to HCBS-CES waiver client eligibility requirements:~~

~~1. A HCBS-CES waiver service is reduced, terminated or denied because it is not a demonstrated need in the Functional Needs Assessment or because it is not available through the current federally approved HCBS-CES waiver,~~

~~2. A service plan for HCBS-CES waiver services exceed the limits as set forth in the in the federally approved HCBS-CES waiver,~~

~~3. The parent or legal guardian has failed to schedule an appointment for the Functional Needs Assessment of the client, service plan, or 6-month visit two (2) times in a thirty (30) day consecutive period,~~

~~4. The parent or legal guardian has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,~~

5. The parent or legal guardian failed to complete the HCBS-CES waiver application within fifteen (15) calendar days of the authorized enrollment date as determined by the Operating Agency,

6. The parent or legal guardian fails to complete the service plan within thirty (30) calendar days of the authorized enrollment date as determined by the Operating Agency,

7. The parent or legal guardian refuses to use the home care allowance to pay for services, or uses the home care allowance payment for services not identified in the service agreement,

8. The parent or legal guardian refuses to sign the statement of agreement or other forms as required to receive services,

9. The client enrolls in a different long term care program,

10. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.

    a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual 9 CCR 2503-1, Section 3.140.2, residence, shall not be discontinued unless one or more of the other client eligibility criteria are no longer met.

11. The parent or legal guardian voluntarily withdraws the client from HCBS-CES waiver. The client shall be discontinued from the program effective upon the day after the date on which the parent or legal guardian request is documented.

12. The CCB shall not send the LTC notice of action form when the basis for discontinuation is death of the client, but shall document the event in the client record and the date of action shall be the day after the date of death.

8.519 Case Management

8.519.1 Definitions

Adverse Action means a denial, reduction, termination, or suspension from a long-term service and support program or service.

Agency Applicant means an entity seeking approval to be a as the provider of case management services for Home and Community Based Services.

Algorithm means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Clients into one of six support levels in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services- Supported Living Services (HCBS-SLS) waivers.

Authorized Representative means an individual designated by a cClient the person receiving services, or by the parent or guardian of the cClientperson receiving services, if appropriate, to assist the Client receiving service in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined in 8.510.1.

Business Day means any day in which the state is open and conducting business, but shall not include Saturday, Sunday, or any day in which the state observes on of the holidays listed in ~~s~~Section 24-11-101(1) C.R.S.

Case Manager means a person who provides case management services and meets all regulatory requirements for case managers.

Case Management means the assessment of an individual's needs 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 services effectiveness, and the periodic reassessment of such individual's needs.

Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for specific Home and Community Based Services waivers pursuant to s~~S~~ections 25.5-10-209.5, C.R.S. ~~and CRS 25.5.6.106, C.R.S.~~ and pursuant to a provider participation agreement with the state department.

Certification means the process by which an agency is approved by the Department to provide case management which includes the submission and approval of a Medicaid Provider Agreement along with submission of verification that the agency meets the qualifications as set forth in Section 8.519.

Client means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to ~~for the agreement~~ to receive Home and Community Based Services (HCBS).

Community Centered Board" means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

~~s~~Comprehensive A~~a~~ssessment means an~~d~~ initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support.

Conflict-Free Case Management means, pursuant to 42 CFR~~RF~~ § 441.301(c)(1)(vi), case management services provided to a Client enrolled in a Home and Community Based Services waiver that are provided by a Case Management Agency that is not the same agency that provides services and supports to that person.

Corrective Action ~~p~~Plan means a written plan by the CMA, which includes a~~t~~he detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which ~~stipulates~~sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

Critical Incident means incidents or allegations involving Clients receiving services to include mistreatment, abuse, neglect, exploitation, illness/injury, death, damage to consumer's property/theft, medication management issues, criminal activity, unsafe housing/displacement, and missing persons.

Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.

Developmental Delay means as defined in Section 8.600.4.

Developmental Disability means as defined in Section 8.600.4.

Executive Director means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

Financial Eligibility means the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources, if applicable.

Guardian means a person who has qualified as a guardian of a minor or incapacitated person pursuant to testamentary or court appointment but excludes ~~one who is merely~~ a Guardian Ad Litem (C.R.S. 15-10-201).

Guardian ad litem" or "GAL" means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963", set forth in article 33 of title 22, C.R.S., and who, if appointed to represent a child in a dependency or neglect proceeding pursuant to article 3 of title 19, C.R.S., shall be an attorney-at-law licensed to practice in Colorado (C.R.S. 13-91-103)

Home and Community Based Services (HCBS) waivers means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires an institutional Level of Care that would otherwise be provided in a h~~H~~ospital, n~~N~~ursing f~~F~~acility, or i~~I~~ntermediate Ce~~C~~are F~~f~~acility for individuals with I~~i~~ntellectual D~~d~~isabilities (ICF-IID).

Incident means an injury to a person receiving services; lost or missing persons receiving services; medical emergencies involving persons receiving services; hospitalizations of persons receiving services; death of persons receiving services; errors in medication administration; incidents or reports of actions by persons receiving services that are unusual and require review; allegations of abuse, mistreatment, neglect, or exploitation; use of safety control procedures; use of emergency control procedures; and stolen personal property belonging to a persons receiving services.

Information Management System (IMS) means an automated data management system approved by the Department to enter case management information for each individual seeking or receiving long term services as well as to compile and generate standardized or custom summary reports.

Interdisciplinary Team (IDT) means a group of people convened by a certified Case Management Agency that includes the person receiving services, the parent or guardian of a minor, guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as chosen by the person receiving services, who are assembled to work in a cooperative manner to develop or review the support plan.

Legally Responsible Persons means the parent of a minor child, or the Client's spouse,

Level of Care Determination means determining eligibility of an individual for a Long-Term Services and Supports (LTSS) program and determined by a Community Centered Board or Single Entry Point Agency.

Level of Care Evaluation means a comprehensive evaluation with the individual seeking services and others chosen by the individual to participate and an evaluation by the case manager utilizing the Department prescribed tool, with supporting diagnostic information from the individual's medical provider, and to determine the individual's level of functioning for admission or continued stay in certain Long-Term Services and Supports (LTSS) programs.

Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

Medicaid Eligible means an applicant or Client meets the criteria for Medicaid benefits based on the applicant's financial determination and disability determination when applicable.

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the Home and Community Based Services-for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

Parent means the biological or adoptive parent.

Performance and Quality Review means a review conducted by the Department or its contractor at any time but no less than the frequency as specified in the approved waiver application. To include a review of required case management services performed by the agency to ensure quality and compliance with all requirements. The agency shall provide all requested information and documents as requested by the Department or by its contractor.

~~termination§~~ Prior Authorization Requests (PAR) means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

Professional Medical Information Page (PMIP) means the medical information document signed by a licensed medical professional used as a component of the Level of Care evaluation to determine the Client's needs for LTSS program.

Provider for the purpose of this section means any person, group or entity approved to render services or provide items to a Client enrolled in an HCBS waiver program.

Regional Center means a facility or program operated directly by the Department of Human Services which provides services and supports to persons with intellectual and developmental disabilities.

Retrospective Review means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the support plan and that the Case Management Agency compiled with the requirements set forth in statute, waiver, and regulations.

Service Plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.

~~Support Planning means the process of working with the individuals receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate services providers based on the individuals 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.~~

Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not subject to the SPAL are set forth at ~~s~~Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

Supports Intensity Scale (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with intellectual and developmental disabilities.

Support Level means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

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

Targeted Case Management (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

Waiver Services means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid state plan services.

8.519.2 ~~In order to be approved as a Case~~ Case Management Agency Qualifications~~, the agency shall meet all of the following qualifications:~~

8.519.2.A. A CMA must meet the following qualifications:

1. Have a physical location in Colorado and provide all required case management activities for the areas in which the agency elects to serve.

2. Be a public or private not for profit or for profit agency that meets all applicable state and federal requirements and is certified by the ~~state d~~Department to provide case management services pursuant to Section~~s~~ 25.5-10-209.5, C.R.S. ~~and §25.5-6-106, C.R.S.~~ Case management agencies that are private not for profit must have certification from the state of Colorado or a letter from the Department of the Treasury, internal revenue service classifying the agency as a private not for profit agency.

3. Provide ~~Demonstrate~~ proof that the agency ~~has employed~~ staff ~~that~~ meet~~s~~ all case manager qualifications.

4. As an agency, have a minimum of two years of agency experience in assisting high-risk, low income individuals, to obtain medical, social, education and/or other services. Case ~~ASE M~~Management~~ANAGEMENT~~ Agencies who were previously affiliated with an agency providing HCBS case management prior to August 30, 2019 are exempt from this requirement.

5.. Demonstrate the agency does not have any fiduciary relation with an agency who provides HCBS waiver services. Agencies providing HCBS case management prior to August 30, 2019 are exempt from this requirement.

~~5~~6.. Provide case management to Clients who select the agency as long as the Client reside in the county for which the agency has elected to provide case management services~~; case management agencies who are also a Single-Entry Point Agency are exempt from this requirement.~~

7~~6~~. Possess the administrative capacity to deliver case management services in accordance with state and federal requirements.

8~~7~~. Have established community referral systems and demonstrate linkages and ~~referral~~ the ability to make community referrals for services with other agencies.

9~~8~~.~~.~~ Demonstrate ability to meet all state and federal requirements governing the participation of case management agencies in the state Medicaid program, including but not limited to the ability to meet state and federal requirements for documentation, billing and auditing.

10~~9~~. Have one month reserve financial capacity to maintain operations. HCBS case management agencies providing case management services in Colorado prior to ~~January~~August 3~~1~~0,2019 are exempt from this requirement.

11~~0~~. Demonstrate that the agency has financial reserves for one month of expenditures to cover costs associated with the number of Clients expected through their catchment area, including reserves to cover salaries and costs for case managers, and Clients. All agencies are required to submit an audited financial statement to the Department for review annually. Agencies providing HCBS case management services in Colorado prior to ~~December 31~~August 30, 201~~98~~ are exempt from this~~e one month financial reserve~~ requirement.

12~~1~~. Possess and maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements.

13. Shall not be an approved provider agency providing direct services to individuals who are enrolled in HCBS waivers. Agencies providing HCBS case management prior to August 30, 2019 are exempt from this requirement.

8.519.3 Functions of all Case Management Agencies~~:~~

8.519.3.A Case Management Agencies must:

1. Maintain sufficient documentation of case management activities performed and to support claims.

2. Not provide guardianship services for any Client for enrolled in an HCBS waiver.

3. Maintain, or have access to, information about public and private state and local services, supports and resources and shall make such information available to the Client and/or persons inquiring upon their behalf.

4. Be separate from the delivery of services and supports for the same individual, unless otherwise approved as an exception by the Centers for Medicare and Medicaid services (CMS) in the approved waiver application. Agencies providing ~~Case Management Agencies providing~~ HCBS case management services prior to August 30, 2019 shall comply with the timelines set forth at S~~s~~ections 25.5-10-211.5(3~~2~~)(f)~~-~~(g), C.R.S. ~~and section 25.5-10-211.5(2)(g), C.R.S.~~

5. Assign one (1) primary person who ensures case management services are provided on behalf of the Client across all programs, professionals within the agency. Reasonable efforts shall be made ~~by the case management agency~~ to include the ~~c~~Client's preference~~s of the client~~ in this assignment.

6. Eensure that services are available on Business Days.~~provide services in accordance with state business days.~~

7. Maintain records for seven (7) years after the date a Client discharges from a waiver program, including~~. Case management agencies shall include~~ all documents, records, communications, notes and other materials related to services provided and ~~maintained by case management agencies that relate to any~~ work performed.

8. Possess appropriate financial management capacity and systems to document and track services and costs in accordance with state and federal requirements.~~gulation.~~

9. Maintain and update records of persons determined to be eligible for services and supports and who are receiving case management services in accordance with ~~reporting requirements of the Department's data system,~~the Departments requirements.

10. Establish and maintain working relationships with community-based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the C~~c~~lients' needs~~ of clients~~.

11. Have a system for recruiting, hiring, evaluating, and terminating employees, and maintain ~~. Case management agencies~~ employment policies and practices that ~~shall~~ comply with ~~all~~ federal and state laws.

12. Maintain current written job descriptions for all positions.

13. Maintain a website that at ~~with~~ a minimum contains~~of~~ contact information for the agency, the ability for electronic communication, hours of operation, available resources, program options, and services provided.

14. Ensure staff have access to statutes and regulations relevant to the provision of authorized services. ~~r~~

15. Provide case management services for Clients without discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression or disability.

16. Provide information and reports as required by the Department including, but not limited to, data and records necessary for the Department to conduct operations.

17. Allow access by authorized personnel of the Department, or its contractors, for the purpose of reviewing documents and systems relevant to the provision of case management services and supports funded by the Department and shall cooperate with the Department in the evaluation of such services and supports.

18. If~~n~~ the ~~case the agency~~Case Management Agency is unable to continue p~~P~~roviding c~~C~~ase m~~M~~anagement ~~servi~~CES~~s~~services~~ng clients~~, the agency must submit a written notice to~~is required to~~ the Department at least ~~120~~90 days prior to terminating services~~closing~~. The written notice shall include ~~dicate~~ the effective date of termination.

19. As part of the application process to be an approved Case Management Agency, the agency shall submit a Closeout Plan that describes all requirements, steps, timelines, and milestones necessary to fully transition the services provided by the agency ~~Case Management Agency~~ to another Case Management Agency. The Closeout Plan shall ~~also~~ designate an individual to act as a closeout coordinator who will ensure that all requirements, steps, timelines, and milestones contained in the Closeout Plan are

completed and work with the Department and any other agency to minimize the impact of the transition on Clients and the Department. The Closeout Plan shall include, but is not limited to, all of the following:

a. Notification and communication of agency closure to the Department, Clients and providers;

b. Transfer of Clients;

c. Transfer of documentation to include all electronic and physical documentation;

d. Transfer of all cClient records through the Department Case Management System; and

e. Transfer of Case Management Services.

20. Ensure services agencies and Case Management Agencies are responsible for ensuring persons who are employed by the agency meet the requirement of these regulations

8.519.4 Staffing PaternsPatterns

8.519.4.A. The case management agency shall provide staff for the following functions: receptionist/clerical, administrative/supervisory, and case management.

1. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, and assisting case management agency staff with clerical duties.

