DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules concerning HCBS Benefit Home Accessibility Adaptations for the CES and SLS Waivers, Sections 8.500.94.B.6 and 8.503.40.A.5
Rule Number: MSB 19-07-02-A
Division / Contact / Phone: Benefits and Services Management Division / Diane Byrne / 4030

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 19-07-02-A , Revision to the Medical Assistance Rules concerning HCBS Benefit Home Accessibility Adaptations for the CES and SLS Waivers, Sections 8.500.94.B.6 and 8.503.40.A.5

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) 8.500.94.B.6 and 8.503.40.A.5, 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 8.500.94.B.6 with the proposed text beginning at 8.500.94.B.6 through the end of 8.500.94.B.6.f.vii. Replace the current text at 8.503.40.A.5 with the propose text beginning at 8.503.40.A.5 through the end of 8.503.40.A.5.f.vii. This rule is effective December 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 rules set forth at 10 CCR 2505-10 §8.500.94.B.6 and §8.503.40.A.5 are being revised to incorporate significant changes developed over the last year to the Home Accessibility Adaptations (HAA) benefit available to clients on the Children's Extensive Supports (CES) and Supported Living Services (SLS) waivers. The cornerstone of these changes has been monthly stakeholder meetings related to the process changes and rule development. Within the partnership with DOH, the Department has focused on ways to increase the quality of work done throughout the state and reduce the difficulties encountered by clients during the home modification process. The main goals of these changes have been 1), reducing miscommunication and shortening timeframes by clarifying policy and creating standard forms for use; 2), increased physical inspections by DOH to promote high quality work; 3), provider billing clarification; and 4) policy and process alignment with the Home Modification benefit for other waivers. Department staff established and have met with the Home Modification Stakeholder Workgroup monthly since December 2018 for input and recommendations on these changes.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   The Childrens Extensive Supports (CES) and Supported Living Services (SLS) programs are authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   C.R.S. 25.5-6-409

Initial Review	**10/11/19**	Final Adoption	**11/08/19**
Proposed Effective Date	**12/30/19**	Emergency Adoption	

DOCUMENT #07

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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.

   People on the CES and SLS waivers who access the Home Accessibility Adaptations (HAA) service will benefit from the proposed rule through less inconsistency and confusion due to more detailed policy and process. People will also benefit from higher quality services due to oversight being moved to DOH, including project review, approval, and inspection. There is no cost to the Department. Funding for DOH FTE for oversight was allocated by the state legislature.

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

   This rule will have a positive impact on the safety, quality of life, and independence of persons who choose to use the HAA benefit. All persons who use HAA should benefit from an increase in the quality of home modifications done throughout the state and reduce the difficulties encountered by clients during this process.

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.

   Funding for DOH FTE for oversight was allocated by the state legislature. This oversight will ensure a more consistent utilization of funding under the benefit for the CES and SLS waivers, increasing compliance with regulatory requirements. Costs are not expected to shift significantly for services, however, the average cost of the same services may decrease and the quality of services received by CES and SLS waiver members may increase.

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

   The Department will increase the quality of home modifications done throughout the state, decrease the number of complaints received, and possibly lower the average cost of home modifications due to decreased mis-billing and fraud from increased

oversight. The costs of inaction include a continuation of miscommunication, lack of oversight, and possible mis-billing and fraud. There is no benefit to inaction.

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

   This rule revision does not increase the cost to the Department for providing the HAA benefit. There is no less intrusive method to increase communication, project quality oversight, and clarity related to billing.

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 considered included the dedication of more Department staff to this benefit. This method was rejected as inadequate to provide clarity to the program, integrate the expertise gained from the partnership with DOH, and costly to implement.

8.500.94.B.6. HOME ACCESSIBILITY ADAPTATIONS

8.500.94.B.6.a DEFINITIONS

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 sections 25.5-10-209.5, C.R.S. and 25.5-6-106, C.R.S. and pursuant to a provider participation agreement with the state Department.

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

The Division of Housing (DOH) is a division ~~State entity~~ within the Colorado Department of Local Affairs that is responsible for approving Home Accessibility Adaptation PARs, oversight on the quality of Home Accessibility Adaptation projects, and inspecting Home Accessibility Adaptation projects, as described in these regulations. ~~10 CCR 2505-10 section 8.500.94.B.6.~~

1. DOH oversight is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, all oversight functions shall be performed by the Department unless specifically allowed by the Participant or their guardian to be performed by DOH.

Home Accessibility Adaptations means~~are~~ the most cost-effective physical modifications, adaptations, or improvements in a Participant's existing home setting which, based on the Participant's medical condition or disability: ~~to the primary residence of the client~~Participant~~, that~~

1. A~~a~~re necessary to ensure the health~~,~~ and safety of the ~~client~~Participant; ~~, or t~~~~hat~~

2. ~~e~~Enable the ~~client~~Participant to function with greater independence in the home; ~~, or~~

3. Prevent institutionalization or support the deinstitutionalization of the Participant. ~~All adaptations shall be the most cost effective means to meet the identified need.~~

Home Accessibility Adaptation Provider means a provider agency that meets ~~has met all~~ the standards for Home Accessibility Adaptation described in ~~10 CCR 2505-10 s~~/Section 8.500.94.B.6.e and is an enrolled Medicaid provider.

Person-Centered Planning ~~as applied~~s to Home Accessibility Adaptations means ~~that~~ Home Accessibility Adaptations that are ~~shall be~~ agreed upon through a process that is driven by the ~~individual~~ Participant and can include people chosen by the Participant, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations; and where the ~~Member~~Participant is provided ~~. The Home Accessibility Adaptation process provides~~ necessary information, support, and choice ~~to the~~ Participant to ensure that the Participant directs the process to the maximum extent possible.

8.500.94.B.6.b INCLUSIONS

8.500.94.B.6.b.i ~~Such~~ Home Accessibility A~~a~~daptations~~, modifications, or improvements~~ may include, but are not limited to the following:

a). ~~The installation of~~Installing or building ramps;~~,~~

b). Installing grab-bars or other Durable Medical Equipment (DME) if such installation cannot be performed by a DME supplier;

c) Widening or modification of doorways;

d)c. Modifying a fication of bathroom facilityties to allowfor purposes of accessibility, health and safety, and assist with needsindependence in Aactivities of Ddaily Lliving;

e) Modifying a kitchen for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

f)d. The installation ofInstalling specialized electric and plumbing systems that are necessary to accommodate the medically necessary equipment and supplies; that are necessary for the welfare of the client, and

g) Installing stair lifts or vertical platform lifts;

h) Modifying an existing second exit or egress window to lead to an area of rescue for emergency purposes;

i) The modification of a second exit or egress window must be approved by the Department or DOH at any funding level as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the Participant.

i)e. Safety enhancing supports such as basic fences, strengthened windows, and door and window alarmsalerts.

8.500.94.B.6.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of 8.500.94.B.6.

8.500.94.B.6.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.

8.500.94.B.6.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.

8.500.94.B.6.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.

a) Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the Participant, or enable the Participant to function with greater independence in the home, if:and

i) The adaptation It decreases the need for paid assistance in another waiver service on a long-term basis, and

ii) Either:

1. There is an immediate risk to the Participant's health or safety, or

2. There has been a significant change in the Participant's needs since a previous Home Accessibility Adaptation.

b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule section 8.500.94.B.6.

8.500.94.B.6.c. EXCEPTIONS AND RESTRICTIONS

8.500.94.B.6.c.i. Home Accessibility Adaptations must be a direct benefit to the Participant ~~as defined in 8.500.94.B.6.a~~ and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.

8.500.94.B.6.c.ii. Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, ~~improvements or modifications~~ are prohibited.

~~This includes, but is not limited to, multiple bathrooms within the same home.~~

8.500.94.B.6.c.iii. Adaptations, improvements, or modifications as a part of new construction costs are prohibited.~~.~~

a) F~~The f~~inishing ~~of~~ unfinished areas in a home to add to or complete ~~the addition of in~~habitable square footage is prohibited.

b) Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i) improve entrance or egress to a residence; or,

ii) configure a bathroom to accommodate a wheelchair.

c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department requirements found in this rule section 8.500.94.B.6.