2. The administrative/ supervisory function of the Case Management Agency shall include, but not be limited to, supervision of staff, training and development of agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, resource development, marketing liaison with the Department, and, as needed, providing case management services in lieu of the case manager.

8.519.5. Qualifications of Case Managers:

8.519.5.A. All Home and Community Based (HCBS) case managers must be employed by a certified Case Management Agency. or Single-Entry Point Agency.

8.519.5.B. The minimum requirementd for Targeted Case Management HCBS case managers for HCBS waivers is a Bachelor'sbachelor's degree in a human behavioral science or related field of study. If an individual who does not meet the minimum requirement, the cCase mManagement aAgency shall request a waiver from the Department and demonstrate that the individual meets one of the following:

1. Experience working with long-term services and supports (LTSS) population, in a private or public agency, which can substitute for the required education on a year for year basis; ; or

2. A combination of LTSS experience and education, demonstrating a strong emphasis in a human behavioral science field.

3. A copy of the is waiver request and with Department approval shall be kept in the case manager's personnel file.

8.519.5.C. ~~For clients for whom the case manager is providing case management services, c~~Case managers may not:

1. Be related by blood or marriage to the Client.

2. Be related by blood or marriage to any paid caregiver of the Client.

3. Be financially responsible for the Client.

4. Be the Client's legal guardian, authorized representative, or be empowered to make decisions on the Client's behalf through a~~the~~ power of attorney.

5. Be a provider for the Client, have an interest in, or be employed by a provider for the same Client.

8.519.5.D. Case managers must complete the Department prescribed attestation form.

8.519.5.E. Case managers must complete and document the following trainings within 120 days from the date of hire and prior to providing case management services independently:

1. Department prescribed assessment tool;

2. Service plan development and revision;

3. Referral for services, to include Medicaid and non-Medicaid;

4. Monitoring;

5. Case documentation;

6. Level of Care determination process;

7. Notices and appeals;

8. Incident and critical incident reporting; ~~include critical incident reporting~~

9. Waiver requirements and services;

10. Person-centered approaches to planning and practice;

11. Interviewing and assessment skills; and

12. Regulations and state statutes for the LTSS program.

8.519.5.F. Case managers must demonstrate and document competency in the following areas:

1. Knowledge and experience working with populations served by the C~~c~~ase M~~m~~anagement A~~a~~gency~~ies~~;

2. Knowledge of the statutes, regulations, policies and procedures regarding public assistance programs and the American with Disabilities Act;

3. Knowledge of LTSS~~ong-Term Supports and Services~~ and other community resources;

4. ~~and n~~Negotiation, conflict resolution, intervention, cultural and linguistic training, disability cultural competency, ~~basis of Americans with Disabilities Act~~, and interpersonal communication skills; and

5~~4~~. Knowledge of consumer direction philosophy and programs.

8.519.5.G. Case managers shall attend any mandatory training ~~as~~ required by the Department.

8.519.5.H. Case manager supervisors shall ~~educational experience:~~

1. ~~The case management agency's supervisor(s) shall~~ meet the minimum requirements for education and/or experience for case managers and shall have one year of competency in pertinent case management knowledge and skills.

8.519.5.I. Background checks.~~:~~

1. Prior to employment, all case management staff must have the following minimal background checks and screenings:

a. Criminal~~;~~ ~~check~~s

b. Child abuse and neglect central registry; ~~checks~~

c. Medicaid or other federal health programs exclusion list;

d. Sex offender registry; and

e. Adult protective services data system ~~check~~.

2. Background checks must be repeated~~,~~ at minimum every five (5) years with the exception of the adult protective services data system.

3. Proof of checks and ~~these~~ screenings must be maintained and made available ~~for adults~~.

8.519.6 Case M~~m~~anagement A~~a~~gency selection~~:~~

8.519.6.A. Clients have the ability to change their C~~c~~ase M~~m~~anagement A~~a~~gency~~ies~~ at any time, with the exception of initial enrollment into a waiver.

1. Clients must remain with the initial chosen Case Management Agency ~~(CMA)~~ for at least 60 calendar days or~~;~~ until the service plan is developed, whichever is sooner.

8.519.6.B. At the time the ~~c~~Client has met all eligibility requirements for an HCBS waiver the Community Centered Board ~~(CCB)~~, shall within two (2) business days send a referral to the Department's contractor to assist the ~~c~~Client in selecting a CMA.

1. The Department's contractor shall contact the ~~c~~Client within two (2) business days from the date of referral from the CCB.

a. ~~When the client seeking case management and/or their guardian, as appropriate, knows which approved case management agency the client wishes to select, the client will inform the Department's contractor of their choice~~The ~~c~~Client, or the C~~c~~lient's guardian, shall inform the Department's contractor of their choice of Case Management Agency. ~~:~~

b. ~~When the client seeking case management services and/or their guardian, as appropriate, does not know which approved case management agency they wish to select, t~~The Department's contractor shall assist the C~~c~~lient in selecting a CMA when necessary, which may include, but is not limited to:

i. Providing a list of qualified CMAs.

ii. Providing the Department's webpage address and information on how to search for a CMA.

iii. Providing information regarding the qualified CMAs based on the ~~c~~Client's preferences.

iv. ~~Or o~~In addition to ~~O~~other assistance as requested or needed by the C~~c~~lient.

2. The Department's contractor shall notify the selected CMA within two (2) business days from the date of selection by the ~~c~~Client.

a. The Departments contractor shall ~~also~~ send a letter to the ~~c~~Client with the following information:

i. The selected CMA, address and contact information;

ii. Information about the Client's right to choose a CMA; ~~document;~~ and

iii. Contact information for the Department's contactor.

3. The selected CMA shall contact the ~~c~~Client within two (2) business days from notification of selection to confirm the choice and schedule a meeting to develop the Service Plan.

8.519.6.C Case M~~m~~anagement A~~a~~gency transfer~~:~~

1 When a ~~c~~Client wishes to change their ~~select a new~~ CMA, the ~~c~~Client must ~~may~~ notify the current CMA or contact the Department's contractor directly.

a. The CMA shall notify the Department's contractor that the ~~c~~Client would like to change their CMA~~case management agencies~~ if the ~~c~~Client did not notify the contractor directly.~~.~~

b The Department's contractor shall contact the ~~c~~Client within two (2) business days from the date of referral from the CMA or notification from the ~~c~~Client.

i. When the ~~c~~Client seeking case management services and/or their guardian, as appropriate, knows which approved CMA~~case management agency~~ the ~~c~~Client wishes to select, the ~~c~~Client will inform the Department's contractor of their choice.

ii. When the ~~c~~Client seeking case management services and/or their guardian, as appropriate, does not know which approved CMA~~case management agency~~ the ~~c~~Client wishes to select, the Department's

contractor shall assist the ~~c~~Client in the selection of a CMA which may include, but is not limited to:

1. Providing a list of qualified CMAs.

2. Providing the Department's webpage address and information on how to search for a CMA.

3. Providing information regarding the qualified CMAs based on the ~~c~~Client's preferences.

4. O~~r o~~ther assistance as requested or needed by the ~~c~~Client

iii. The Department's contractor shall notify the selected CMA within two (2) business days from the date of selection by the ~~c~~Client. The Department's contractor shall also send a letter to the C~~c~~lient with the following information:

1. The selected CMA;

2. Contact information for the CMA;

3. Information about the r~~R~~ight to choose a CMA; and

4. Contact information for the Department's contractor.

iv. The selected CMA shall contact the ~~c~~Client within two (2) business days from notification of selection to confirm the choice and ~~schedule a meeting to develop the Sservice Pplan~~review service pan and any changes necessitated by the transfer.. ~~with the client receiving services and/or their guardian, as appropriate.~~

v. ~~During a CMA transfer, t~~The transferring CMA shall continue to provide case management services until the new CMA has been assigned in the Department's prescribed system and contacted the C~~c~~lient in accordance with 8.519.6.B(3).

8.519.7 Functions of Case Management Agencies for HCBS-CES, HCBS-DD, and HCBS-SLS

8.519.7.A. Case M~~m~~anagement A~~a~~gencies shall comply with the ~~all applicable~~ regulations ~~pursuant to~~ at Sections 8.500 *et seq.*, ~~,~~8.503 *et seq.*, ~~,~~8.600 *et seq.* and 8.760 *et seq.*

8.519.7.B. The C~~c~~ase M~~m~~anagement A~~a~~gency chosen by the ~~c~~Client is responsible for providing case management services ~~is the one chosen by the client~~.

8.519.7.C. Case ~~m~~Management A~~a~~gencies shall establish agency written procedures sufficient to execute case management services according to the provisions of these regulations. Such procedures shall include, but are not limited to:

1. Comprehensive assessment and periodic reassessment of individual's needs;

2. Development and periodic revision of Client Service Plans;

3. Referral and related activities;

4. Monitoring;

5, The authorization and purchase of services and supports;

6. Services and support coordination;

7. Any safeguards necessary to prevent conflict of interest between case management and direct services provision; and

8. Denial and discontinuation of services.

8.519.7.D. Case ~~m~~Management ~~a~~Agencies shall have written procedures concerning the exercise and protection of Client rights pursuant to s~~S~~ections~~s~~ 25.5-10-~~,~~218 through ~~-~~231, C.R.S.

8.519.7.E. Case M~~m~~anagement A~~a~~gencies shall have written procedures for Clients to ~~protest~~dispute agency decisions, adverse ~~agency~~ actions, or actions of the agency's employees or contractors. ~~Protests~~Disputes may be fi~~l~~led by the Client, or parent of a minor Client, the Client's guardian, advocate, or the Client's authorized representative if within the scope of his/her duties. Agency procedures shall meet the requirements of Section 8.605.5. The agency shall offer and provide interpretation or translation services in languages other than English, and through such other modes of communication as may be necessary.

8.519.8 Compliance

8.519.8.A. Pursuant to s~~S~~ection 25.5-10-208 (4), C.R.S., upon a determination by the executive director or designee that services and supports have not been provided in accordance with the program or financial administration standards contained in these rules, the executive director or designee may reduce, suspend, or withhold payment to a C~~c~~ase M~~m~~anagement A~~a~~gency from which the Department purchases services or supports directly.

8.519.8.B. Prior to initiating action to reduce, suspend, or withhold payment to a C~~c~~ase ~~m~~Management A~~a~~gency for failure to comply with Department regulations ~~to the Department~~, the executive director or designee shall provide written notice which must ~~shall~~ specify the reasons for the action and the ~~therefore in writing and shall specify the~~ actions necessary to achieve compliance.

8.519.8.C. The executive director or designees may revoke the C~~c~~ase M~~m~~anagement A~~a~~gency's certification upon a finding that the ~~case management~~ agency is in violation of provisions of Section 25.5-10-209.5, C.R.S, other state or federal laws, or these rules.

8.519.9 Payment for Case Management Services

8.519.9.A. Targeted case management services are only reimbursed for Clients enrolled in the HCBS-CES, HCBS-CHRP, HCBS-DD, HCBS-SLS~~,~~ -waivers, -and only if the services are in compliance with ~~must comply with~~ the requirements set forth at Section 8.760 *et seq*.

8.519.10 Case Management ~~p~~Payment ~~l~~Liability

8.519.10.A. Failure to prepare the service plan and prior authorization or failure to submit the service plan forms in accordance with Department policies and procedures shall result in the denial of reimbursement for service~~s~~ authorized retroactive to first date of service. The C~~c~~ase M~~m~~anagement A~~a~~gency and/or providers may not seek reimbursement for these services from the Client receiving services.

B. If the Ccase Mmanagement aAgency causes a Client enrolled in HCBS waiver services to have a break in payment authorization, the case management agency will ensure that all services continue and will be solely financially responsible for any losses incurred by service providers until payment authorization is reinstated.

8.519.11 Case Management Services

8.519.11.A. Clients must be determined eligible for an HCBS waiver specifspecific for individuals with Iintellectual or Ddevelopmental Ddisabilities by a Single Entry Point or Community Centered Board prior to receivingpt of case management services.

8.519.11.B. Case management services include the following:

1. Assessment: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support. These Aassessment activities include:

   a. Obtaining Client history;

   b. Identifying the Client's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators, as necessary, to form a complete assessment of the Client.

2. Service plan development and revision:revision: occurss no less than annually or as a warranted by the Client's needs or change in condition, at a time and location convenient for the Client with the Client and others chosen by the Client. The case manager shall complete and review a service plan for each Client enrolled in the HCBS-CES, HCBS-DD, and HCBS-SLS waivers.

   a. The service plan at minimum shall:

      i. Identify needs, personal goals, preferences, unique strengths, abilities, desires, health and safety, and risk factors;

      ii. Be in accordance with the Department's regulations, policies and procedures;

      iii. Identify the specific services and supports appropriate to meet the needs of the eligible Client, and family, as applicable;

      iv. Document decisions made through the service planning process including, but not limited to, rights suspension/modifications, the existence of appropriate services and supports and the actions necessary for the plan to be achieved;

      v. Document the authorized services and supports funded by the Department and the date authorized services begin or the projected date of initiation;

      vi. Identify a contingency plan for how necessary supports will be provided in the event that the Client's family, caregiver, or direct HCBS waiver provider is unavailable due to an emergency situation or to unforeseen circumstances;

vii. Have a listing of the service plan participants and their relationship to the Client; ~~and~~

viii. Contain a statement of agreement with the plan signed by the Client or other such person legally authorized to sign on the ~~c~~Client's behalf ~~of the client~~; and

ix. Be in effect for a period not to exceed one year without review and be reviewed and amended as determined by the case manager, Client, and others as applicable.

b. The service plan shall document that the Client has been offered a choice:

i. In the Home and Community Based Services or institutional care,

ii. Of waiver services, including service delivery options, and

iii. Of qualified providers.

c. The service plan shall contain documentation that the Client is aware of the conflict of interest in situations where the C~~c~~ase ~~m~~Management A~~a~~gency is ~~also~~ the only agency able to provide direct HCBS waiver services, as approved in the waiver application, and that the Client has been provided a complaint and grievance procedure.

d. The service~~s~~ plan development shall occur~~,~~ at times and locations chosen by the Client to include but not limited to the Client's place of residence, place of service, or other appropriate setting as determined by the Client's needs or preferences.

e. Others chosen by the Client shall be provided notification at least ten (10) days prior to the service plan meeting, if possible.

f. Copies of the service plan shall be disseminated to all persons and providers involved in implementing the service plan including the Client, their legal guardian, authorized representative and parent(s) of a minor, and others as applicable. If requested, copies shall be made available prior to the provision of services or supports, ~~;~~ or within a reasonable period of time not to exceed thirty (30) days from the development of the service plan and in accordance with these rules;

3. Referral: the case manager shall assist Clients to obtain needed HCBS waiver services or other programs and services, to include non-Medicaid services, which include making referrals to providers, scheduling appointments, and assisting with access to transportation as needed or requested by the Client, and assisting with .

4. Monitoring: the case manager shall ensure that Clients receive services in accordance with their service plan and monitor the quality of the services and supports provided to the Clients.

a. The frequency and level of monitoring shall meet the requirements of the waiver in which the Client is enrolled. At a minimum, monitoring shall occur at least once per quarter, face-to-face, in a place where services are delivered, and review the following for each Client:

i. The delivery and quality of services and supports identified in the service plan including ~~e~~ ensuring that services are ~~nd~~ delivered in accordance with the scope, frequency, and duration documented in~~on~~ the service plan;

ii. The health, safety and welfare of Clients, including the provider agencies' procedures to address the ~~e~~Client's needs ~~of the client~~;

iii. The satisfaction with services and choice in providers;

iv. Services are being delivered in a way that promote a Client's ability to engage in self-determination, self- representation and self-advocacy;

v. Concerns or issues as they relate to provider agencies. The case manager shall contact the provider agency to coordinate, arrange, or adjust services to address and resolve quality issues or concerns; ~~and to resolve any issues;~~

vi. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or misutilization of any public assistance benefit and shall cooperate with the appropriate agency in any subsequent recovery process.

5. Remediation: the case manager shall identify and implement ~~, resolve, and to the extent possible, established~~ strategies to prevent and ~~help~~ resolve problems with the delivery of services and supports.

8.519.12 Case Documentation

8.519.12.A. The C~~c~~ase M~~m~~anagement A~~a~~gency shall complete and maintain all required records in the state approved IMS and shall maintain individual case records at the agency level for any additional documents associated with the individual enrolled in a HCBS waiver.

1. The case records shall include:

a. Identifying information, including the Client's state identification (Medicaid) number, date of birth (DOB) social security number (SSN), address and phone number;

b. Department required forms specific to the program in which the Client is enrolled; and

c. Documentation of all case management activity ~~required by regulation~~.

2. Case management documentation shall meet all of the following standards:

a. Be objective and understandable;

b. Occur at the time of the activity or no later than five (5) business days from the time of the activity;

c. Dated according to the date of the activity, including the year;

d. Entered into the Department's IMS;

e. Identify the person creating the documentation;

f. Entries must be concise and include all pertinent information;

g. ~~All i~~Information ~~regarding an individual~~ must be kept together, in a logical organized sequence, for easy access and review;

h. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact or is a someone's judgement or conclusion; ~~on the part of anyone;~~

i. All persons and agencies referenced in the documentation must be identified by name and by relationship to the individual;

j. All forms prescribed by the Department shall be completely and accurately filled out by the case manager; and,

k. ~~Whenever~~If the case manager is unable to comply with any of the regulations specifying the time frames within which case management activities~~gencies~~ are to be completed, due to circumstances outside the case management agency's control, the circumstances shall be documented in the case record.

These circumstances shall be taken into consideration when ~~upon~~ monitoring the ~~of~~ C~~c~~ase M~~m~~anagement A~~a~~gency's performance.

8.519.13 Choice of provider agency for authorized HCBS waiver services

8.519.13. A. ~~—~~Clients and/or their guardians and authorized representatives, as appropriate, ~~and families~~ who enroll in HCBS waiver~~s~~ services ~~will be receiving support services~~ shall have the freedom to choose from qualified provider agencies ~~from service agencies which have been selected or selected and approved~~ in accordance with Section~~s 8.602.1 and~~ 8.603, as applicable~~, and section 8.609.1~~.

8.519.13.B. Case Management Agencies shall provide ~~C~~C~~e~~lients, ~~and/or,~~and/or their guardian~~s~~, and ~~and~~ authorized representative~~s~~, ~~(~~as ~~appropriat~~appropriate, ~~)~~ ~~e, shall be provided~~informed choice ~~information~~ on all provider~~s~~ agencies qualified to provide the authorized HCBS waiver services.

1. When the Client ~~or his~~ or ~~her~~ guardian, or authorized ~~-~~representative when applicable, knows which qualified provider agency(ies) they ~~wish~~ want to provide the authorized HCBS waiver service(s), the Client shall inform the case manager of their choice.

a. The case manager shall contact the selected provider agency(ies) regarding the Client's needs, the services authorized, and the scope, frequency, and duration of services.

b. If the provider agency(ies) are willing to provide the authorized HCBS waiver service(s), the case manager shall create the Prior Authorization Request in accordance with Section 8.519.14.

c. If the provider agency(ies) are not willing to provide the authorized HCBS waiver service(s), the case manager shall inform the Client and discuss options for additional provider selection as outlined in Section 8.519.13.B(2).

2. If the Client or ~~or his or her~~ guardian~~,~~ (as appropriate) does not know which provider agency(ies) the ~~c~~Clientey ~~client~~ ~~wishes~~wants to select, the case manager shall provide informed choice to the Client which may include, but is not limited to:

a. Providing a list of qualified provider agencies; ~~or~~

b. Providing the Department's webpage address and information on how to search for a qualified provider agency; ~~or~~

c. Providing ~~information~~ resources for accessing information about provider agency quality, such as survey information, that is available to the public; ~~or~~

d. Providing information regarding qualified provider agencies based on the ~~c~~Client's preferences; ~~or~~
~~regarding qualified provider agencies based on the client's preferences; or~~

~~d~~e. Contacting all qualified provider agencies, with ~~the~~ information regarding the requested and authorized service(s)~~s~~ ~~and~~including the scope, frequency, level of support necessary, and duration of the ~~authorized~~ services for the purpose of receiving responses from qualified service agencies who can serve the ~~c~~Client; or

~~e~~f. In addition to o~~r o~~ther assistance as requested or needed by the Client.

3. The case manager shall document the C~~c~~lient's choice of provider agency(ies) and the method by which the choice was made in the Service Plan and ~~notes~~ in the Department's p~~P~~rescribed s~~S~~ystem.

4. Case Manager shall contact all requested providers within five (5) business days of the Clients selection.

8.519.14 Prior Authorization Requests (PAR)

8.519.14.A. The case manager shall submit a ~~the~~ PAR in compliance with all applicable regulations and ensure requested services are:

1. Consistent with the Client's documented medical condition and needs assessment;

2. Adequate in amount, frequency, scope and duration in order to meet the Client's needs and within the limitations set forth in the current federally approved waiver; ~~,~~ and

3. Not duplicative of another service, including but not limited to services provided through:

a. Medicaid state plan benefits,

b. Third party resources,

c. Natural supports,

d. Charitable organizations, or

e. Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to Section 8.058.4.

8.519.15 Regional Center Referral Process

8.519.15.A. Referrals to the Regional Centers shall comply with the Regional Centers admission policy located on the Colorado Department of Human Services website.

8.519.16 Incident Reporting

8.519.16.A. Case Mmanagement Aagencies shall have a written policy and procedure for the recording, reviewing, and reporting ~~and reviewing of~~ incidents. Incident reporting is required when the following occurs: ~~which shall include, but not limited to:~~

1. Injury ~~to a client receiving services~~;

2. Lost or missing Client~~s receiving service~~;

3. Medical emergencies ~~involving clients receiving services~~;

4. Hospitalization~~s of clients receiving services~~;

5. Death ~~of client receiving services~~;

6. Errors in medication administration;

7. Incidents or reports of actions by Clients ~~receiving services~~ that are unusual and required review;

8. Allegations of abuse, mistreatment, neglect, or exploitation;

9. Use of safety control procedures;

10. Use of emergency control procedures; and,

11. Stolen personal property belonging to a Client receiving services.

8.519.16.B. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the agency administrator or designee, Ccase Mmanagement Aagency, and to the CCB~~community centered board~~ within 24 hours.

1. Case managers shall comply mandatory reporting requirements set forth at C.R.S 18-6-108 and C.R.S 26-3.1-102.

8.519.16.C. Incident r~~R~~eports ~~of incidents~~ shall be placed in the ~~c~~Client's record ~~of the client~~.

8.519.16.D. Incident reports ~~Records of incidents~~ shall be made available to the CCB, ~~community centered board, c~~Case ~~m~~Management Aagencies, and the Department upon request.

8.519.17 Client Responsibilities

8.519.17.A. A Client, when provided with appropriate and necessary accommodations, or guardian is responsible to:

1. Provide ing accurate information regarding the Client's ability to complete activities of daily living; ,

2. Assist in promoting the Client's independence; ,

3. Cooperate in the determination of financial eligibility for Medicaid; ,

4. Notify the case manager within thirty (30) days after:

a. Changes in the Client's support system, medical, physical or psychological condition, or living situation including any hospitalizations, emergency room admissions, placement in to a nursing home or Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID)

b. The Client has not received an HCBS waiver service during one (1) calendar (1) month; ,

c. Changes in the Client's care needs;,

d. Problems with receiving HCBS waiver services for which the Client would like the case manager's assistance to resolve; ,and

e. Changes that may affect Medicaid financial eligibility, including promptly reporting of changes in income or assets;

f. Client will notify the Case Manager when withdrawing from services.

5. Cooperate with Case Management Agency requirements for the functions of case management outlined in 8.519 et seq.

8.519.18 Use of an Aauthorized Rrepresentative

8.519.18.A. Clients who are eligible for services and supports, the parent or guardian of a minor, or legal guardian of an adult, shall be informed at the time of enrollment and at each annual review of the service plan that they may designate an authorized representative. The designation of an authorized representative must occur with informed consent of the Client receiving services, or the parent or guardian of a minor, or legal guardian of an adult.

8.519.18.B. A The designation of an authorized representative shall be in writing and specify the extent of the authorized representative's involvement in assisting the Client receiving services, in acquiring or utilizing services or supports available, and in safeguarding the Client's rights.

8.519.18.C. The written designation of an authorized representative shall be maintained in the eClient's record of the client receiving services and shall be reviewed annually.

8.519.18.D. The Client receiving services may withdraw their designation of an authorized representative at any time, and must and will notify theo case manager of the withdrawal.

8.519.19 Petitions for Declaratory Orders

8.519.19.A. Disposition of petitions for declaratory orders

1. The executive director of the Department or designee may entertain petitions for declaratory orders in accordance with Section 24-42-105 (11), C.R.S., when a controversy or uncertainty exists as to the applicability of any statutory or regulation of the Department to a party. involving the application of these rules of Article 10 of Title 25.5. A petition may be filled when a process for resolving the controversy or uncertainty is not otherwise provided in these rules. and in interpretation of the law assist the parties.

8.519.19.B. Any petition filled pursuant to this rule shall set forth the following:

1. The name and address of the petitioner;

2. The statute, rule or order to which the petition relates;

3. A concise statement of all of the facts necessary to show the nature of the controversy of uncertainty; and.

4. All parties directly involved in the subject matter of the petition as known to the petitioner.

8.519.19.C. If the executive director or designee decides to rule on the petition, the following procedure shall apply:

1. The executive director or designee shall provide notice of the petition and an opportunity to respond to the petition to all parties noted by the petitioner or otherwise known to the Department to be directly interested in the petition.;

2. The executive director or designee may rule upon the petition based solely upon the facts presented in the petition and response. In such a case any ruling of the Department will apply only to the extent of the facts presented in the petition and the response.;

3. The executive director or designee may request the petitioner or any involved party to submit additional information, or file a written brief, memorandum, or statement of position.;

4. The executive director or designee may rule upon the petition without a hearing or may set the petition for hearing, upon due notice to all parties to obtain additional facts or information. ; and,

5. The ruling of the Department shall be Final Agency Action subject to judicial review. binding upon all parties to the matter.

8.519.20 Grievance/Complaint process

8.519.20.A. Case Mmanagement aAgencies shall have procedures setting forth a process for the timely resolution of grievances or complaints of the client receiving services, parents of a minor, guardian and/or authorized representative, as applicable.. Use of the grievance procedure shall not prejudice the future provision of appropriate services or supports.

8.519.20.B. The grievance procedure shall be provided, orally and in writing, to all Clients receiving services, the parents of a minor, guardian and/or authorized representative, as applicable, at the time of submission and at any time that changes to the procedure occur.

8.519.20.C. The grievance procedure shall, at a minimum, including the following:

1. Contact information for a person within the CMA who will receive grievances. Who within the agency will receive grievances, to include the contact information for the individual;

2. Identification of support person(s) who can ~~to~~ assist the ~~c~~Client in submitting ~~in the submission of~~ a grievance.~~:~~

3. An opportunity ~~for clients~~ to find a mutually acceptable solution. This could include the use of mediation if both parties voluntarily agree ~~to this process;~~.

4. Timelines for resolving the ~~resolution of the~~ grievance.~~:~~

5. Consideration by the agency director or designee if the grievance cannot be resolved at a lower level. ~~; and,~~

6. Assurances that n~~N~~o Client shall be coerced, intimidated, threatened or retaliated against because the Client has exercised his or her right to file a grievance or has participated in the grievance process.

8.519.21 Termination from services and supports

8.519.21.A. A Client shall be terminated from services and supports if ~~upon determination by the community centered board~~ CCB or C~~c~~ase m~~M~~anagement A~~a~~gency determines that the Client no longer meets the eligibility criteria.

8.519.21.B. A Client ~~receiving services~~ shall be discontinued from a service or support upon determination, made pursuant to the service planning process, that the services or supports are no longer appropriate or necessary to meet the ~~c~~Client's needs. ~~of a client receiving services.~~

8.519.21.C. A Client receiving services may notify a service agency, verbally or in writing, that he or she no longer wishes to receive services from the provider agency. If the Client is a minor, has a legal guardian, authorized representative or is under court jurisdiction, the Client's parent(s), guardian or authorized representative shall be notified immediately after the Client notifies the service agency of the desire to discontinue services. The parent(s) of a minor or legal guardian shall be provided the option to exercise their decision-making authority on behalf of the Client receiving service, unless otherwise ordered by a court.

8.519.22 Notice and Appeal Rights

8.519.22.A. The Case Management Agency shall provide the long-term care notice of action form to Clients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq,* when:

1. An ~~adverse~~ adverse action occurs that affects the provision of the Client's waiver services, or:

8.519.22.B. The case management agency shall notify all providers in the Client's service plan within one (1) business day of the adverse ~~adverse~~ action.