8.500.94.B.6.c.iv. The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.

8.500.94.B.6.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.

8.500.94.B.6.c.vi. Upgrades beyond what is the most cost-effective means of meeting the ~~Member~~Participant's identified need, including, but not limited to items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

8.500.94.B.6.c.vii. ~~f.~~ The following items are specifically excluded from Hh~~h~~ome Aa~~a~~ccessibility Aa~~a~~daptations and shall not be reimbursed:

~~i) Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,~~

~~ii) Carpeting,~~

a~~iii~~) Roof repair,

~~iv~~b)~~.~~ Central air conditioning,

c~~v~~) Air duct cleaning,

d~~vi~~) Whole house humidifiers,

e~~vii~~) Whole house air purifiers,

f~~viii~~) Installation or repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,

g~~ix~~) Monthly or ongoing home security monitoring fees,~~.~~

~~, and~~

h~~x~~) Home furnishings of any type,

i) HOA fees.~~, and~~

~~xi) Luxury upgrades.~~

~~g. When the HCBS-SLS waiver has provided modifications to the client's home and the client moves to another home, those modifications shall not be duplicated in the new residence unless prior authorized in accordance with Operating Agency procedures.~~

~~Adaptation to rental units, when the adaptation is not portable and cannot move with the client shall not be covered unless prior authorized in accordance with Operating Agency procedures.~~

~~h. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:~~

~~i. improve entrance or egress to a residence; or,~~

~~ii. configure a bathroom to accommodate a wheelchair.~~

~~i. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agency procedures.~~

8.500.94.B.6.c.viii. ~~j.~~Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.~~All devices and adaptations shall be provided in accordance with applicable state or local building codes or applicable standards of manufacturing, design and installation. Medicaid state plan, EPSDT or third party resources shall be utilized prior to authorization of waiver services.~~

~~k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health, and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis.~~

~~Requests to exceed the limit shall be prior authorized in accordance with Operating Agency procedure.~~

8.500.94.B.6.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.500.94.B.6.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to §24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8.500.94.B.6.d CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.500.94.B.6.d.i. The Case Manager shall consider alternative fund ing sources to complete the Home Accessibility Adaptation. The alternatives considered and the reason they are not available shall be documented in the case record.

1) The Case Manager must confirm that the Participant is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding. Case Managers may request confirmation of a property owner's~~'s~~ obligations through DOH.

8.500.94.B.6.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval ~~authorization~~ and confirmation of Home Accessibility Adaptation fund availability.

8.500.94.B.6.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization R~~r~~equest form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6. Home Accessibility Adaptations submitted with improper documentation will not be approved.

2) The Case Manager and CMA are responsible for retaining and tracking all documentation related to a Participant's Home Accessibility Adaptation funding use and communicating that information to the Participant and Home Accessibility Adaptation providers. The Case Manager may request confirmation of a Participant's Home Accessibility Adaptation fund use from the Department or DOH.

3) The Case Manager shall discuss any potential plans to move to a different residence with the Participant or their guardian and advise them on the most prudent utilization of available funds.~~the benefit.~~

8.500.94.B.6.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1) An occupational or physical therapist (OT/PT) shall assess the Participant's needs and the therapeutic value of the requested Home Accessibility Adaptation. When an OT/PT with experience in Home Accessibility Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Accessibility Adaptation would contribute to a Participant's ability to remain in or return to his/her home, and how the Home Accessibility Adaptation would increase the ~~Member~~Participant's ~~individual's~~ independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

a) The evaluation must be performed in the home to be modified. If the Participant is unable to access the home to be modified without the modification, the OT/PT must evaluate the Participant and home separately and document~~note~~ why the Participant was not able to be evaluated in the home.

2) The evaluation ~~services~~ may be provided by a home health agency or other qualified and approved OT/PT through the Medicaid Home Health benefit.

a) A Case Manager may initiate the OT/PT evaluation process before the Participant has been approved for waiver services, as long as the Participant is Medicaid eligible.

b) A Case Manager may initiate the OT/PT evaluation process before the Participant physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

c) OT/PT evaluations performed by non-enrolled Medicaid providers may be accepted when an enrolled Medicaid provider is not available. A Case Manager must document the reason why an enrolled Medicaid provider is not available.

3) The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Participant's needs. The Case Manager shall document these alternatives and why they did not meet the Participant's needs in the Participant's case file.

8.500.94.B.6.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:

1) The Case Manager shall assist the Participant in soliciting bids from at least two Home Accessibility Adaptation Providers for Home Accessibility Adaptations estimated to cost $2,500 or more. Participant choice of provider shall be documented throughout.

2) The Case Manager must verify that the provider is an enrolled Home Accessibility Adaptation Provider for Home Accessibility Adaptations.

4) The bids for Home Accessibility Adaptations at all funding levels shall include a breakdown of the costs of the project and the following: ~~including:~~

a) Description of the work to be completed,

b) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour,

c) Estimate for building permits, if needed,

d) Estimated timeline for completing the project,

e) Name, address and telephone number of the Home Accessibility Adaptation Provider,

f) Signature of the Home Accessibility Adaptation Provider,

g) Signature or other indication of approval, such as email approval, of the Participant or their guardian, that indicates all aspects of the bid have been reviewed with them,

h) Signature of the home owner or property manager if the home is not owned by the Participant or their guardian.

5) Home Accessibility Adaptation Providers have a maximum of thirty (30) days to submit a bid for the Home Accessibility Adaptation project after the Case Manager has solicited the bid.

a) If the Case Manager has made three attempts to obtain a bid from a second Home Accessibility Adaptation Provider and the provider ~~Home Accessibility Adaptation Provider~~ has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

6) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.500.94.B.6. and the recommendations of the OT/PT evaluation.

a) If a Participant or home owner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

7) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.500.94.B.6.~~, according to Department prescribed processes and procedures.~~

8.500.94.B.6.d.vi. If a property to be modified is not owned by the Participant, the Case Manager shall obtain signatures from the home owner or property manager on the submitted bids authorizing the specific modifications described therein.

1) Written consent of the home owner or property manager~~, as evidenced by the above mentioned signatures,~~ is required for all projects that involve permanent installation within the Participant's residence or installation or modification of any equipment in a common or exterior area.

2) The authorization shall include confirmation that the home owner or property manager agrees that if ~~If~~ the Participant vacates the property, ~~these signatures evidence that the home owner or property manager agrees to allow~~ the Participant may choose to either ~~to~~

leave the modification in place or remove the modification, that the home owner or property manager may not hold any party responsible for removing all or part of a Home Accessibility Adaptation project, and that if the Participant chooses to remove the modification, the property must be left in equivalent or better than its pre-modified condition.

~~in than~~ 8.500.94.B.6.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation, the Department may hold the CMA financially liable for the increased cost.

8. 500.94.B.6.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR.

8.500.94.B.6.e PROVIDER RESPONSIBILITIES

8.500.94.B.6.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in ~~10 CCR 2505-10 s~~Section 8.500.98.

8.500.94.B.6.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the ~~they propose to provide~~ the Home Accessibility Adaptation services will be performed~~to perform the work proposed, ~~,if required by that city or county.

8.500.94.B.6.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH~~the Division of Housing (DOH)~~ or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline ~~period~~ and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

1) If any changes to the approved scope of work are made without DOH or Department authorization, the cost of those changes will not be reimbursed.

2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline ~~period~~ and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi

8.500.94.B.6.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's ~~their~~ expense.

1) The ~~P~~provider shall give the Participant or their guardian all manufacturer's or seller's warranties on completion of work.

8.500.94.B.6.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications (2018) developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8.500.94.B.6.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Accessibility Adaptation projects may be

inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. ~~or the Department.~~ Participants must provide access for inspections.

1) DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion for sampled projects, or receipt of a Participant's reasonable request.

2) DOH shall produce a written inspection report within the time frame agreed upon in the Home Accessibility Adaptations work plan that notes the Participant's specific complaints. The inspection report shall be sent to the Participant, Case Manager, and provider.

3) Home Accessibility Adaptation P~~p~~roviders must repair or correct any noted deficiencies within twenty (20) days or the time required in the inspection report, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline ~~period~~ and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.500.94.B.6.f.vi.

8.500.94.B.6.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis ~~justification~~ for non-payment or ~~-~~recovery of payment by the Department.

1) Volunteer work on a Home Accessibility Adaptation project approved by the Department shall be completed under the supervision of the Home Accessibility Adaptation Provider as stated on the bid.

a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family of the Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.500.94.B.6.

8.500.94.B.6.f REIMBURSEMENT

8.500.94.B.6.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments ~~per Home Accessibility Adaptation~~.

8.500.94.B.6.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8.500.94.B.6.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation ~~below~~ to DOH:

1) Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2) Required permits;

3) One year written warranty on materials and labor; and

4) Documentation in the Participant's file that the Home Accessibility Adaptation has been completed satisfactorily through:

a) Receipt of the inspection report approving work from the state, county, or local building, plumbing, or electrical inspector;

b) Approval by the Participant, representative, or other designee;

c) Approval by the home owner or property manager;

d) A final ~~By conducting an~~ on-site inspection report by DOH or its designated inspector; or

e) DOH acceptance of photographs taken both before and after the Home Accessibility Adaptation.

8.500.94.B.6.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the ~~Home Accessibility Adaptationp P~~provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8.500.94.B.6.f.v. The Home Accessibility Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.

1) All required repairs noted on inspections shall be completed before the Home Accessibility Adaptation Provider submits a final claim for reimbursement.

2) If a Home Accessibility Adaptation Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the p~~P~~rovider during an inspection. The p~~P~~rovider shall only be reimbursed for the value of the work completed satisfactorily.

a) A Home Accessibility Adaptation Provider may request DOH perform one (1) reconsideration of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the p~~P~~rovider's expense.

8.500.94.B.6.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.~~deficiencies.~~

1) Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 7 day deadline ~~period~~ and be supported by documentation, including Participant notification.

2) The Home Accessibility Adaptation reimbursement reduced pursuant to this subsection shall be considered part of the Participant's remaining funds.

8.500.94.B.6.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

8.503.40.A.5. HOME ACCESSIBILITY ADAPTATIONS

8.503.40.A.5.a DEFINITIONS

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 sections 25.5-10-209.5, C.R.S. and 25.5-6-106, C.R.S. and pursuant to a provider participation agreement with the state Department.

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

The Division of Housing (DOH) is a division within the Colorado Department of Local Affairs that is responsible for approving Home Accessibility Adaptation PARs, oversight on the quality of Home Accessibility Adaptation projects, and inspecting Home Accessibility Adaptation projects, as described in these regulations~~, S~~

2. DOH oversight is contingent and shall not be in effect until approved by the Centers for Medicare and Medicaid Services (CMS). Until approved by CMS, all oversight functions shall be performed by the Department unless specifically allowed by the Participant or their guardian to be performed by DOH.

Home A~~a~~accessibility A~~a~~daptations ~~are~~ means the most cost-effective physical modifications, adaptations, or improvements in a Participant's existing home setting which, based on the Participant's medical condition or disability: ~~to the primary residence of the Client, that~~

1. A~~a~~re necessary to ensure the health and safety of the ~~Client~~Participant, or

2. ~~or that e~~Enable the ~~Client~~Participant to function with greater independence in the home, or

3. Prevent institutionalization or support the deinstitutionalization of the Participant. ~~All adaptations shall be the most cost-effective means to meet the identified need.~~

Home Accessibility Adaptation Provider means a provider agency that meets all the standards for Home Accessibility Adaptation described in ~~,~~Ss~~s~~ection 8.503.A.5.e and is an enrolled Medicaid provider.

Person-Centered Planning means Home Accessibility Adaptations that are agreed upon through a process that is driven by the Participant and can include people chosen by the Participant, as well as the appropriate health care professionals, providers, and appropriate state and local officials or organizations; and where the Participant is provided necessary information, support, and choice Participant to ensure that the Participant directs the process to the maximum extent possible.

8.503.40.A.5.b INCLUSIONS

8.503.40.A.5.b.i. ~~Such~~ Home Accessibility A~~a~~daptations may include, but are not limited to, the following:

a~~).~~ ~~The installation of~~ Installing or building ramps;~~,~~

b~~).~~ ~~.~~ Installing grab-bars or other Durable Medical Equipment (DME) if such installation cannot be performed by a DME supplier;

c) Widening or modification of doorways;~~,~~

~~c~~d). Modifying a~~ication~~ of bathroom facility~~ies to allow~~for the purposes of accessibility, health and safety, and ~~assist with needs~~ independence in Activities of Daily Living;~~,~~

e) Modifying a kitchen for purposes of accessibility, health and safety, and independence in Activities of Daily Living;

d~~).~~ ~~The installation of~~Installing specialized electric and plumbing systems that are necessary to accommodate ~~the~~ medically necessary equipment and~~or~~ supplies; ~~that are necessary for the health and safety of the Client, and~~

g) Installing stair lifts or vertical platform lifts;

h) Modifying an existing second exit or egress window to lead to an area of rescue for emergency purposes;

i) The modification of a second exit or egress window must be approved by the Department or DOH at any funding level as recommended by an occupational or physical therapist (OT/PT) for the health, safety, and welfare, of the Participant.

i)~~e.~~ Safety enhancing s~~S~~upports such as basic fences, strengthened windows, and ~~or basic~~ door and window ~~alarms~~alerts.~~,~~

8. 503.40.A.5.b.ii Previously completed Home Accessibility Adaptations, regardless of original funding source, shall be eligible for maintenance or repair within the Participant's remaining funds while remaining subject to all other requirements of Section 8.503.40.A.5.

8. 503.40.A.5.b.iii All adaptations, modifications, or improvements must be the most cost-effective means of meeting the Participant's identified need.

8. 503.40.A.5.b.iv Adaptations, modifications, or improvements to rental properties should be portable and able to move with the Participant whenever possible.

8. 503.40.A.5.b.v The combined cost of Home Accessibility Adaptations, Vehicle Modifications, and Assistive Technology shall not exceed $10,000 per Participant over the five-year life of the waiver.

a) Costs that exceed this cap may be approved by the Department or DOH to ensure the health, and safety of the Participant, or enable the Participant to function with greater independence in the home, if:

i) The adaptation decreases the need for paid assistance in another waiver service on a long-term basis, and

ii) Either:

1. There is an immediate risk to the Participant's health or safety, or

2. There has been a significant change in the Participant's needs since a previous Home Accessibility Adaptation.

b) Requests to exceed the limit shall be prior authorized in accordance with all other Department requirements found in this rule section 8.503.A.5.

8. 503.40.A.5**.c EXCEPTIONS AND RESTRICTIONS**

8. 503.40.A.5.c.i Home Accessibility Adaptations must be a direct benefit to the Participant ~~Section~~ and not for the benefit or convenience of caregivers, family Participants, or other residents of the home.

8. 503.40.A.5.c.ii Duplicate adaptations, such as adaptations to multiple bathrooms within the same home, are prohibited.

8. 503.40.A.5.c.iii Adaptations, improvements, or modifications as a part of new construction costs are prohibited.

a) Finishing unfinished areas in a home to add to or complete habitable square footage is prohibited.

b) Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i) improve entrance or egress to a residence; or,

ii) configure a bathroom to accommodate a wheelchair.

c) Any request to add square footage to the home must be approved by the Department or DOH and shall be prior authorized in accordance with Department procedures.

8. 503.40.A.5.c.iv The purchase of items available through the Durable Medical Equipment (DME) benefit is prohibited.

8.503.40.A.5.c.v. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Participant's individual ability and needs are prohibited.

8.503.40.A.5.c.vi. Upgrades beyond what is the most cost-effective means of meeting the Participant's identified need, including, but not limited to, items or finishes required by a Homeowner Association's (HOA), items for caregiver convenience, or any items and finishes beyond the basic required to meet the need, are prohibited.