1. The case management agency shall notify the county Department of Human/Social services income maintenance technician within ten (10) business days of an adverse action that may affect financial eligibility for HCBS waiver services.

8.519.22.C. The applicant or Client shall be ~~informed of an adverse~~provided a notice of adverse action if the applicant or Client is determined to be ineligible as set forth in the waiver specific Client eligibility criteria and the following:

1. The Client cannot be served safely within the cost containment as identified in the HCBS waiver;

2. The Client is placed in an institution for treatment for more than thirty (30) consecutive days;~~.~~

3. The Client is detained or resides in a correctional facility; or~~.~~

4. The Client enters an institute for mental health for more than thirty (30) consecutive days.

8.519.22.D. The Client shall be notified, pursuant to Section 8.057.2.A., when the following results in an adverse action that does not relate to waiver Client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the needs assessment;

2. A service plan or waiver service exceeds the limits set forth in the federally approved waiver;~~.~~

3. The Client is being terminated from HCBS due to a failure to attend a Level of Care assessment appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

4. The Client is being terminated from HCBS due to a failure to attend a Service Plan appointment after three (3) attempts to schedule by the case manager within a thirty (30) day consecutive period.

5. The Client enrolls in a different LTSS program, or

6. Benefits are terminated because the ~~The~~ Client moves out of state. ~~The client shall be discontinued effective the day after the date of move.~~

A. A Client who leaves the state on a temporary basis, with intent to return to Colorado, pursuant to Section 8.100.3.B.4, shall not be terminated unless one or more of the other Client eligibility criteria are no longer met.

7. The Client voluntarily withdraws from the waiver. The Client shall be terminated from the waiver effective upon the day after the date on which the Client's request is documented.

A. The case manager shall review with the Client their decision to voluntarily withdraw from the waiver. The Case Manager shall not send a notice of action, upon confirmation of withdraw.

8.519.22.E. The case management agency shall not send the LTC notice of action form~~rom~~ when the basis for termination is death of the Client, but shall document the event in the Client record. The date of action shall be the day after the date of death.

8.519.22.F. The case management agency shall appear and defend their decision at the Office of Administrative Courts when the case management agency has made a denial or adverse action against a Client.

1. When the Office of Administrative Courts rules in favor of the appellant, the Case Management Agency shall file exceptions when appropriate~~licable~~.

8.519.23 Retrospective review process

8.519.23.A. Services provided to a Client are subject to a retrospective review which includes but is not limited to a performance and quality review by the Department. The retrospective review shall ensure that services:

1. Identified in the service plan are based on the Client's assessed needs;

2. Have been requested and approved prior to the delivery of services;

3. Provided to a Client are in accordance with the service plan, and;

4. Provided within the specified HCBS waiver service definition in the federally approved HCBS waiver.

8.519.23.B When the retrospective review identifies areas of noncompliance, the case management agency shall be required to submit a corrective action plan that is monitored for completion by the Department.

8.519;23.C. The inability of the case management agency to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.519.23.D. When the provider has received reimbursement for services and the review by the Department identifies that it is not in compliance with requirements, the amount identified is subject to recovery pursuant to Section 8.076. ~~amount reimbursed may be subject to the reversal of claims, recovery of amount reimbursed, withholding of payments, or termination of provider status.~~

8.519.27 Transition Coordination Services

8.519.27.A Definitions

1. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to S~~s~~ection~~s~~ 25.5.-10-209.5, C.R.S. ~~and CRS 25.5-6-106,~~ and pursuant to a provider participation agreement with the state department.

2. Community risk level means the potential for a ~~c~~Client living in a community-based arrangement to require emergency services, to be admitted to a hospital, skilled nursing facility, or ~~i~~Intermediate C~~c~~are F~~f~~acility for I~~i~~ndividuals with I~~i~~ntellectual D~~d~~isabilities, be evicted from their home or be involved with law enforcement due to identified risk factors.

3. Post-transition monitoring means the activities that occur after a ~~c~~Client has successfully transitioned into the community and is a recipient of home-and community-based services.

4. Pre-T~~t~~ransition ~~c~~Coordination means activities that occur before a C~~c~~lient has transitioned into the community to prepare the C~~c~~lient for success in community living and integration.

5. Risk factors means factors that include but are not limited to health, safety, environmental, community integration, service interruption, inadequate support systems

and substance abuse that may contribute to an individual's community risk level and potential for readmission to an institution.

6. Risk mitigation plan means the document that records the risk mitigation planning process. Risk mitigation plans are used to conduct post-discharge monitoring of effectiveness of risk prevention strategies; to document identification of additional risk factors, and to revise risk incident response plans.

7. Risk mitigation planning means the process of identifying risk factors, developing options and actions to enhance opportunities and prevent adverse consequences that would result if risk is not managed and identifying planned actions to take in response to an adverse consequence should a risk be realized.

8. Service plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a ~~c~~Client to remain safely in the community and developed in accordance with the Department regulations.

9. Transition ~~c~~Coordination means support provided to a ~~c~~Client who is transitioning from a skilled nursing facility, ~~i~~Intermediate C~~c~~are F~~f~~acility for ~~i~~Individuals with ~~i~~Intellectual ~~d~~Disabilities, or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition.

10. Transition assessment means the process of capturing a comprehensive understanding of the ~~c~~Client's health conditions, functional needs, transition needs, behavioral concerns, social and cultural considerations, educational interests, risks and other areas important to community integration and transition to a home and community-based setting.

11. Transition ~~c~~Coordination agency (TCA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide T~~t~~ransition C~~c~~oordination pursuant to a provider participation agreement with the ~~state~~ D~~d~~epartment.

12. Transition coordinator (TC) means a person who provides ~~t~~Transition ~~c~~Coordination services and meets all regulatory requirements for a transition coordinator.

13. Transition options team (TOT) means the group of people involved in supporting and implementing the transition, to include the person receiving services, the transition coordinator, the family, guardian or authorized representative, the home- and community-based services case manager, and others chosen by the individual receiving services as being valuable to participate in the transition process.

14. Transition period means the period of time in which the ~~c~~Client receives Transition Coordination for the purpose of successful integration into community living. A transition period is complete when the ~~c~~Client has successfully established community residence and is no longer in need of Transition Coordination based on the risk mitigation plan.

15. Transition plan means the written document that identifies person-centered goals, assessed needs, and the choices and preferences of services and supports to address the identified goals and needs; appropriate services and additional community supports; outlines the process and identifies responsibilities of transition options team members; details a risk mitigation plan; and establishes a timeline that will support an individual in transitioning to a community setting of their choosing.

16. Transition planning means development of a transition plan, risk mitigation plan and transition plan in coordination with the transition options team.

8.600 Services for Individuals with Intellectual and Developmental Disabilities

8.600.2 Scope and Purpose

These rules govern services and supports for individuals with developmental disabilities authorized and funded in whole or in part through the Colorado Department of Health Care Policy and Financing. These services and supports include the following, as provided by the Colorado Revised Statutes and through annual appropriation authorizations by the Colorado General Assembly:

A. Services and supports provided to residents of a State operated facility or program or purchased by the Department.

B. The purchase of services and supports through Cc~~c~~ommunity ~~c~~Centered Bb~~b~~oards, case management agencies, ~~-~~and service agencies.

C. ~~Such c~~Other services and supports specifically authorized by the Colorado General Assembly.

D. S~~uch s~~ervices and supports ~~as are~~ funded through the Home and Community-Based Services w~~W~~aivers under~~to~~ S~~s~~ections 1915(c), 1902(a)(10), and 1902(a)(1) of the Social Security Act and under~~by~~ S~~s~~ection 25.5-4-401, et seq., C.R.S.

8.600.4 Definitions

As used in these rules, unless the context requires otherwise:

“Abuse,” for the purpose of mistreatment, abuse, neglect and exploitation, means any of the following acts or omissions committed against a person with an intellectual or developmental disability:

A. The non-accidental infliction of physical pain or injury, as demonstrated by, but not limited to, substantial or multiple skin bruising, bleeding, malnutrition, dehydration, burns, bone fractures, poisoning, subdural hematoma, soft tissue swelling, or suffocation;

B. Confinement or restraint that is unreasonable under generally accepted caretaking standards; or

C. The subjection to sexual conduct or contact classified as a crime under the “Colorado Criminal Code,” Title 18, C.R.S.

“Algorithm” means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign ~~c~~Clients into one of six support levels in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.

“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.

“Assistive Technology Services” includes, but is not limited to, the evaluation of a person's need for assistive technology; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and, training the individual, or if appropriate a family member, to use the devices effectively.

Authorized Representative means an individual designated by a Client or by the parent or guardian of the Client, if appropriate, to assist the Client in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined in 8.510.1.

~~“Authorized Representative” means an individual designated by the person receiving services, or by the parent or guardian of the person receiving services, if appropriate, to assist the person receiving services in acquiring or utilizing services and supports pursuant to section 25.5-10, C.R.S.~~

“Authorized Services” means those services and supports authorized pursuant to S~~s~~ection 25.5-10-206, C.R.S., which the Department shall provide directly or purchase subject to available appropriations for persons who have been determined to be eligible for such services and supports and as specified in the eligible person's individualized plan.

“Caretaker” means a person who:

A. Is responsible for the care of a person with an intellectual or developmental disability as a result of a family or legal relationship;

B. Has assumed responsibility for the care of a person with an intellectual or developmental disability; or

C. Is paid to provide care, services, or oversight of services to a person with an intellectual or developmental disability.

“Caretaker Neglect” means neglect that occurs when adequate food, clothing, shelter, psychological care, physical care, medical care, habilitation, supervision, or other treatment necessary for the health and safety of a person with an intellectual and developmental disability is not secured for a person with an intellectual and developmental disability or is not provided by a caretaker in a timely manner and with the degree of care that a reasonable person in the same situation would exercise, or a caretaker knowingly uses harassment, undue influence, or intimidation to create a hostile or fearful environment for an at-risk adult with an intellectual and developmental disability.

A. Notwithstanding the provisions of this subsection, the withholding, withdrawing, or refusing of any medication, any medical procedure or device, or any treatment, including but not limited to resuscitation, cardiac pacing, mechanical ventilation, dialysis, artificial nutrition and hydration, in accordance with any valid medical directive or order, or as described in a palliative plan of care, shall not be deemed caretaker neglect.

B. As used in this subsection, “medical directive or order” includes a medical durable power of attorney, a declaration as to medical treatment executed pursuant to S~~s~~ection 15-18-108, C.R.S., a medical order for scope of treatment form executed pursuant to Article 18.7 of Title 15, C.R.S., and a CPR Directive executed pursuant to Article 18.6 of Title 15, C.R.S.

“Case Management Agency” (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case

management services for Home and Community Based Services waivers pursuant to Sections 25.5-10-209.5, C.R.S. and ~~CRS 25.5-6-106, C.R.S. and~~ pursuant to a provider participation agreement with the state department.

~~"Case Management Agency" (CMA) means a Community Centered Board within a designated service area where an applicant or client can obtain case management services.~~

"Challenging Behavior" means behavior that puts the person at risk of exclusion from typical community settings, community services and supports, or presents a risk to the health and safety of the person or others or a significant risk to property.

"Client" means an individual who has met Long Term Services and Supports (LTSS) ~~Care (LTC)~~ eligibility requirements and has been offered and agreed to receive Home and Community Based Services (HCBS) in the Children's Extensive Supports (HCBS-CES) waiver, the HCBS waiver for Children's Habilitation Residential Program (CHRP), ~~the~~ the HCBS waiver for Persons with Developmental Disabilities (HCBS-DD), Family Support Services Program (FSSP), ~~or~~ the Supported Living Services (HCBS-SLS) waiver.

"Community Centered Board" means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

~~s.~~

~~"Community Centered Board (CCB)" means a private corporation, for profit or not for profit, which, when designated pursuant to section 25.5-10-209, C.R.S., provides case management services to persons with developmental disabilities, is authorized to determine eligibility of such persons within a specified geographical area, serves as the single point of entry for persons to receive services and supports under section 25.5-10, C.R.S., and provides authorized services and supports to such persons either directly or by purchasing such services and supports from service agencies.~~

"Comprehensive Review of the Person's Life Situation" means a thorough review of all aspects of the person's current life situation by the program approved service agency in conjunction with other members of the interdisciplinary team.

"Comprehensive Services" means habilitation services and supports that provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services include residential habilitation services and supports, day habilitation services and supports and transportation.

"Consent" means an informed assent, which is expressed in writing and is freely given. Consent shall always be preceded by the following:

A. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

B. A description of the attendant discomforts and risks;

C. A description of the benefits to be expected;

D. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

E. An offer to answer any inquiries regarding the procedure;

F. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

G. A statement that withholding or withdrawal of consent shall not prejudice future provision of appropriate services and supports to individuals.

“Developmental Delay” means that a child meets one or more of the following:

A. A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more of the following:

1. Chromosomal conditions associated with delays in development,

2. Congenital syndromes and conditions associated with delays in development,

3. Sensory impairments associated with delays in development,

4. Metabolic disorders associated with delays in development,

5. Prenatal and perinatal infections and significant medical problems associated with delays in development,

6. Low birth weight infants weighing less than 1200 grams, or

7. Postnatal acquired problems resulting in delays in development.

B. A child less than five (5) years of age who is significantly delayed in development in one or more of the following areas:

1. Communication,

2. Adaptive behavior,

3. Social-emotional,

4. Motor,

5. Sensory, or

6. Cognition.

C. A child less than three (3) years of age who lives with one or both parents who have a developmental disability.

“Developmental Disabilities Professional” means a person who has at least a Bachelor’s Degree and a minimum of two (2) years’ experience in the field of developmental disabilities or a person with at least five (5) years of experience in the field of developmental disabilities with competency in the following areas:

A. Understanding of civil, legal and human rights;

B. Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies;

C. Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.

"Developmental Disability" means a disability that:

A. Is manifested before the person reaches twenty-two (22) years of age;

B. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria below at C, 1 and/or C, 2; and,

C. Is attributable to an intellectual and developmental disability or related conditions which include Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found 42 U.S.C. § 15002, et seq., shall not apply. ~~s attributable to mental retardation or related conditions which include cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in either impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation.~~

1. "Impairment of general intellectual functioning" means that the person has been determined to have a full scale intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15).

   a. A secondary score comparable to the General Abilities Index for a Wechsler Intelligence Scale that is two or more standard deviations below the mean may be used only if a full scale score cannot be appropriately derived.

   b. Score shall be determined using a norm-referenced, standardized test of general intellectual functioning comparable to a comprehensively administered Wechsler Intelligence Scale or Stanford-Binet Intelligence Scales, as revised or current to the date of administration. The test shall be administered by a licensed psychologist or a school psychologist.

   c. When determining the intellectual quotient equivalent score, a maximum confidence level of ninety percent (90%) shall be applied to the full scale score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the applicant being determined to have a developmental disability.