8.503.40.A.5.c.vii.~~f.~~ The following items are specifically excluded from H~~h~~ome A~~a~~ccessibility A~~a~~daptations and shall not be reimbursed:

~~i. Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Client's disability,~~

~~ii. Carpeting,~~

~~iii.~~a) Roof repair,

~~iv.~~b) Central air conditioning,

~~v.~~c) Air duct cleaning,

~~vi.~~d) Whole house humidifiers,

~~vii.~~e) Whole house air purifiers,

~~viii.~~f) Installation and repair of driveways and sidewalks, unless the most cost-effective means of meeting the identified need,

~~ix.~~g) Monthly or ongoing home security monitoring fees,

~~x.~~h) Home furnishings of any type,

i) HOA fees.

~~xi. Adaptations to rental units when the adaptation is not portable and cannot move with the renter, and~~

~~xii. Luxury upgrades.~~

~~g. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:~~

~~i. Improve entrance or egress to a residence; or,~~

~~ii. Configure a bathroom to accommodate a wheelchair.~~

~~h. Any request to add square footage to the home shall be prior authorized in accordance with the Department's procedures.~~

~~i. All devices and adaptations shall be provided in accordance with applicable state or local building codes and applicable standards of manufacturing, design and installation. Medicaid State~~

~~Plan, EPSDT or third-party resources shall be utilized prior to authorization of HCBS-CES waiver services.~~

8.503.40.A.5.c.viii.~~j. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the Client, enable the Client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with the Department's procedure.~~

Home Accessibility Adaptation projects are prohibited in any type of certified or non-certified congregate facility, including, but not limited to, Assisted Living Residences, Nursing Facilities, Group Homes, Host Homes, and any settings where accessibility or safety modifications to the location are included in the provider reimbursement.

8.503.40.A.5.c.ix. If a Participant lives in a property where adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing are required by Section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding, the Participant's Home Accessibility Adaptation funds may not be used unless reasonable accommodations have been denied.

8.503.40.A.5.c.x. The Department may deny requests for Home Accessibility Adaptation projects that exceed usual and customary charges or do not meet local building requirements, the 2018 Home Modification Benefit Construction Specifications developed by the Division of Housing (DOH), or industry standards. The Home Modification Benefit Construction Specifications (2018) are hereby incorporated by reference. The incorporation of these guidelines excludes later amendments to, or editions of, the referenced material. The 2018 Home Modification Benefit Construction Specifications can be found on the Department website. Pursuant to §24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

8. 503.40.A.5.d CASE MANAGEMENT AGENCY RESPONSIBILITIES

8. 503.40.A.5.d.i. The Case Manager shall consider alternative funding sources to complete the Home Accessibility Adaptation. These alternatives considered and the reason they are not available shall be documented in the case record.

1) The Case Manager must confirm that the Participant is unable to receive the proposed adaptations, improvements, or modifications as a reasonable accommodation through federally funded assisted housing as required by section 504 of the Rehabilitation Act of 1973, the Fair Housing Act, or any other federal, state, or local funding. Case Managers may request confirmation of a property owner's obligations through DOH.

8. 503.40.A.5.d.ii. The Case Manager may prior authorize Home Accessibility Adaptation projects estimated at less than $2,500 without DOH or Department approval, contingent on Participant approval and confirmation of Home Accessibility Adaptation fund availability.

8. 503.40.A.5.d.iii. The Case Manager shall obtain prior approval by submitting a Prior Authorization Request form (PAR) to DOH for Home Accessibility Adaptation projects estimated above $2,500.

1) The Case Manager must submit the required PAR and all supporting documentation according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5. Home Accessibility Adaptations submitted with improper documentation will not be approved.

2) The Case Manager and CMA are responsible for retaining and tracking all documentation related to a Participant's Home Accessibility Adaptation funding use and communicating that information to the Participant and Home Accessibility Adaptation providers. The Case Manager may request confirmation of a Participant's Home Accessibility Adaptation fund use from the Department or DOH.

3) The Case Manager shall discuss any potential plans to move to a different residence with the Participant or their guardian and advise them on the most prudent utilization of available funds.

8. 503.40.A.5.d.iv. Home Accessibility Adaptations estimated to cost $2,500 or more shall be evaluated according to the following procedures:

1) An occupational or physical therapist (OT/PT) shall assess the Participant's needs and the therapeutic value of the requested Home Accessibility Adaptation. When an OT/PT with experience in Home Accessibility Adaptation is not available, a Department-approved qualified individual may be substituted. An evaluation specifying how the Home Accessibility Adaptation would contribute to a Participant's ability to remain in or return to his/her home, and how the Home Accessibility Adaptation would increase the individual's independence and decrease the need for other services, shall be completed before bids are solicited. This evaluation shall be submitted with the PAR.

a) The evaluation must be performed in the home to be modified. If the Participant is unable to access the home to be modified without the modification, the OT/PT must evaluate the Participant and home separately and document why the Participant was not able to be evaluated in the home.

2) The evaluation may be provided by a home health agency or other qualified and approved OT/PT through the Medicaid Home Health benefit.~~,~~

a) A Case Manager may initiate the OT/PT evaluation process before the Participant has been approved for waiver services, as long as the Participant is Medicaid eligible.

b) A Case Manager may initiate the OT/PT evaluation process before the Participant physically resides in the home to be modified, as long as the current property owner agrees to the evaluation.

c) OT/PT evaluations performed by non-enrolled Medicaid providers may be accepted when an enrolled Medicaid provider is not available. A Case Manager must document the reason why an enrolled Medicaid provider is not available.

3) The Case Manager and the OT/PT shall consider less expensive alternative methods of addressing the Participant's needs. The Case Manager shall document these alternatives and why they did not meet the Participant's needs in the Participant's case file.

8. 503.40.A.5.d.v. The Case Manager shall assist the Participant in soliciting bids according to the following procedures:

1) The Case Manager shall assist the Participant in soliciting bids from at least two Home Accessibility Adaptation Providers for Home Accessibility Adaptations estimated to cost $2,500 or more.

2) The Case Manager must verify that the provider is an enrolled Home Accessibility Adaptation Provider for Home Accessibility Adaptations.

3) The bids for Home Accessibility Adaptations at all funding levels shall include a breakdown of the costs of the project and the following:

a) Description of the work to be completed.

b) Description and estimate of the materials and labor needed to complete the project. Material costs should include price per square foot for materials purchased by the square foot. Labor costs should include price per hour.

c) Estimate for building permits, if needed,

d) Estimated timeline for completing the project,

e) Name, address and telephone number of the Home Accessibility Adaptation Provider,

f) Signature of the Home Accessibility Adaptation Provider,

g) Signature or other indication of approval, such as email approval, of the Participant or their guardian, that indicates all aspects of the bid have been reviewed with them,

h) Signature of the home owner or property manager if the home is not owned by the Participant or their guardian.

4) Home Accessibility Adaptation Providers have a maximum of thirty (30) days to submit a bid for the Home Accessibility Adaptation project after the Case Manager has solicited the bid.

a) If the Case Manager has made three attempts to obtain a bid from a Home Accessibility Adaptation Provider and the provider has not responded within thirty (30) calendar days, the Case Manager may request approval of one bid. Documentation of the attempts shall be attached to the PAR.

5) The Case Manager shall submit copies of the bid(s) and the OT/PT evaluation with the PAR to the Department. The Department shall authorize the lowest bid that complies with the requirements found in this rule section 8.503.40.A.5 and the recommendations of the OT/PT evaluation.

a) If a Participant or home owner requests a bid that is not the lowest of the submitted bids, the Case Manager shall request approval by submitting a written explanation with the PAR.

6) A revised PAR and Change Order request shall be submitted for any changes from the original approved PAR according to the procedures found in this rule section 8.503.40.A.5.

8. 503.40.A.5.d.vi. If a property to be modified is not owned by the Participant or their guardian, the Case Manager shall obtain signatures from the home owner or property manager on the submitted bids authorizing the specific modifications described therein.

1) Written consent of the home owner or property manager is required for all projects that involve permanent installation within the Participant's residence or installation or modification of any equipment in a common or exterior area.

2) The authorization shall include confirmation that the home owner or property manager agrees that if the Participant vacates the property, the Participant may choose to either leave the modification in place or remove the modification, that the home owner or property manager may not hold any party responsible for removing all or part of a Home Accessibility Adaptation project, and that if the Participant chooses to remove the modification, the property must be left in equivalent or better than its pre-modified condition.