2. "Adaptive behavior similar to that of a person ~~with~~ with intellectual disability ~~mental retardation~~" means that the person has an overall adaptive behavior composite or equivalent score that is two or more standard deviations below the mean.

   a. Measurements shall be determined using a norm-referenced, standardized assessment of adaptive behaviors that is appropriate to the person's living environment and comparable to a comprehensively administered Vineland Scale of Adaptive Behavior, as revised or current to the date of administration. The assessment shall be administered and determined by a professional qualified to administer the assessment used.

b. When determining the overall adaptive behavior score, a maximum confidence level of ninety percent (90%) shall be applied to the overall adaptive behavior score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the applicant being determined to have a developmental disability.

D. A person shall not be determined to have a developmental disability if it can be demonstrated such conditions are attributable to only a physical or sensory impairment or a mental illness.

"Division for Intellectual and Developmental Disabilities" means the unit within the Colorado Department of Health Care Policy and Financing, responsible for the administration of state sponsored services and funding for developmental disabilities for the state of Colorado.

"Emergency", as used in Ssection 8.608.3 regarding restraint, means a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to effectaffect such bodily harm.

"Emergency Control Procedure" means an unanticipated use of a restrictive procedure or restraint in order to keep the person receiving services and others safe.

"Executive Director" means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

"Exploitation" means an act or omission committed by a person who:

A. Uses deception, harassment, intimidation, or undue influence to permanently or temporarily deprive a person with an intellectual or developmental disability of the use, benefit, or possession of anything of value;

B. Employs the services of a third party for the profit or advantage of the person or another person to the detriment of the person with an intellectual or developmental disability; or

C. Forces, compels, coerces, or entices a person with an intellectual or developmental disability to perform services for the profit or advantage of the person or another person against the will of the person with an intellectual or developmental disability; or

D. Misuses the property of a person with an intellectual or developmental disability in a manner ngor that adversely affects the person with an intellectual or developmental disability's ability to receive health care or health care benefits or to pay bills for basic needs or obligations.

"Extreme Safety Risk to Self" means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a cClient's support level. This factor shall be identified when a cClient:

A. Displays self-destructiveness related to self-injury, suicide attempts or other similar behaviors that seriously threaten the cClient's safety; and,

B. Has a rights suspension in accordance with Ssection 8.604.3 or has a court order that imposes line of sight supervision unless the Cclient is in a controlled environment that limits the ability of the cClient to harm himself or herself.

"Family", as used in rules pertaining to support services and, the Family Support Services Program and the Colorado Family Support Loan Fund herein, means a group of interdependent persons residing in the same household that consists of a family member with a developmental disability or a child under the age of five (5) years with a developmental delay, and one or more of the following:

A. A mother, father, brother(s), sister(s) or any combination; or,

B. Extended blood relatives such as grandparent(s), aunt(s) or uncle(s); or,

C. An adoptive parent(s); or,

D. One or more persons to whom legal custody of a person with a developmental disability has been given by a court; or,

E. A spouse and/or his/her children.

"Family Support Council" means the local group of persons within the Cc~~c~~ommunity Cc~~c~~entered Bb~~b~~oard's designated service area who have the responsibility for providing guidance and direction to the ~~c~~Community ~~c~~Centered ~~b~~Board for the implementation of the Family Support Services Program.

"Family Support Plan (FSP)" means a plan which is written for the delivery of family support services as specified in S~~s~~ection 8.613~~, herein~~.

"Functional Analysis" means a comprehensive analysis of the medical, social, environmental, and personal factors that may influence current behavior. This analysis shall also investigate the person's ability to communicate, analyze whether the current behavior is a means to communicate, and identify historical factors which may contribute to the understanding of the current behavior.

"Guardian" means a person who has qualified as a guardian of a minor or incapacitated person pursuant to testamentary or count appointment but excludes ~~is~~ a Guardian Ad Litem (C.R.S. 15-10-201).

~~"Guardian" means a person appointed by the court, or named in a will to be the guardian or a minor child, and charged with limited, temporary, or full guardian's power and duties.~~

"Home and Community-Based Services Waivers (HCBS)" means HCBS waiver programs, including the Home and Community Based Waiver for the Developmentally Disabled (HCBS-DD), Supported Living Services (SLS) and Children's Extensive Support (CES). ~~These waivers are authorized by section 25.5-6-404, C.R.S., et seq., for alternatives to long- term services and supports care for individuals with the developmentally disabilities disabled by waivers to section 1915(c), 1902(a)(10)(B), and 1902(a)(1) of the Social Security Act approved by the United States Department of Health and Human Services, in accordance with section 2176 of Public Law No. 97-35 and approved for implementation by the Colorado General Assembly, and regulated by those sections of the Medical Assistance Staff Manual Volume 8 (10 C.C.R. 2505-10) of the Colorado Department of Health Care Policy and Financing, pertaining to Long Term Care and Home and Community-Based Services for the Developmentally Disabled.~~

"Host Home Provider" is an individual(s) ~~(or individuals)~~ who provides residential supports in his/her home to persons receiving comprehensive services who are not family members as defined in S~~s~~ection 25.5-10-202(16), C.R.S. A host home provider is not a developmental disabilities service agency pursuant to S~~s~~ection 8.602 of these rules.

"Human Rights Committee" means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and reviewing investigations of allegations of mistreatment of persons with intellectual and developmental disabilities who are receiving services or supports.

“Individual Service and Support Plan (ISSP)” means a plan of intervention or instruction which directly addresses the needs identified in the person's Individualized Plan and which provides specific direction and methodology to employees and contractors providing direct service to a person.

“Individualized Plan (IP)” means a written plan designed by an interdisciplinary team for the purpose of identifying:

A. The needs of the person receiving services or family;

B. The specific services and supports appropriate to meet those needs;

C. The projected date for initiation of service and supports; and,

D. The anticipated results to be achieved by receiving the services and supports.

“Interdisciplinary Team (IDT)” means a group of people convened by a Ccommunity Ccentered Bboard which shall include the person 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 such person's needs and preferences, who are assembled in a cooperative manner to develop or review the individualized plan.

~~“Loan Fund” means the Colorado Family Support Loan Fund.~~

“Mechanical Restraint” means the use of devices intended to restrict the movement or normal functioning of a portion of an individual's body. Mechanical restraint does not include the use of protective devices used for the purpose of providing physical support or prevention of accidental injury.

~~“Mental Retardation” means substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work. Mental retardation manifests before age 18.~~

“Minimum Effective Dose” means the smallest medication dosage necessary to produce the intended effect.

“Mistreated” or “Mistreatment” means:

A. Abuse,

B. Caretaker Neglect,

C. Exploitation,

D. An act or omission that threatens the health, safety, or welfare of a person with intellectual or developmental disability, or

E. An act or omission that exposes the person with an intellectual or developmental disability to a situation or condition that poses an imminent risk of bodily injury.

“Notice” means written notification hand delivered to or sent by first class mail that contains at least all of the following:

A. The proposed action;

B. The reason or reasons for that action;

C. The effective date of that action;

D. The specific law, regulation, or policy supporting the action;

E. The responsible agency with whom a protest of the action may be filed including the name and address of the director.

F. The dispute resolution procedure, including deadlines, in conformity with Ssection 8.605 and procedures on accessing agency records:

1. For disputes involving individuals as defined in section Section 8.605.2, information on availability of advocacy assistance, including referral to publicly funded legal services, corporation, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under 42 U.S.C. 15001~~6012~~, the Developmental Disabilities Assistance and Bill of Rights Act; and,

2. For disputes involving individuals as defined in ~~s~~Section 8.605.2 an explanation of how the agency will provide services to a currently enrolled person during the dispute resolution period, including a statement that services will not be terminated during the appeal. Such explanation will include a description of services currently received.

“Parent” means the biological or adoptive parent.

“Physical Restraint” means the use of manual methods to restrict the movement or normal functioning of a portion of an individual's body through direct physical contact by others except for the purpose of providing assistance/prompts. Assistance/prompts is the use of manual methods to guide or assist with the initiation or completion of and/or support the 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.

“PRN” (Pro Re Nata) means giving drugs on an “as needed” basis through a standing prescription or standing order.

“Program Approved Service Agency” means a developmental disabilities service agency or typical community service agency as defined in Ssection 8.602, which has received program approval by the Department pursuant to Ssection 8.603 of these rules.

“Program Services” means an organized program of therapeutic, habilitative, specialized support or remedial services provided on a scheduled basis to individuals with developmental disabilities.

“Prospective New Service Agency” means an individual or any publicly or privately operated program, organization or business that has completed and submitted an application with a ~~c~~Community ~~c~~Centered ~~b~~Board for selection and approval as a service agency to provide comprehensive services.

“Public Safety Risk-Convicted” means a factor in addition to specific SIS scores that is considered in the calculation of a ~~c~~Client's support level. This factor shall be identified when a C~~c~~lient has:

A. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,

B. A rights suspension in accordance with Ssection 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the ~~c~~Client is in a controlled environment

that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

"Public Safety Risk-Not Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a ~~c~~Client's support level. This factor shall be identified when a ~~c~~Client has:

A. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,

B. A rights suspension in accordance with S~~s~~ection 8.604.3or through parole or probation, or a court order that imposes line of sight supervision unless the ~~c~~Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

"Rate" means the amount of money, determined by a standardized rate setting methodology, reimbursed for each unit of a defined waiver service provided to a ~~c~~Client by a qualified provider.

"Referral" means any notice or information (written, verbal, or otherwise) presented to a C~~c~~ommunity C~~c~~entered B~~b~~oard which indicates that a person may be appropriate for services or supports provided through the developmental disabilities system and for which the ~~c~~Community ~~c~~Centered ~~b~~Board determines that some type of follow-up activity for eligibility is warranted.

"Referral and Placement Committee (RPC)" means an interdisciplinary or interagency committee authorized by a C~~c~~ommunity C~~c~~entered B~~b~~oard or the department to make referral and placement recommendations for persons receiving services.

"Regional Center" means a facility or program operated directly by the Department of Human Services, which provides services and supports to persons with developmental disabilities.

"Respondent" means a person participating in the SIS assessment who has known the C~~c~~lient for at least three months and has knowledge of the C~~c~~lient's skills and abilities. The respondent must have recently observed the ~~person~~ C~~c~~lient directly in one or more places such as home, work, or in the community.

"Restrictive Procedure" means any of the following when the intent or plan is to bring an individual's ~~the person's~~ behavior into compliance:

A. Limitations of an individual's movement or activity against his or her wishes; or,

B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences.

"Request for Developmental Disability Determination" means written formal documentation, either handwritten or a signed standardized form, which is submitted to a Community Centered Board requesting that a determination of developmental disability be completed.

"Safety Control Procedure" means a restrictive procedure or restraint that is used to control a previously exhibited behavior which is anticipated to occur again and for which the planned method of intervention is developed in order to keep the person and others safe.

"Screening~~"~~ for Early Intervention Services" means a ~~quick~~ preliminary review~~look at~~ of how a child is developing and learning ~~to determine~~ in comparison to other similarly situated children. ~~what areas of development, if any, are behind what would be expected for a child.~~

“Seclusion” means the placement of a ~~person~~ Cclient ~~receiving services~~ alone in a closed room for the purpose of punishment. Seclusion for any purpose is prohibited.

“Service Agency” means an individual or any publicly or privately operated program, organization or business providing services or supports for persons with developmental disabilities.

~~“Service Plan Authorization Limit” (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the client's ongoing needs. Purchase of services not subject to the SPAL are in accordance with the Department of Health Care Policy and Financing rules in section 8.500.102.B (10 C.C.R. 2505-10). A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of clients in each level, and projected utilization.~~

“Sexual contact” means the intentional ~~knowing~~ touching of the victim's intimate parts by the actor, or of the actor's intimate parts by the victim, or the ~~knowing~~ intentional touching of the clothing covering the immediate area of the victim's or actor's intimate parts if that sexual contact is for the purposes of sexual arousal, gratification, or abuse.

"Sexual intrusion" means any intrusion, however slight, by any object or any part of a person's body, except the mouth, tongue, or penis, into the genital or anal opening of another person's body if that sexual intrusion can reasonably be construed as being for the purposes of sexual arousal, gratification, or abuse.

"Sexual penetration" means sexual intercourse, cunnilingus, fellatio, analingus, or anal intercourse. Emission need not be proved as an element of any sexual penetration. Any penetration, however slight, is sufficient ~~to~~ to meet this definition.~~complete the crime~~.

“SIS Interviewer” means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department approved trainer using the Department approved curriculum. SIS Interviewers must maintain a standard for conducting SIS assessments as measured through periodic interviewer reliability reviews.

“Statewide Database” means the state web-based system that contains consumer-related demographic and program data.

“Support Coordinating Agency” means a ~~c~~Community ~~c~~Centered ~~b~~Board which has been designated as the agency responsible for the coordination of support services (supported living services for adults and the children's extensive support program) within its service area.

“Supports Intensity Scale” (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed~~ated~~ to identify and measure the practical support requirements of adults with developmental disabilities. ~~means the standardized assessment tool published in 2004 by the American Association on Intellectual and Developmental Disabilities. The assessment gathers information from a semi-structured interview of respondents who know the client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities. No later editions or amendments are included. Copies may be obtained or examined by contacting the Case Management Specialist, Colorado Department of Health Care Policy and Financing, Division for Intellectual and Developmental Disabilities, 1570 Grant Street, Denver, Colorado 80203; or any State Publications Depository Library.~~

“Support Level” means a numeric value determined using an algorithm that places ~~c~~Clients into groups with other ~~c~~Clients who have similar overall support needs.

“Undue Influence” means use of influence to take advantage of a person with an intellectual or developmental disability’s vulnerable state of mind, neediness, pain, or emotional distress.

"Waiver Services" means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid State Plan services.