8. 503.40.A.5.d.vii. If the CMA does not comply with the process described above resulting in increased cost for a Home Accessibility Adaptation, the Department may hold the CMA financially liable for the increased cost.

8. 503.40.A.5.d.vii. The Department or DOH may conduct on-site visits or any other investigations deemed necessary prior to approving or denying the Home Accessibility Adaptation PAR.

8. 503.40.A.5.e PROVIDER RESPONSIBILITIES

8. 503.40.A.5.e.i. Home Accessibility Adaptation Providers shall conform to all general certification standards and procedures set forth in ~~,~~Ssection 8.500.98.

8. 503.40.A.5.e.ii. Home Accessibility Adaptation Providers shall be licensed in the city or county in which the Home Accessibility Adaptation services will be performed, if required by that city or county.

8. 503.40.A.5.e.iii. Home Accessibility Adaptation Providers shall begin work within sixty (60) days of signed approval from the Department. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 60 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

1) If any changes to the approved scope of work are made without DOH or Department authorization, the cost of those changes will not be reimbursed.

2) Projects shall be completed within thirty (30) days of beginning work. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 30 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

8. 503.40.A.5.e.iv. The Home Accessibility Adaptation Provider shall provide a one-year written warranty on materials and labor from date of final inspection on all completed work and perform work covered under that warranty at provider's expense.

1) The Provider shall give the Participant or their guardian all manufacturer's or seller's warranties on completion of work.

8. 503.40.A.5.e.v. The Home Accessibility Adaptation Provider shall comply with the Home Modification Benefit Construction Specifications developed by the DOH, which can be found on the Department website, and with local, and state building codes.

8. 503.40.A.5.e.vi. A sample of Home Accessibility Adaptation projects set by the Department shall be inspected upon completion by DOH, a state, local or county building inspector in accordance with state, local, or county procedures, or a licensed engineer, architect, contractor or any other person as designated by the Department. Home Accessibility Adaptation projects may be inspected by DOH upon request by the Participant at any time determined to be reasonable by DOH. Participants must provide access for inspections.

1) DOH shall perform an inspection within fourteen (14) days of receipt of notification of project completion for sampled projects, or receipt of a Participant's reasonable request.

2) DOH shall produce a written inspection report within the time frame agreed upon in the Home Accessibility Adaptations work plan that notes the Participant's specific complaints. The inspection report shall be sent to the Participant, Case Manager, and provider.

3) Home Accessibility Adaptation providers must repair or correct any noted deficiencies within twenty (20) days or the time required by the inspection, whichever is shorter. Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 20 day deadline and be supported by documentation, including Participant notification. Reimbursement may be reduced for delays in accordance with Section 8.503.40.A.5.f.vi.

8. 503.40.A.5.e.vii. Copies of building permits and inspection reports shall be submitted to DOH. In the event that a permit is not required, the Home Accessibility Adaptation Provider shall formally attest in their initial bid that a permit is not required. Incorrectly attesting that a permit is not required shall be a basis for non-payment or recovery of payment by the Department.

1) Volunteer work on a Home Accessibility Adaptation project approved by the Department shall be completed under the supervision of the Home Accessibility Adaptation Provider as stated on the bid.

a) Volunteer work must be performed according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5.

b) Work performed by an unaffiliated party, such as, but not limited to, volunteer work performed by a friend or family Participant, or work performed by a private contractor hired by the Participant or family, must be described and agreed upon, in writing, by the provider responsible for completing the Home Accessibility Adaptation, according to Department prescribed processes and procedures found in this rule section 8.503.40.A.5.

8. 503.40.A.5.f REIMBURSEMENT

8. 503.40.A.5.f.i Payment for Home Accessibility Adaptation services shall be the prior authorized amount or the amount billed, whichever is lower. Reimbursement shall be made in two equal payments.

8. 503.40.A.5.f.ii. The Home Accessibility Adaptation Provider may submit a claim for an initial payment of no more than fifty percent of the project cost for materials, permits, and initial labor costs.

8. 503.40.A.5.f.iii. The Home Accessibility Adaptation Provider may submit a claim for final payment when the Home Accessibility Adaptation project has been completed satisfactorily as shown by the submission of the following documentation to DOH:

1) Signed lien waivers for all labor and materials, including lien waivers from sub-contractors;

2) Required permits;

3) One year written warranty on materials and labor; and

4) Documentation in the Participant's file that the Home Accessibility Adaptation has been completed satisfactorily through:

a) Receipt of the inspection report approving work from the state, county, or local building, plumbing, or electrical inspector;

b) Approval by the Participant, guardian, representative, or other designee;

c) Approval by the home owner or property manager;

d) A final on-site inspection report by DOH or its designated inspector; or

e) DOH acceptance of photographs taken both before and after the Home Accessibility Adaptation.

8. 503.40.A.5.f.iv. If DOH notifies a Home Accessibility Adaptation Provider that an additional inspection is required, the provider may not submit a claim for final payment until DOH has received documentation of a satisfactory inspection report for that additional inspection.

8. 503.40.A.5.f.v. The Home Accessibility Adaptation Provider shall only be reimbursed for materials and labor for work that has been completed satisfactorily and as described on the approved Home Accessibility Adaptation Provider Bid form or Home Accessibility Adaptation Provider Change Order form.

1) All required repairs noted on inspections shall be completed before the Home Accessibility Adaptation Provider submits a final claim for reimbursement.

2) If a Home Accessibility Adaptation Provider has not completed work satisfactorily, DOH shall determine the value of the work completed satisfactorily by the provider during an inspection. The provider shall only be reimbursed for the value of the work completed satisfactorily.

a) A Home Accessibility Adaptation Provider may request DOH perform one (1) reconsideration of the value of the work completed satisfactorily. This request may be supported by an independent appraisal of the work, performed at the provider's expense.

8. 503.40.A.5.f.vi. Reimbursement may be reduced at a rate of 1% (one percent) of the total project amount every seven (7) calendar days beyond the deadlines required for project completion, including correction of all noted deficiencies in the inspection report.

1) Extensions of time may be granted by DOH or the Department for circumstances outside of the provider's control upon request by the provider. Requests must be received within the original 7 day deadline and be supported by documentation, including Participant notification.

2) The Home Accessibility Adaptation reimbursement reduced pursuant to this subsection shall be considered part of the Participant's remaining funds.

8. 503.40.A.5.f.vii. The Home Accessibility Adaptation Provider shall not be reimbursed for the purchase of DME available as a Medicaid state plan benefit to the Participant. The Home Accessibility Adaptation Provider may be reimbursed for the installation of DME if such installation is outside of the scope of the Participant's DME benefit.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Residential Habilitation and Individual Residential Services and Supports (IRSS), Section 8.609
Rule Number: MSB 19-08-13-B
Division / Contact / Phone: Benefits and Services Management Division / Cassandra Keller / 303-866-5181

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 19-08-13-B, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Residential Habilitation and Individual Residential Services and Supports (IRSS), Section 8.609

3. This action is an adoption of: an amendment

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

   Sections(s) 10 CCR 2505-10 8.609.5 and 8.609.7, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.609 with the proposed text beginning at 8.609.5 through the end of 8.609.5.B.4. Replace the current text at 8.609.7 with the proposed text beginning at 8.609.7 through the end of 8.609.7.B.10. This rule is effective December 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Residential Habilitation and Individual Residential Services and Supports (IRSS), Section 8.609
Rule Number: MSB 19-08-13-B
Division / Contact / Phone: Benefits and Services Management Division / Cassandra Keller / 303-866-5181

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 proposing to make comprehensive revisions to the Residential Habilitation and Individual Residential Services and Supports (IRSS) regulations within the Developmental Disabilities (DD) Waiver. Over the past two years, the Department and stakeholders have had increasing concerns for the health, safety and welfare of participants receiving residential services due to a lack of oversight of residential settings. Due to the nature of the service, Host Homes, one model of service available to DD waiver participants, do not all receive surveys and inspections through the Colorado Department of Public Health and Environment (CDPHE). Seeing a need for enhanced oversight of this service, the Department put forth a budget request to the Joint Budget Committee (JBC). The budget request, approved, for the 2019-2020 fiscal year, will transfer funds to the Department of Local Affairs (DOLA) to create an inspection program of all Host Homes.

   In order to implement the inspection program with DOLA, revisions to the regulations are necessary to incorporate the inspection and oversight requirements. The Department is also taking this opportunity to make needed changes to the Residential Habilitation regulations. The changes include: incident reporting requirements; contract requirements for the Program Approved Service Agency (PASA) and Host Home provider; Colorado Adult Protective Services (CAPS) background check requirements; HCBS Settings Final Rule inclusions; responsibilities for the home environment; additional safety provisions; updated language and person centered language throughout; and restructured the rule for improved clarity and organization.

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:

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

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3. Federal authority for the Rule, if any:

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

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   C.R.S. 25.5-6-313(1)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Residential Habilitation and Individual Residential Services and Supports (IRSS), Section 8.609
Rule Number: MSB 19-08-13-B
Division / Contact / Phone: Benefits and Services Management Division / Cassandra Keller / 303-866-5181

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 on the Developmental Disabilities (DD) waiver will be impacted the by revisions to these regulations. Individuals on the DD waiver utilize the residential services described in these regulations and will benefit from the changes being made. Increased safety measures, oversight by the Division of Housing, and outlined provider expectations will provide better service outcomes for members. Service providers will also benefit from the improved clarity and organization of 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.

   Individuals on the Developmental Disabilities (DD) waiver will be positively impacted the by revisions to these regulations. These revisions should have a significant and positive impact on the quality of services provided and the safety measures in place in order to protect the health, safety and welfare of members.

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.

   By developing an inspection program of all Host Homes, there is a cost to the Department. However, those costs have been accounted for and budgetary resources have been allocated. There are no additional expected costs to the Department from the revisions to these regulations.

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

   The benefits of action on this change include: incident reporting requirements; contract requirements for the Program Approved Service Agency (PASA) and Host Home provider; Colorado Adult Protective Services (CAPS) background check

requirements; HCBS Settings Final Rule inclusions; responsibilities for the home environment; additional safety provisions; updated language and person centered language throughout; and restructured the rule for improved clarity and organization. The cost of inaction is to continue to operate a residential service where there is a lack of oversight and insufficient safety measures.

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

   The Department has considered other means of increasing oversight of Residential Habilitation settings. It was determined that the most efficient and cost-effective means of increasing oversight was to delegate certain authority to the Department of Local Affairs (DOLA). In order to operationalize the new oversight measures, the regulations must be revised to make the necessary incorporations.

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

   There are no alternative methods for achieving of increasing oversight of Residential Habilitation settings than by rule revisions.

8.609 PROGRAM SERVICES AND SUPPORTS

8.609.5 ~~COMPREHENSIVE~~ RESIDENTIAL HABILITATION SERVICES AND SUPPORTS DESCRIPTION AND GENERAL PROVISIONS

~~A. Comprehensive~~ Residential 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 assessed needs, personal goals, and other input provided by the Interdisciplinary T~~t~~eam, defined at 10 CCR 2505-10, Section 8.519.1, and to provide access to and participation in typical activities and functions of community life.

A~~B~~. Program Approved Service Agency Policies, Procedures and Service Provisions

~~Program approved service agencies providing Comprehensive Habilitation Services and Supports shall conform to the following provisions:~~

1. ~~1.~~ Each Program Approved Service Agency (PASA) providing residential services must establish and implement written policies and procedures concerning the use and handling of personal needs funds and include a record of personal possessions, including clothing, of the participant.

2. PASA's must conduct an evaluation of consumer satisfaction with services and supports no less than every three years. The PASA ~~program approved service agency~~ must review and analyze this data and address any complaints or problematic practices requiring corrective action.

3. The PASA must maintain a record for each participant which includes the information required by these rules and as prescribed by the Department.

4. Participants receiving ~~Comprehensive~~Residential Habilitation Services and Supports must have 24-hour supervision. Supervision may be on-site (direct service provider or caregiver is present) or accessible (direct service provider or caregiver is not on site but available to respond when needed). Staffing arrangements must be adequate to meet the health, safety and welfare of participants and the needs of the individual as determined by the Service Plan.

5. Physical facilities utilized as residential settings ~~and/or adult day service sites~~ must~~shall~~ meet all applicable fire, building, licensing and health regulations.

6. Services and supports must be provided pursuant to the person's Service Plan, in accordance with Department guidelines and service descriptions, and the HCBS Settings Final Rule at 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified in relevant part at 42 C.F.R. § 441.301).

7. The PASA is responsible for providing services, supplies and equipment as prescribed by the Department.

8. Caregivers, providers and other support personnel must have ready access to records and all necessary, detailed protocols about the participant required to carry out their responsibilities.

9. PASA's must comply with the Colorado Adult Protection Services (CAPS) requirements, outlined in §26-3.1-111, C.R.S. and 12 CCR 2518-1, Volume 30.960.

10~~1~~. Incident Reporting

a. The PASA must comply with all incident reporting requirements, as outlined in 10 CCR 2505-~~—~~10, Section 8.608.6.

b. The PASA must notify guardians and/or representatives of Incident Reports (IR).

c. The PASA must have policies and procedures in place for handling cases of alleged or suspected abuse, mistreatment, neglect, or exploitation of any participant, pursuant to 10 CCR 2505-~~—~~10, Section 8.608.8.

d. The PASA must notify the waiver participant and guardians and/or participants' representatives of investigations, including summary information pertaining to the outcome of the investigation, victim supports accessed, and recommendations to prevent recurrence.

11. The PASA is responsible for the monitoring of conditions at the property and must provide oversight and guidance to safeguard the health, safety, and welfare of the participant.

12. The PASA must provide for and document the regular on-site monitoring of ~~Comprehensive~~Residential Habilitation Services and Supports. PASA's must conduct an on-site visit of each Individual Residential Support Services (IRSS) or Group Residential Support Services (GRSS) setting~~ite~~ before a participant moves in, and at a minimum once every quarter, with at least one visit annually that is unscheduled. On-site monitoring of IRSS and GRSS settings~~ites~~ must include, but not be limited to:

a. Inspection of all smoke alarms and carbon monoxide detectors;

b. Ensuring all exits are free from blockages to egress;

c. Review of each participant's emergency and disaster assessment; and

d. Medication administration records and physician orders.

13. The PASA must have a protocol in place for the emergency placement of the participant if a home is deemed not safe by the Division of Housing (DOH).

14. The PASA must have a written contract with each direct service provider providing IRSS under the PASA's authority, such as a Host Home provider or family caregivers not directly employed by the PASA~~, backup caregiver, or other person providing care~~.

a. A current list of the above-mentioned contracted IRSS providers and their accompanying contracts must be on file with the program approved service agency and a copy must be provided to the Department or its agent upon request.

b. Each contract must be in writing and contain the following information:

i. Name of contracted IRSS provider;

ii. Responsibilities of each party to the contract, including, but not limited to, responsibility for the safety and accessibility of the physical environment of the home;

iii. process for correcting non-compliance;

iv. process for termination of the contract;

v. process for modification or revision of the contract;~~,~~

vi. process for relocation of the participant if they are in immediate jeopardy;

vii. process for coordinating the care of the participant;

vii.~~iii~~ Payment rate and method; and

viii.~~iv.~~ Beginning and ending dates.

c. If a contract is terminated with a contracted IRSS provider due to health, safety or welfare concerns, the PASA must report to the following parties:

i. Within 30 days to the Department regarding the cited reason for termination of a contracted IRSS provider.

ii. Within 10 days to the guardian or authorized representative and case manager of the participant from the terminated contracted IRSS provider.

15. The PASA must require each contracted direct service provider providing IRSS to document each approved caregiver(s) and report to the agency the names of all persons that reside in the home. No backup provider may be hired without PASA approval. The agency must ensure criminal background checks are completed for any non-participant over the age of 18 who lives in the home.

16. The Host Home must be the primary residence of the Host Home provider.

~~11.~~

~~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 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.~~

B.~~6.~~ Rights of Participants

1. A participant ~~person receiving services~~ must~~shall~~ be presumed able to manage his/her own funds and possessions unless otherwise documented in the ~~the~~ ~~Individualized~~ Service Plan. ~~documents and justifies limitations to self-management, and where appropriate, reflects a plan to increase this skill.~~

2. Participants must have a key or key code to their home, a bedroom door with a lock, lockable bathroom doors, access to all common areas of the home, and a residential agreement that provides protections for evictions.