~~8.602.5 CHOICE OF SERVICE AGENCIES FOR COMPREHENSIVE SERVICES FOR AN INDIVIDUAL~~

~~A. Each community centered board shall develop and implement a process for the selection of service agencies for comprehensive services which considers the preferences and needs of the person who will be receiving those services and supports and/or his/her guardian, and which provides a fair opportunity to existing service agencies and prospective new service agencies.~~

~~1. The community centered board shall provide persons, their guardians, and authorized representative, as appropriate, information concerning all existing service agencies program approved to provide comprehensive services within the service area.~~

~~2. When the person who will be receiving the services and supports or his or her guardian, as appropriate, knows which approved service agency(ies) they wish to provide the specific services or supports sought, they may choose that agency(ies) to provide the authorized services as long as the agency has the ability and is willing to provide the authorized services, and the choice is approved by the community centered board.~~

~~3. If the person who will be receiving the services and supports does not have a preference for a particular agency, the community centered board shall notify all existing service agencies and prospective new service agencies about the available resource(s) and provide sufficient information for agencies to determine if they are interested in participating in a request of proposal process.~~

~~4. Existing and prospective new service agencies expressing interest in providing services and supports shall be provided the following additional information in the form of a request for proposal.~~

~~a. A profile of the person, the anticipated services and supports to be provided, the desired configuration of services and supports, and the timeframes during which services and supports would be provided.~~

~~b. Instructions for submitting the proposal and the deadline for receipt of the proposal. The community centered board shall establish a reasonable timeframe between issuing the request for proposal and the deadline for receipt of proposals.~~

~~c. The evaluation criteria to be used and when the community centered board intends to review the proposals.~~

~~5. In order to allow for the development of needed services or supports in emergencies/crises, in exceptional circumstances and in situations where competition would not be fostered by the issuance of a request for proposal, the Department shall, at its discretion, have the flexibility to determine that a waiver of the request for proposal requirements specified in these rules and regulations is justified. The community centered board may also request such a waiver pursuant to section 8.600.5.G.~~

~~6. In evaluating proposals from service agencies, the community centered board shall apply criteria in a like manner to all service agencies, including the community centered board itself. Criteria which shall be used by the community centered board for assessing the~~

~~capabilities of service agencies, including the community centered board itself, if applicable to provide a specific service or support as outlined in a request for proposal shall include, but are not limited to:~~

~~a. Experience of the agency in providing the specific services or supports being sought;~~

~~b. Most recent accreditation, inspections and reviews by regulatory and licensing agencies;~~

~~c. Fiscal capacity of the agency to initiate and operate the specified services and supports on an ongoing basis;~~

~~d. The agency plan for service sites, if applicable, including appropriate location, size and appearance;~~

~~e. The suitability of the agency plan for providing services and supports, including the anticipated impact on the existing environment; and,~~

~~f. The cost associated with the plan.~~

~~7. The rationale used by the community centered board to evaluate the proposals shall be documented and any applicant has the right, upon request, to review the community centered board's evaluation of its proposal.~~

~~8. The community centered board shall maintain all proposals received and written documents relevant to its evaluation of these proposals for 90 days after the award, or, if there is a dispute of the award, the records shall be maintained until the dispute is resolved.~~

~~B. Persons who will be receiving the services and supports and/or their guardian, as appropriate, shall have the opportunity to choose among the service agencies which the community centered board has determined to meet the evaluation criteria pursuant to section 8.602.5.A.6.~~

~~C. Community centered boards shall provide persons who will be receiving the services and supports and/or their guardian, as appropriate, an opportunity to review the proposals, if so requested.~~

~~D. The community centered board shall notify in writing all applicants if they were chosen within a reasonable timeline after the person who will be receiving the services and supports has chosen the approved service agency(ies) to provide the authorized services.~~

8.607 CASE MANAGEMENT SERVICES

~~A case~~Case management service for Individuals with Intellectual and Developmental Disabilities HCBS waivers shall be provided pursuant to Section 8.519.1 through 8.519.23.

8.607.1 ADMINISTRATION

A. Community ~~c~~Centered ~~B~~boards and regional centers shall be responsible to maintain sufficient documentation of case management activities performed and to support billings.

B. Community Cc~~c~~entered Bb~~b~~oards shall be responsible to maintain or have access to information about public and private, state and local services, supports and resources which may be available for persons with developmental disabilities, and shall make such information available to persons eligible for services and supports and authorized persons inquiring upon their behalf.

C. Each Cc~~c~~ommunity Cc~~c~~entered Bb~~b~~oard and regional center, as appropriate, shall establish agency procedures sufficient to execute case management services according to the provisions of these rules and regulations. ~~Such procedures shall include, but are not limited to:~~

~~1. The determination of eligibility;~~

~~2. Management of the waiting list;~~

~~3. The authorization and purchase of services and supports;~~

~~4. Service and support coordination;~~

~~5. Monitoring;~~

~~6. Any safeguards necessary to prevent conflict of interest between case management and direct service provision; and,~~

~~7. Termination and discharge.~~

D. Case management services shall be a direct responsibility of the executive level of the ~~c~~Community ~~c~~Centered Bb~~b~~oard or regional center ~~organization, and~~organization and are separate from the delivery of services and supports unless otherwise approved by the Department.

E. The Cc~~c~~ommunity Cc~~c~~entered Bb~~b~~oard or regional center shall assign one (1) primary person who ensures case management services are provided on behalf of the person receiving services across all program, professional and agency lines. Reasonable efforts shall be made by the Cc~~c~~ommunity Cc~~c~~entered ~~b~~Board or regional center to include the preferences of the eligible person in this assignment.

~~F. The community centered board responsible for providing ongoing case management services is the one in whose designated service area the person receiving services resides, except when the following conditions apply:~~

~~1. If the person receiving services is reasonably expected to reside in a designated service area for ninety (90) days or less and was previously receiving case management services from another community centered board, the community centered board of origin shall retain case management responsibility for the person;~~

~~2. If the person receiving services is placed into a state operated program for ninety days or fewer under short term emergency or respite care status, the community centered board of placement origin shall retain case management responsibility for the person; or,~~

~~3. For purposes of transition, if a person is receiving residential services funded by the Colorado Department of Human Services, Division of Child Welfare Services, the person (if over eighteen (18) years of age), parent(s) of a minor, or legal guardian, as appropriate, shall have the option of choosing either the designated service area where the person receiving services currently resides for continuity of service provision or the designated service area of placement origin from the county department of social services.~~

4. If case management responsibility cannot be determined at the local level, then the Department shall assign case management responsibility.

8.607.6 MONITORING

Community centered boards or Rregional centers shall be responsible to monitor the overall provision of services and supports authorized by the Department. (25.5-10, C.R.S).

A. The frequency and level of monitoring shall meet the guidelines of the program in which the person is enrolled. At a minimum, monitoring shall include the following for each person:

1. The delivery and quality of services and supports identified in the Individualized Plan;

2. The health, safety and welfare of individuals;

3. The satisfaction with services and choice in providers; and,

4. That community centered board, the regional center's and service agency's practices promote a person's ability to engage in self-determination, self-representation and self-advocacy.

B. A rReview of overall services and supports provided on an agency and system level shall be conducted to determine:

1. The general satisfaction of persons in regards toin regard to services and supports received;

2. The general practices of service agencies regarding health, safety and welfare of persons receiving services;

3. Fiscal compliance related to the implementation of Individualized Plans for individuals; and,

4. The nature and frequency of complaints regarding a service agency.

8.607.7 DISCHARGE FROM SERVICES AND SUPPORTS

A. Unless otherwise specified by the Department, a person shall be discharged from the community centered board upon determination by the community centered board that the person no longer meets the eligibility criteria, subject to dispute resolution procedures.

B. A person receiving services shall be discharged from a service or support upon determination, made pursuant to the individualized planning process, that the services or supports are no longer appropriate or necessary to meet the needs of the person receiving services.

C. A person receiving services may notify a service agency, verbally or in writing, that such person no longer wishes to participate in a program, and discharge from such services or supports shall occur within a reasonable time period.

If the person receiving services is a minor, has a legal guardian, authorized representative or is under court jurisdiction, said parties shall be notified immediately after such person notifies the

~~service agency of the desire to be discharged. The parent(s) of a minor, legal guardian and court shall be provided the option to exercise their decision-making authority on behalf of the person receiving services.~~

8.607.8 MEDICAID PROGRAMS FOR PERSONS WITH DEVELOPMENTAL DISABILITIES

~~A. For persons with developmental disabilities who are enrolled in Title XIX Medicaid programs, case management services shall be provided as required herein, and through the Colorado Department of Health Care Policy and Financing rules for Medicaid services (10 C.C.R. 2505-10), and the guidelines of the Department.~~

~~B~~A. Regional Center Referral Process

1 A Client may be referred to a regional center for emergency short-term placement not to exceed ninety (90) days. Such referral shall be made as specified by the Colorado Department of Human Services (CDHS) and, at minimum, shall ensure that the CMA has exhausted all reasonable alternatives in an effort to procure or provide emergency services and supports in the Client's local c~~C~~ommunity.

2. Clients may be referred to a regional center for long-term placement as specified by the CDHS. Such procedures shall include, but are not limited to:

A. The CMA responsible for case management services has notified the appropriate regional center and has involved the regional center in the evaluation process; ~~and,~~

B. The ~~case management agency~~CMA, ~~and the~~ Client, and ~~to include~~ the service planning team have reviewed and recommended placement; ~~and,~~

C. All reasonable alternatives have been exhausted by the CMA~~case management agency~~ to procure services and supports ~~for the client~~ in the C~~c~~lient's ~~ir~~ local community and such efforts have been documented;~~,~~ and,

D. The Client or legal guardian is a resident of Colorado.

~~. Persons eligible or receiving services or supports may be referred to a regional center for emergency short-term placement not to exceed ninety (90) days. Such referral shall be made as specified by the Department and, at a minimum, shall ensure that the community centered board has exhausted all reasonable alternatives in an effort to procure or provide emergency services and supports in the person's local community.~~

~~2. Persons eligible for or receiving services or supports may be referred to a regional center for long-term placement as specified by the Department. Such procedures shall include, but not be limited to:~~

~~a. The Community Centered Board responsible for case management services has notified the appropriate regional center and has involved the regional center in the evaluation process; and,~~

~~b. The designated service area Community Centered Board and the person's Interdisciplinary Team have reviewed and recommended the placement; and,~~

~~c. All reasonable alternatives have been exhausted by the Community Centered Board in an effort to procure or provide services and supports for the person in their local community and such efforts have been documented; and,~~

~~d. The person or legal guardian is a bona fide resident of Colorado.~~

B~~C~~. Nursing Facilities

For persons referred for a Preadmission Screening and Annual Resident Review (PASARR), the completion of the PASARR in accordance with the ~~guidelines of the~~ Department's guidelines, shall be the responsibility of the Community Centered Board in the area in which the person is physically residing, unless otherwise agreed upon by the Community Centered Boards affected.

8.608 SERVICE AND SUPPORT PLANNING, SUPPORTING PEOPLE WITH CHALLENGING BEHAVIOR, AND PROTECTIONS

8.608.4 REQUIREMENTS FOR EMERGENCY AND SAFETY CONTROL PROCEDURES

A. An Emergency Control Procedure is the unanticipated use of a restrictive procedure or restraint in order to keep the person receiving services and others safe.

1. Each C~~c~~ommunity ~~c~~Centered ~~b~~Board, program approved service agency, and regional center shall have written policies on the use of emergency control procedures, the types of procedures which may be used, and requirements for staff training.

2. Behaviors requiring emergency control procedures are those which are infrequent and unpredictable.

3. Emergency control procedures shall not be employed as punishment, for the convenience of staff, or as a substitute for services, supports or instruction.

4. Within twenty-four (24) hours after the use of an emergency control procedure, the responsible staff person shall file an incident report. The incident report shall meet all requirements of ~~s~~Section 8.608.6.B and shall also include:

   a. A description of the emergency control procedure employed, including beginning and ending times;

   b. An explanation of why the procedure was judged necessary; and,

   c. An assessment of the likelihood that the behavior that prompted the use of the emergency control procedure will recur.

5. Within three (3) days after use of an emergency control procedure, the ~~c~~Community C~~c~~entered B~~b~~oard, case management agency or regional center, parent of a minor, guardian, and authorized representative if within the scope of his or her duties, shall be notified.

B. Safety control procedures must be developed when it can be anticipated that there will be a need to use restrictive procedures or restraints to control a previously exhibited behavior which is likely to occur again. The use of safety control procedures shall comply with the following:

1. Each ~~c~~Community C~~c~~entered B~~b~~oard, program approved service agency, and regional center shall have written policies on the use of safety control procedures, the types of procedures which may be used, and requirements for staff training;

2. When a safety control procedure is used, the service agency shall file an incident report within three (3) days with the ~~c~~Community ~~C~~Centered ~~b~~Board, case management agency or regional center which meets all requirements of ~~s~~Section 8.608.6.B and the conditions associated with each use of a safety control procedure; and,

3. If the safety control procedure is used more than three times within the previous thirty (30) days, the person's interdisciplinary team shall meet to review the situation and to endorse the current plans or to prepare other strategies.

8.608.8 ABUSE, MISTREATMENT, NEGLECT, AND EXPLOITATION

A. Pursuant to S~~s~~ection 25.5-10-221, C.R.S., all C~~c~~ommunity C~~c~~entered B~~b~~oards, case management agencies, service agencies and regional centers shall prohibit abuse, mistreatment, neglect, or exploitation of any person receiving services.

B. Community C~~c~~entered B~~b~~oards, case management agencies, program approved service agencies and regional centers shall have written policies and procedures for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any person receiving services. These policies and procedures must be consistent with state law and:

1. Definitions of abuse, mistreatment, neglect, or exploitation must be consistent with state law and these rules;

2. Provide a mechanism for monitoring to detect instances of abuse, mistreatment, neglect, or exploitation. Monitoring is to include, at a minimum, the review of:

   a. Incident reports;

   b. Verbal and written reports of unusual or dramatic changes in behavior(s) of persons receiving services; and,

   c. Verbal and written reports from persons receiving services, advocates, families, guardians, and friends of persons receiving services.

3. Provide procedures for reporting, reviewing, and investigating all allegations of abuse, mistreatment, neglect, or exploitation;

4. Ensure that appropriate disciplinary actions up to and including termination, and appropriate legal recourse are taken against employees and contractors who have engaged in abuse, mistreatment, neglect, or exploitation;

5. Ensure that employees and contractors are made aware of applicable state law and agency policies and procedures related to abuse, mistreatment, neglect or exploitation;

6. Require immediate reporting when observed by employees and contractors according to agency policy and procedures and to the agency administrator or his/her designee;

7. Require reporting of allegations within 24 hours to the parent of a minor, guardian, authorized representative, and Cc~~c~~ommunity Cc~~c~~entered Bb~~b~~oard or regional center;

8. Ensure prompt action to protect the safety of the person receiving services. Such action may include any action that would protect the person(s) receiving services if determined necessary and appropriate by the service agency or ~~c~~Community ~~c~~Centered ~~b~~Board pending the outcome of the investigation. Actions may include, but are not limited to, removing the person from his/her residential and/or day services setting and removing or replacing staff;

9. Provide necessary victim supports;

10. Require prompt reporting of the allegation to appropriate authorities in accordance with statutory requirements and pursuant to Ss~~s~~ection 8.608.8.C of these rules;

11. Ensure Human Rights Committee review of all allegations; and,

12. Ensure that no individual is coerced, intimidated, threatened or retaliated against because the individual, in good faith, makes a report of suspected abuse, mistreatment, neglect or exploitation or assists or participates in any manner in an investigation of such allegations in accordance with Ss~~s~~ection 8.608.8.D.

C. Any and all actual or suspected incidents of abuse, mistreatment, neglect, or exploitation shall be reported immediately to the agency administrator or designee. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, Ss~~s~~ection 19-1~~10-~~103, C.R.S., (Colorado Children's Code), Ss~~s~~ection 18-8-115, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Ss~~s~~ection 26-3.1-102, C.R.S., (Human~~Social~~ Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

D. All alleged incidents of abuse, mistreatment, neglect, or exploitation shall be thoroughly investigated in a timely manner using the specified investigation procedures. However, such procedures must not be used in lieu of investigations required by law or which may result from action initiated pursuant to Ss~~s~~ection C, herein.

1. Within twenty-four hours of becoming aware of the incident, a written incident report shall be made available to the agency administrator or designee and the Cc~~c~~ommunity Cc~~c~~entered Bb~~b~~oard or regional center.

2. The agency shall maintain a written administrative record of all such investigations including:

   a. The incident report and preliminary results of the investigation;

   b. A summary of the investigative procedures utilized;

   c. The full investigative finding(s);

   d. The actions taken; and,

   e. Human Rights Committee review of the investigative report and the action taken on recommendations made by the committee.

3. The agency shall ensure that appropriate actions are taken when an allegation against an employee or contractor is substantiated, and that the results of the investigation are recorded, with the employee's or contractor's knowledge, in the employee's personnel or contractor's file.

8.609 PROGRAM SERVICES AND SUPPORTS

8.609.1 SUPPORT SERVICES

Support services include supported living services for adults 18 years and older and the children's extensive support program for children through age 17.

A. Supported Living Services for adults are intended to provide the necessary assistance and support to meet the daily living and safety needs of persons who are responsible for their own living arrangements in the community. Services are intended to augment available supports for those individuals who can live independently with limited supports, or who, if they need extensive support, are getting that support from other sources.

B. Children's extensive support services are intended to provide the services and supports to children most in need because of the severity of the disability and provide for stability of the family setting which would allow the child to continue to remain in the family home.

C. Medicaid funded supported living services for adults and children's extensive support services are provided through the home and community based services program which is described in ~~the Colorado Department of Health Care Policy and Financing rules and regulations, Medical Assistance Staff Manual, S~~section 8.500. ~~(10 C.C.R. 2505-10).~~

~~. and the Department's program descriptions. State funded supported living services for adults are provided pursuant to the Department's program description.~~

~~D. Each community centered board has been designated as the agency responsible for the coordination of support services within its service area. As the support coordinating agency, the community centered board is responsible for the overall administration of the program and is authorized to provide services directly and to sub-contract with other service agencies.~~

8.609.2 SUPPORT SERVICES GENERAL PROVISIONS

A. Services and supports shall be provided pursuant to the person's Individualized Plan and Individual Service and Support Plans, as appropriate.

Individual Service and Support Plans shall be developed, as needed, to ensure that services and supports are provided consistently and reach the intended results, ~~and~~ as determined by the Interdisciplinary Team.

B. Services and supports provided shall be in accordance with the Department's ~~service descriptions and the Colorado Department of Health Care Policy and Financing~~ rules. ~~and regulations, Medical Assistance staff manual, and sSection 8.500. (10 C.C.R. 2505-10).~~

C. Each support coordinating agency shall be responsible to ensure there is no interruption of services and supports that are critical to a person's health and safety and which if not delivered could result in imminent harm to the person.

D. Individuals, parents of a minor or guardians shall have the opportunity to choose and direct services necessary to meet their identified and prioritized needs and to choose among qualified service providers. Provision of services by family members, as defined in S~~s~~ection 25.5-10-

202(16), C.R.S., living in the same household (under the same roof and same physical address) with the program participant shall be on an exception basis only and in accordance with the requirements of the applicable Medicaid waiver.

E. Each support coordinating agency shall establish and implement written procedures for:

1. The assignment of resources as prescribed by the Department; and,

2. Approving expenditures for adaptations and devices as prescribed by the Department.

F. For persons receiving services who are assisted in the administration of medications by a person other than a relative, the following is required:

1. A written record of medications, including time and the amount of medication, taken by the person; ~~and,~~

2. Written orders by a licensed physician or dentist for all medications; ~~and,~~

3. Documentation of the effects of psychotropic medications and any changes in medication; and,

4. The use of medication reminder boxes ~~shall be~~ pursuant to S~~s~~ection 25-1.5-303(1) C.R.S.

G. The support coordinating agency shall provide for the regular monitoring of the health, safety and welfare of persons and the services and supports provided.

H. The support coordinating agency shall conduct an evaluation of consumer satisfaction no less than every three (3) years. ~~Such an~~The evaluation shall, at a minimum, include satisfaction with choice of services and providers.

I. ~~Each~~ The support coordinating agency shall maintain a record for each person receiving services which includes the information required by these rules ~~and regulations~~ and as prescribed by the Department.

Staff, providers and other support personnel shall have ready access to records and information required by them to carry out their responsibilities.

8.609.5 COMPREHENSIVE HABILITATION SERVICES AND SUPPORTS DESCRIPTION AND GENERAL PROVISIONS

A. Comprehensive Habilitation Services and Supports provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training (i.e., instruction, skill acquisition) and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services and supports are designed to meet the unique needs of each person as determined by the interdisciplinary team and to provide access to and participation in typical activities and functions of community life.

B. Program approved service agencies providing Comprehensive Habilitation Services and Supports shall conform to the following provisions:

1. Physical facilities utilized as residential settings and/or adult day service sites shall meet all applicable fire, building, licensing and health regulations.

2. Persons receiving Comprehensive Habilitation Services and Supports shall have 24-hour supervision. Supervision may be on-site (staff is present) or accessible (agency personnel is not on site but available to respond when needed). Staffing arrangements must be adequate to ensure the health, safety and welfare of persons receiving services and the needs of the individual as determined by the Individualized Plan.

3. Services and supports shall be provided pursuant to the person's Individualized Plan and pertinent Individual Service and Support Plans and in accordance with Department guidelines and service descriptions.

   Individual Service and Support Plans shall be developed for all persons receiving comprehensive services and meet requirements of ~~s~~Section 8.608.

4. The program approved service agency shall provide for the regular on-site monitoring of Comprehensive Habilitation Services and Supports.

5. Each program approved service agency providing residential services shall establish and implement written policies and procedures concerning the use and handling of the personal needs funds and personal possessions, including clothing, of the person receiving services as prescribed by the Department.

6. A person receiving services shall be presumed able to manage his/her own funds and possessions unless the Individualized Plan documents and justifies limitations to ~~self management~~self-management, and where appropriate, reflects a plan to increase this skill.

7. The program approved service agency shall be responsible for providing services, supplies and equipment as prescribed by the Department.

8. Persons receiving services, guardians, authorized representatives, as appropriate, and the case management agency ~~community centered board~~ shall be notified at least fifteen (15) days prior to proposed changes in residential placements.

   a. If an immediate move is required for the protection of the person, notification shall occur as soon as possible before the move or not later than three (3) days after the move.

   b. Persons receiving services, guardians, and authorized representatives, as appropriate, shall be involved in planning subsequent placements and any member of the interdisciplinary team may request a meeting to discuss the change in placement.

   c. If the person receiving services, guardian, or authorized representative, as appropriate, wants to contest the move they should follow the grievance procedure of the agency. If they remain dissatisfied, they may ask the case management agency ~~community centered board~~ to review the decision.

   d. If there is a concern regarding the health, safety, or welfare of the person being jeopardized as a result of the move then any interested party may request an emergency order from the D~~d~~epartment pursuant to S~~s~~ection 8.605.4.

9. Program approved service agencies shall conduct an evaluation of consumer satisfaction with services and supports no less than every three (3) years.

10. The program approved service agency shall maintain a record for each person receiving services which includes the information required by these rules and as prescribed by the Department.

Staff, providers and other support personnel shall have ready access to records and information required by them to carry out their responsibilities.

8.611 TRANSPORTATION

E. Prior to the use of funds for transportation acquisition services, the ~~c~~Community ~~c~~Centered ~~b~~Board, case management agency or program approved service agency shall investigate the feasibility of the use of public transportation options. If public transportation options are found to be inadequate or inappropriate, this shall be documented.

8.612 SUPPORTS INTENSITY SCALE ASSESSMENT AND SUPPORT LEVELS

8.612.1 Supports Intensity Scale (SIS) Assessment [Eff. 2/1/12]

A. Completion of a Supports Intensity Scale (SIS) Assessment is a requirement for a ~~c~~Client to participate in the Home and Community Based Services-Supported Living Services (HCBS-SLS) or the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver. A ~~c~~Client or his or her guardian refusing to have a SIS assessment shall not be enrolled in the HCBS-SLS or HCBS-DD waivers.

B. Specific scores from the C~~c~~lient's SIS assessment shall be used in addition to other factors to obtain the C~~c~~lient's Support Level in the HCBS-DD and HCBS-SLS waivers.

C. The ~~Case Management Agency (CMA)~~ Community Centered Board (CCB) shall conduct a SIS assessment for a ~~c~~Client at the time of enrollment. Additional assessments will be conducted at a frequency determined by the Department.

D. The CCB~~CMA~~ shall:

1. Notify the ~~c~~Client, his or her legal guardian, authorized representative, or family member, as appropriate, of the requirement for and the right to participate in the SIS assessment.

2. Support and encourage the C~~c~~lient to participate in the SIS assessment. If the C~~c~~lient chooses not to participate in the SIS assessment, the CMA shall document his or her choice in the C~~c~~lient record on the Department required data system.

3. Schedule a SIS Interviewer to conduct the assessment. If the ~~c~~Client, his or her legal guardian, authorized representative, or family member, as appropriate, objects to the

assigned SIS Interviewer, he or she shall be offered a choice of a different SIS Interviewer.

4. Assist the Cclient or other interdisciplinary team (IDT) members to identify at least two people who know the Cclient well enough to act as respondents for the SIS assessment. If at least two respondents cannot be identified, the CMA shall document the efforts to find two respondents and the reasons this could not be done, anddone and proceed with the assessment using the information available.

E. A qualified SIS Interviewer shall conduct the assessment. A SIS Interviewer shall not act as the respondent for a SIS assessment.

F. The CCB CMA shall inform the cClient, his or her legal guardian, authorized representative, or family member, as appropriate, of the purpose of the SIS, the SIS Complaint Process, the Support Level Review Process, and that he or she may receive a copy of the completed SIS assessment upon request. The CCB CMA shall document that this information was provided and received on the SIS and Support Level disclosure form.

G. After the initial SIS assessment has been completed, the CMA shall conduct another SIS assessment for the cClient only when approved by the Department through the following process:

1. Prior to a subsequent SIS assessment being conducted, the CMA shall submit a request to the Department for approval in the format prescribed by the Department.

2. The Department shall provide the CMA with a written decision regarding the request to conduct another SIS assessment within fifteen (15) business days after the date the request was received.

3. Upon receiving approval to conduct a subsequent SIS the case management agencyCMA shall contact the designated CCB to request a SIS reassessment.

34. If the Cclient, his or her legal guardian, authorized representative or family member, as appropriate, disagrees with the decision, then a request for review of the decision may be submitted to the Executive Director of the Department within fifteen (15) business days after the date the decision was received. by the Executive Director of the Department or his or her designee.

54. The Executive Director or his or her designee shall review the request for conducting another SIS reassessment and provide a written decision within fifteen (15) business days.

65. The decision of the Executive Director or his or her designee shall constitute the final agency decision and will be subject to judicial review pursuant to Ssection 24-4-106, C.R.S.

H. A subsequent SIS assessment shall be conducted only when approved by the Department and when:

1. There has been a change in the cClient's life circumstances or condition resulting in a the significant change to the amount of services and supports needed to keep the cClient safe;

2. The cClient or his or her legal guardian, authorized representative, family member or case manager as appropriate, has reason to believe that the results of the most recent SIS assessment do not accurately reflect his or her current support needs; or,

3. The Department deems it necessary to complete a new assessment in order to ensure its accuracy.

I. Administration of the SIS assessments shall be reviewed by the Department for the purpose of quality assurance.

J. When the Department identifies SIS Interviewer practices that result in inaccurate SIS assessments:

1. Remediation efforts may occur to ensure that the SIS Interviewer performs assessments according to Department standards. The SIS Interviewer(s) who conducted the inaccurate SIS assessment(s) may be deemed no longer qualified to conduct SIS assessments.

2. Payments made for the administration of the inaccurate SIS assessments may be recovered through a repayment agreement; by offsetting the amount owed against current and future SIS determination payments; or, by any other appropriate action within the Department's legal authority.

3. The ~~e~~Client shall receive another SIS assessment conducted by a SIS Interviewer designated by the Department.

4. The ~~e~~Client's Support Level and Service Plan Authorization Limit will be adjusted as necessary and effective on the date determined by the Department.

8.612.2 SIS Complaint Process [Eff. 2/1/12]

A. The ~~e~~Client, his or her legal guardian, authorized representative, or family member as appropriate, may file a complaint regarding the administration of the SIS assessment up to thirty (30) calendar days after the SIS assessment is conducted.

B. The complaint shall be filed verbally or in writing with the ~~e~~Client's ~~CMA~~CCB. Additional information to support the complaint may be submitted at that time. If the complaint has been filed verbally the CMA shall document in the ~~e~~Client's record on the Department required data system the time, date and details surrounding the complaint.