~~7. The program approved service agency shall be responsible for providing services, supplies and equipment as prescribed by the Department.~~

3~~8~~. ~~Persons receiving services~~A participant, guardians, authorized representatives, as appropriate, and the ~~community centered board~~ case manager 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~~ must occur as soon as possible before the move or no~~t~~ later than three ~~(3)~~ days after the move.

b. A ~~P~~participant~~ersons receiving services~~, guardians, and authorized representatives, as appropriate, ~~shall~~ must be involved in planning subsequent placements and any member of the ~~i~~interdisciplinary T~~t~~eam may request a meeting to discuss the change in placement.

c. When a participant moves settings or PASA, all residential PASA's involved must be present for the move whenever possible, and will ensure all possessions, medications, money and pertinent records are transferred to the participant within 24 hours.

d~~c~~. If the ~~person receiving services~~participant, guardians, 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 community centered board to review the decision.~~

e~~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.

4. Participants have a right to annual notification of PASA appeal/grievance policies and procedures.

~~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.~~

8.609.7 INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) SPECIFICATIONS

~~A.~~ Individual Residential Services and Supports (IRSS) use a variety of living arrangements ~~individually designed~~ to meet the unique needs for support, guidance and habilitation of each participant~~person receiving services~~. ~~The program approved service agency has the responsibility for the living environment and persons~~Participants may live in a home owned or leased by the agency, ~~their own home or~~ a Host Home, or their own home. ~~Services are generally provided to no more than two persons receiving services per setting.~~

A. Program Approved Service Agency Policies, Procedures and Service Provisions

1. The Program Approved Service Agency (PASA) has the responsibility for the living environment, regardless of the setting type.

2. ~~Individual Residential Services and Supports~~IRSS may be provided to no more than three participants in a single setting. For each participant in a setting, ~~Three persons may be served in a single setting~~the PASA must ensure ~~when~~the following criteria are met and documented:~~:~~

   a. The participants~~persons~~ involved elect to live in the setting; ~~so choose; and,~~

   b. Each participant~~person is~~ ~~afforded~~ must have~~the opportunity for~~ their own bedroom, unless they elect to share a bedroom with a roommate of their choice, which must be documented in the Service Plan; ~~and,~~

   c. Back-up providers are identified, available and agreed upon by the participant and PASA. When a back-up provider is not available, the PASA assumes responsibility for identifying a provider;

   d. The PASA and case management agency of each participant in the setting must be involved in the coordination of placement of each participant;

   e. Participants are afforded regular opportunities for community inclusion of their choice;

   f. Participants are afforded individual choice, including preference to live near family; ~~and~~

   g. Distance from other homes (e.g., apartments, houses) of participants is examined so that persons with developmental disabilities are not grouped in a conspicuous manner~~.~~;

   h. For the placement of an individual into a three-person setting, the following factors must be examined to determine reasonableness of the placement:

      i. Level of care and needs of each participant in the home;

      ii. Availability to support and provide supervision to participants;

      iii. Compliance with HCBS Settings Final Rule at 79 Fed. Reg. 2948 (Jan. 16, 2014) (codified in relevant part at 42 C.F.R. § 441.301); and

      iv. Each participant's ability to evacuate.

   i. When three participants reside in a single setting, the PASA must conduct monthly monitoring of the setting.

~~c. The setting is not a host home; or,~~

~~d. The interdisciplinary team determines placement in the setting is the best alternative in an emergency and placement does not exceed thirty days; or,~~

~~e. Placement is to provide short-term relief for a Host Home provider and does not exceed fourteen (14) days.~~

~~2. Living environments utilized for IRSS shall be selected in accordance with Department guidelines implementing section 1616(e) of the Social Security Act (42 U.S.C. section 1382e (e)(1)) and addressing building capacity, including the maximum number of persons receiving services and the number of units which may be utilized under a single roof or in a single setting.~~

~~3. The selection of a living environment shall include consideration of the following:~~

~~a. Opportunities for community inclusion for persons receiving services;~~

~~b. Individual choice, including preference to be close to family; and,~~

~~c. Distance from other homes (e.g., apartments, houses) of persons receiving services so that persons with developmental disabilities are not grouped in a conspicuous manner.~~

3. Participants must live safely in environments common to other citizens with reasonable and appropriate supports provided to protect their health and safety while simultaneously promoting community inclusion. Providers and caregivers must have the appropriate knowledge, skills, and training to meet the individual needs of the participant before providing care and services. The PASA must have policies and procedures in place outlining the required trainings for providers and caregivers. The policy and procedure shall include, but not be limited to, the following:

a. Training specific to the participants' needs shall be completed by all providers and caregivers. Such training shall include, at a minimum, medical protocols and activities of daily living needs.
b. Providers and caregivers shall receive training in resident rights, abuse and neglect prevention, and reporting abuse, neglect, mistreatment and exploitation.

4. Upon enrollment in services, the PASA must assess each participant's ability to care for their safety needs and take appropriate action in case of an emergency. The assessment must be kept up to date and, at a minimum, address the following emergencies and disasters:
a. Fire;
b. Severe weather and other natural disasters;
c. Serious accidents and illness;
d. Assaults; and,
e. Intruders.

~~6~~5. There must be a written plan for each person addressing how the emergencies specified above will be handled. The plans must be based on an assessment, maintained current and shall, at minimum, address:
a. Specific responsibilities/actions to be taken by the participant, approved caregivers or other providers of supports and services in case of an emergency;

b. How the participant will evacuate in case of fire by specifying, at minimum, two exit routes from floors used for sleeping and the level of assistance needed; and

c. Telephone access (by the participant or with assistance) to the nearest poison control center, police, fire and medical services.

6~~7~~. Safety plans and evacuation procedures must be reviewed and practiced at sufficient frequency and varying times of the day, but no less than once a quarter, to ensure all persons with responsibilities for carrying out the plan are knowledgeable about the plan and capable of performing it. All safety plans must be on site at the home and be reviewed by the PASA agency during each on-site monitoring visit.

~~8~~7. The PASA must provide sufficient oversight and guidance and have established procedures to ensure that the health and medical needs of the participant are addressed. This includes:

a. Each participant must have a primary physician;

b. Each participant must receive a medical evaluation at least annually unless a greater or lesser frequency is specified by his/her primary physician. If the physician specifies an annual evaluation is not needed, a medical evaluation must be conducted no less frequently than every two years;

c. Each participant must be encouraged and assisted in getting a dental evaluation annually;

d. Other medical and dental assessments and services must be completed as the need for these is identified by the physician, dentist, other medical support personnel or the Interdisciplinary Team; and

e. Records must contain documentation of:

i. medical services provided;

ii. results of medical evaluations/ assessments and of follow-up services required, if any;

iii. acute illness and chronic medical problems; and,

iv. weight taken annually or more frequently, as needed.

~~9~~8. The PASA must ensure nutritionally balanced meals are available to participants. Based on an assessment of the person's capabilities, preferences and nutritional needs, the PASA may provide guidance and support to monitor nutritional adequacy.

a. Therapeutic diets must be prescribed by a licensed physician or dietician.

b. Participants must have access to food at all times, choose when and what to eat, the opportunity to provide input into menu planning, comfortable seating for meals where they can choose their own seat, and shall have access to food preparation areas~~, if they can appropriately handle kitchen equipment~~ as documented in the Service Plan.

B. Living Environment

1. Homes of ~~persons receiving services and supports~~participants must~~shall~~, at minimum, meet standards set forth in the Colorado Division of Housing (DOH) IRSS Inspection Protocol. ~~HUD Section 8 Housing Quality Standards.~~ The following setting types must pass the DOH IRSS Inspection Protocol every two years:

a. All Host Homes; and

b. All IRSS settings that are owned or leased by a PASA.

Settings must request an inspection prior to placement of a participant and must pass an inspection within 90 days of becoming an approved setting and providing services. Existing settings have until January 1, 2022 to pass an inspection.