C. When the complaint requests that another SIS assessment be completed, the ~~CMA~~ CCB shall submit a request for approval to conduct another SIS assessment, pursuant to the process identified in S~~s~~ection 8.612.1.G.

D. The ~~CMA~~ CCB shall make efforts ~~within the CCB~~ to resolve the complaint and provide the complainant with a written response within ten (10) business days after receipt of the complaint.

E. When a resolution cannot be reached, the ~~CMA~~ CCB shall inform the complainant that he or she may submit the complaint to the Department within fifteen (15) business days after receipt of the ~~CMA~~ CCB response.

F. The Department shall provide a written response to the complainant within fifteen (15) business days after receipt of the complaint.

8.612.3 Support Levels [Eff. 2/1/12]

A. A Cclient is assigned into one of six Support Levels according to his or her overall support needs and based upon the standardized algorithm for the HCBS-DD or HCBS-SLS waivers. The SIS-A Assessment converts subscale raw scores for each section into standard scores for each section, which are used in the algorithm for support levels. Additional information can be found on the Department's webpage or can be obtained in writing by requesting from the Department.

B. The structure of the algorithm, defined at Sectionat Section 10 CCR 2505-10, 8.600.4 definitions, includes the following:

1. Algorithm factors:

a. Standard scores from Section 2: Parts A (Home Living Activities), B (Community Living Activities), and E (Health and Safety Activities) (ABE) from the SIS assessment;

b. Total scores from Section 1A: Exceptional medial support needs score from the SIS assessment;

c Total scores from Section 1B: exceptional behavioral support needs score from the SIS assessment; and,

d. Whether the cClient presents as a safety risk, defined at Section10 CCR 2505-10, 8.600.4 definitions, as follows:

1) In the HCBS-SLS waiver, Public Safety Risk-Convicted.

2) In the HCBS-DD waiver, Public Safety Risk-Convicted/Not Convicted or Extreme Safety Risk to Self.

2. The subgroups in the algorithm table under each support level reflect variations of the intensity of the Cclient's basic support, medical support and behavioral support needs; no matter which subgroup a Cclient falls into, he or she is eligible for that support level. The subgroups cluster individuals with similar behavioral and medical support needs within each major group. Additional information can be found on the Department's website or can be obtained in writing by requesting from the Department.

3. Following an assessment of the factors defined above, standard scores for each factor are applied to the algorithm.

The Support Level is determined when the scores for each factor meet all of the criteria of a support level subgroup

4. The results of the algorithm are used to assign cClients to support levels one through six; with a support level one indicating a minimal need for supports and a support level six indicating a significantly higher need for supports.

5. For the HCBS-SLS wWaiver, the support level determines the Service Plan Authorization Limit (SPAL), which is defined at Section10 CCR 2505-10, 8.600.4 definitions. The SPALs are posted annually by the Department on the Department's webpage or available in writing by contacting the Department.

For the HCBS-DD wWaiver, the support level determines the rate of reimbursement for the provider(s).

C. The formula for the algorithm is:

Support Level/Subgroup
Support Level 1
Subgroup 1A: ABE < 25; 1A<1 AND 1B< 2
Subgroup 1B: ABE < 25; 1A< 2 AND 1B< 5
Subgroup 1C: ABE < 25; 1A<4 and 1B< 5
Support Level 2
Subgroup 2A: ABE 26-30; 1A<1 AND 1B<2
Subgroup 2B: ABE 26-30; 1A< 2 AND 1B< 5
Subgroup 2C: ABE 26-30; 1A<4 AND 1B< 5
Subgroup 1D: ABE < 25; 1A<6
Subgroup 1G: ABE < 25; 1B<9
Subgroup 2D: ABE 26-30; 1A<6
Subgroup 2G: ABE 26-30; 1B<9
Subgroup 3A: ABE 31-33; 1A< 1 AND 1B< 2
Subgroup 3B: ABE 31-33 1A< 2 AND 1B< 5
Support Level 3
Subgroup 1H: ABE < 25; 1B<13
Subgroup 2H: ABE 26-30; 1B<13
Subgroup 3C: ABE 31-33; 1A<4 AND 1B< 5
Subgroup 3D: ABE 31-33; 1A<6
Subgroup 3G: ABE 31-33; 1B<9
Subgroup 4A: ABE > 34; 1A< 1 AND 1B< 2
Subgroup 4B: ABE >34 1A< 2 AND 1B< 5
Support Level 4
Subgroup 1E: ABE < 25; 1A<8
Subgroup 1F: ABE < 25; 1A>9
Subgroup 1I: ABE < 25; 1B<15
Subgroup 1J: ABE < 25; 1B>16
Subgroup 2E: ABE 26-30; 1A<8
Subgroup 2I: ABE 26-30; 1B<15
Subgroup 2J: ABE 26-30; 1B>16
Subgroup 3E: ABE 31-33; 1A<8
Subgroup 3H: ABE 31-33; 1B<13
Subgroup 4C: ABE > 34; 1A<4 AND 1B< 5
Subgroup 4G: ABE > 34; 1B<9
Support Level 5
Subgroup 2F: ABE 26-30; 1A>9

Subgroup 3I: ABE 31-33; 1B<15
Subgroup 3J: ABE 31-33; 1B>16
Subgroup 4D: ABE >34; 1A<6
Subgroup 4E: ABE > 34; 1A<8
Subgroup 4H: ABE > 34; 1B<13
Subgroup 4I: ABE > 34; 1B<15
Group 5A: Community Safety (either status) AND 1b<11
Support Level 6
Subgroup 4J: ABE > 34; 1B>16
Group 6A: Community Safety (either status) AND 1b>12
Subgroup 3F: ABE 31-33; 1A>9
Subgroup 4F: ABE > 34; 1A>9
Level 7
Group 7: Individuals with Tier 7 Rates

Extreme Safety Risk to Self (as defined ~~at~~ at Section~~10 CCR 2505-10,~~ 8.600.4 definitions) -This factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 3, level 2 increases to level 4, level 3 increases to level 4, level 4 increases to level 5. No change to levels 5 or 6, as this factor is already considered in the algorithm. Public Safety Risk (as defined at Section ~~10 CCR 2505-10,~~ 8.600.4 definitions) – this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 5, level 2 increases to level 5, level 3 increases to level 5, and level 4 increases to level 6. No change to levels 5 or 6 as this factor is already considered in the algorithm.

D. The CMA in conjunction with the IDT shall make a determination whether a C~~c~~lient meets the definition of Public Safety Risk or Extreme Safety Risk to Self through the following process:

1. The decision shall be made by a case management supervisor ~~meeting the qualifications of a Developmental Disabilities Professional as defined in section 8.600.4~~. He or she shall:

   a. Document the rationale to support the decision which shall be kept in the C~~c~~lient's record;

b. Document that the ~~c~~Client meets the definition in the Department required data system; and,

c. Review the ~~c~~Client at least annually or when significant changes occur to assure that the C~~c~~lient continues to meet the definition.

2. At the point when a C~~c~~lient no longer meets the definition, his or her status must be changed in the Department-required data system and his or her Support Level must be re-calculated.

E. The CMA shall inform each ~~c~~Client, his or her legal guardian, authorized representative, or family member, as appropriate, of his or her Support Level at the time of the Service Plan development or when the Support Level changes for any reason.

F. Notification of a Support Level change shall occur within ten (10) business days of the date after the Service Plan development or Support Level change.

G. Each Support Level corresponds with the standardized reimbursement rates for individual waiver services and the Service Plan Authorization Limits (SPAL) in HCBS-SLS.

H. In HCBS-DD, the Department may assign a reimbursement rate for day habilitation services and residential habilitation services provided to a C~~c~~lient with exceptional overall needs in accordance with the Support Level Review Process.

8.760 TARGETED CASE MANAGEMENT SERVICES

8.760.1 DEFINITIONS

.10 "Case Management Agency" (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management service for Home and Community Based waivers pursuant to Section~~s~~ 25.5-10-209.5, C.R.S. ~~and CRS 25.5-6-106, C.R.S.~~ and pursuant to a provider participation agreement with the state department.

.11 "Child with a developmental delay" means: a person less than five years of age with delayed development or who is at risk of having a developmental disability. ~~as set forth at 2 CCR 503-1 Section 16.120, or as amended.~~

.12 Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

~~"Community Centered Board" means a private corporation, for profit or not for profit, which, when designated pursuant to C.R.S. 27-10.5-105, as amended, is authorized to determine eligibility of persons with developmental disabilities within a specific geographic catchment area for services authorized under C.R.S. 27-10.5, as amended, provide case management services to such persons, and provide authorized services to such persons either directly or by purchasing such services from local service agencies.~~

a. Persons receiving targeted case management services may not be restricted from requesting, on a statewide basis, which ~~c~~Community ~~c~~Centered ~~b~~Board or Case Management Agency will provide them with targeted case management services.

.13 "Developmental disability" means a disability that is manifested before the person reaches twenty-two years of age; which constitutes a substantial disability to the affected individual; and is attributable to ~~mental retardation~~ a developmental delay or intellectual disability or related conditions which include cerebral palsy, epilepsy, autism, or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with intellectual disability ~~mental retardation and as set forth in 2 CCR 503-1 Section 16.120, or as amended.~~ Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 15002~~6000~~, et seq., shall not apply.

8.761 TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITITES

.14 Targeted Case Management services for P~~p~~ersons with D~~d~~evelopmental D~~d~~isabilities consists of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources. Targeted case management services includes the following activities:

a. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the ~~c~~Client experiences significant change in need or in level of support. These assessment activities include:

1. T~~t~~aking ~~c~~Client history; and

2. I~~i~~dentifying the C~~c~~lient's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators as necessary, to form a complete assessment of the C~~c~~lient.

b. Development and periodic revision of a specific care plan that:

1. I~~i~~s based on the information collected through the assessment;

2. S~~s~~pecifies the goals and actions to address the medical, social, educational, and other services needed by the C~~c~~lient;

3. I~~i~~ncludes activities such as ensuring the active participation of the C~~c~~lient, and working with the C~~c~~lient (or the ~~c~~Client representative as defined in ~~10 CCR 2505-10~~ Section 8.500.1) and others to develop those goals; and

4. I~~i~~dentifies a course of action to respond to the assessed needs of the ~~c~~Client.

c. Referral and related activities to help a C~~c~~lient obtain needed services including activities that help link a ~~c~~Client with:

1. M~~m~~edical, social, educational providers; or

2. Oother programs and services including, making referrals to providers for needed services and scheduling appointments, as needed.

d. Monitoring and follow-up includes activities that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual'sClient's needs. Monitoring and follow up actions shall:

1. Bbe performed when necessary to address health and safety and services in the care plan;.

2. Iinclude activities to ensure:

A. Sservices are being furnished in accordance with the cClient's care plan;

B. Sservices in the care plan are adequate; and

C. Nnecessary adjustments in the care plan and service arrangements with providers are made if the needs of the Cclient have changed;.

3. Iinclude direct contact and observation with the Cclient in a place where services are delivered to a cClient in accordance with the following frequency:

A. Face to face monitoring shall be completed for a cClient enrolled in HCBS-DD at least once per quarter;.

B. Face to face monitoring shall be completed for a Cclient enrolled in HCBS-SLS at least once per quarter;.

C. Face to face monitoring shall be completed for a cClient in HCBS-CES at least once per quarter; and, or

D. Face to face monitoring shall be completed at least once every per six months period for children in Early Intervention Services.

.15 All case documentation must be entered into the Department's IMS within five (5) business days of case activityfrom the date of activity.

8.761.2 DETERMINATION OF CLIENT ELIGIBLITY

.21 To receive targeted case management services individuals must meet the following criteria:

a. Bbe determined to be eligible for Medicaid by the County Department of Social/Human Services in the county in which the person resides;

b. Bbe determined by the designated Community Centered Board to have a developmental disability or developmental delay; and

c. Bbe actively enrolled in one of the following programs :

1. Home and Community Based Services for Persons with Developmental Disabilities waiver;

2. Home and Community Based Services - Supported Living Services waiver;

3. Home and Community Based Services- Children's Habilitation Residential Program

3. Home and Community Based Services - Children's Extensive Support waiver; or

4. Early Intervention Services.

.22 The specific programs listed in Section 8.761.21 (cC)(1) through (4) are the only programs which are eligible for targeted case management services.

8.761.3 PROVIDER ELIGIBILITY

.31 Only certified Early Intervention Services designated Community Centered Boards may be reimbursed for targeted case management services for persons enrolled in Early Intervention Services pursuant to 12 CCR 2509-10-7.913with developmental disabilities.

.32 Only case management agencies certified by the Department pursuant to Section 8.519 through 8.519.23 may provide case management for persons enrolled in the Home and Community Based Services outlined in Section 8.503 Home and Community Based Services for Children's Extensive Support (HCBS-CES) Waiver, 8.500 Home and Community Based Services for the Developmentally Disabled (HCBS-DD) Waiver, and 8.500.90 Home and Community Based Services for Supported Living Services (HCBS-SLS) Waiver *et seq.*

8.761.4 REIMBURSEMENT

.41 Claims are reimbursable only when supported by the following documentation:

a. The name of the Cclient;

b. The date of the activity;

c. The nature of the activity including whether it is direct or indirect contact with the Client;

d. The content of the activity including the relevant observations, assessments, findings;

e. Ooutcomes achieved, and as appropriate, follow up action; and

f. The total number of units associated with the activity; and.

g. Ffor HCBS waiver programss, documentation required under comply with requirements set forth at Sections 8.519 and 8.760.

.42 TCM providers shall recordput what documentation exists in the in log notes and enter it into the state data system as required by the Department.

.43 Claims for travel time to and from a TCMargeted Case Management activity are reimbursable at the same unit rate as TCMtargeted case management services. The time claimed for travel shall be documented separately from the time claimed for the TCMtargeted case management activity.

.44 Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at 42 C.F.R. § 447.205, and447.205 and shall be based upon a market-based rate with a unit of service equal to fifteen (15) minutes according to the State's approved fee schedule.

.45 TCMargeted case management services may not be claimed prior to the first day of enrollment into an eligible program nor prior to the actual date of eligibility for Medicaid benefits.

.46 TCMargeted Case Management is limited to 60 units per cClient for State Fiscal Year 2011-12 (April 1 to June 30, 2012). Thereafter, TCMargeted Case Management is limited to 240 units per cClient per state fiscal year. This limitation is in effect upon approval from the Centers for Medicare and Medicaid Services (CMS).