~~5~~2. The home (exterior and interior) and grounds must~~shall be maintained~~:

a. Be maintained ~~l~~in good repair;~~,~~

b. ~~To p~~Protect the health, comfort and safety of ~~persons receiving services~~the participant; and~~,~~

c. Be ~~F~~free of offensive odors, accumulation of dirt, rubbish and dust.

3~~6~~. There must~~shall~~ be two means of exit from floors with rooms used for sleeping. Exits must remain clear and unobstructed.

4. The PASA must ensure entry to the home and an emergency exit is accessible to participants, including ~~those~~participants utilizing a wheelchair or other mobility device.

5. The PASA must ensure that participants who utilize a wheelchair or other mobility device have access to all common areas of the home~~.~~

6~~7~~. Bedrooms must~~shall~~ meet minimum space requirements (single 80 square feet, double 120 square feet). (Not applicable for studio apartments.)

7~~8~~. Adequate and comfortable furnishings and ~~adequate~~ supplies must~~shall~~ be provided and maintained in good condition.

8~~9~~. Participants have the right to furnish and decorate their sleeping and/or living units in the way that suits them, while maintaining a safe and sanitary environment.~~All areas of a home needing to be accessed by persons receiving services who use a wheelchair or other assistive technology devices shall be accessible.~~

9. ~~10.~~ A fire extinguisher must be available in each home. Presence of an operational fire extinguisher shall be confirmed by the PASA during each on-site monitoring visit.

a. PASA's must follow manufacturer specifications and expiration dates for all fire extinguishers.

10. Smoke alarms and carbon monoxide detectors must be installed in the proper locations in each home to meet Housing and Urban Development (HUD) requirements and/or local ordinances. Smoke and carbon monoxide detectors shall be tested during each on-site monitoring visit by the PASA.

~~10. The primary entry to the home of a person receiving services who utilizes a wheelchair or other assistive technology devices shall be accessible.~~

~~B. Persons receiving services shall live safely in environments common to other citizens with reasonable supports provided to protect their health and safety while simultaneously promoting community inclusion.~~

~~1. An assessment of each person's capability to take appropriate action in case of an emergency and to take care of safety needs shall be conducted upon enrollment into services and be maintained current. This assessment, at a minimum, shall address the following emergencies and disasters:~~

~~a. Fire;~~

b. Severe weather and other natural disasters;

c. Missing persons;

d. Serious accidents and illness;

e. Assaults; and,

f. Intruders.

2. There shall be a written plan for each person addressing how emergencies specified above will be handled. The plans shall be based on assessments, maintained current and shall, at minimum, address:

a. Specific responsibilities/actions to be taken by persons receiving services, staff or other providers of supports and services in case of an emergency;

b. How the person receiving services will evacuate in case of fire by specifying, at minimum, two exit routes from floors used for sleeping and level of assistance needed; and,

c. Telephone access (by the person receiving services or with assistance) to the nearest poison control center, police, fire and medical services.

3. Safety plans shall be reviewed and practiced at sufficient frequency to ensure all persons with responsibilities for carrying out the plan are knowledgeable about the plan and capable of performing it.

4. A fire extinguisher shall be available in each home.

5. Smoke detectors shall be installed in each home to meet HUD requirements and/or local ordinances.

6. Each home shall have first aid supplies.

C. The program approved service agency shall provide sufficient oversight and guidance and have established procedures to ensure that the health and medical needs of persons receiving services are addressed. The amount and type of guidance provided shall be directly related to an assessment of the person's capabilities.

1. Each person receiving services shall have a primary physician.

2. Each person receiving services shall receive a medical evaluation at least annually unless a greater or lesser frequency is specified by his/her primary physician. If the physician specifies an annual evaluation is not needed, a medical evaluation shall be conducted no less frequently than every two years.

3. Each person receiving services shall be encouraged and assisted in getting a dental evaluation at least annually.

4. Other medical and dental assessments and services shall be completed as the need for these is identified by the physician, dentist, other medical support personnel or the interdisciplinary team.

5. Records shall contain documentation of:

a. medical services provided;

b. results of medical evaluations/ assessments and of follow-up services required, if any;

c. acute illness and chronic medical problems; and,

d. weight taken annually or more frequently, as needed.

D. The program approved service agency shall provide sufficient support and guidance to ensure that persons receiving services have a nutritionally adequate diet. Decisions concerning the amount and type of support and guidance provided shall be based on an assessment of the person's capabilities and nutritional needs.

1. The program approved service agency shall regularly monitor the diets of persons receiving services to determine their nutritional adequacy.

2. Therapeutic diets shall be prescribed by a licensed physician.

DO NOT PUBLISH THIS PAGE

Title of Rule: Home and Community Based Services for the Elderly Blind and Disable, 8.485; Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Setup, 8.553, Sections 8.485 and 8.553.
Rule Number: MSB 19-07-24-A
Division / Contact / Phone: Office of Community Living / Matthew Baker / 303-866-6381

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 19-07-24-A, Home and Community Based Services for the Elderly Blind and Disable, 8.485; Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Setup, 8.553, Sections 8.485 and 8.553.
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) 8.485 and 8.553, 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).	<Select One>

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.485 with the proposed text beginning at 8.485.60through the end of 8.485.60.B.1. Replace the current text at 8.553 with the proposed text beginning at 8.553.2.A through the end of 8.553.2.A.f.iv. Replace the current text at 8.553.3 with the proposed text beginning at 8.553.3.C through the end of 8.553.3.C.2. Replace the current text at 8.553.4 with the proposed text beginning at 8.553.4.D through the end of 8.553.4.D.5. Replace the current text at 8.553.5 with the propose text beginning at 8.553.5.C through the end of 8.553.5.C.4. Replace the current text at

*to be completed by MSB Board Coordinator

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8.553.6 with the proposed text beginning at 8.553.6.D through the end of 8.553.6.D.5. This rule is effective December 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Home and Community Based Services for the Elderly Blind and Disable, 8.485; Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Setup, 8.553, Sections 8.485 and 8.553.
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STATEMENT OF BASIS AND PURPOSE

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

   The rule revisions pertain to the Colorado Department of Health Care Policy & Financing's administrative rules: HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY BLIND AND DISABLED 8.485, specifically Rule 8.485.61 (B); and LIFE SKILLS TRAINING, HOME DELIVERED MEALS, PEER MENTORSHIP, & TRANSITION SETUP SERVICES, Section 8.553, specifically Sections 8.553.2, 8.553.3, 8.553.4, 8.553.5, and 8.553.6.

   Rule 8.485.61(B) concerns eligibility requirements for HCBS-EBD services. The rule states that the single entry point agency shall only certify HCBS-EBD eligibility for those clients who meet the target group definition including, in part, persons living with AIDS. Section 25.5-6-501 et seq. concerning home and community based services for persons with health complexes related to acquired immunity deficiency syndrome was repealed. Therefore the Department proposes to strike language pertaining to persons living with AIDs.

   Section 8.553 regulates Home and Community Based Services of Life Skills Training 8.553.3, Home Delivered Meals 8.553.4, Peer Mentorship 8.553.5, and Transition Setup Services 8.553.6. Section 8.553.2 concerns service access and authorization to those services. The Department proposes revisions to the correct the numbering format of the needs based requirements within 8.553.2.

   Within each Section 8.553 service subpart, 8.553.3 - 8553.6, includes a conflict of interest provision that precludes providers of the service from performing case management functions to the same individual. The conflict of interest provision for each respective service can be found in rule at: Life Skills Training 8.553.3.C.2; Home Delivered Meals 8.553.4.D.5; Peer Mentorship 8.553.5.C.1; and Transition Setup 8.553.6.D.3. In the current language, the conflict of interest provisions are not wholly consistent with Federal Regulation 42 C.F.R Section 441.301(c)(1)(vi). The respective provisions of in 8.553 do not include the exception language in the federal regulation., C.F.R. 441.301(c)(1)(vi). Without the exception language, the rule provisions conflict with federal law. To align with Federal law requirement to Department must include the exception language with the conflict-free requirement to ensure a full representation of the scope of the extent to which conflict protections do and do not apply. The Department proposes to revise the respective sections of CCR 8.553

revised to fully align with C.F.R. 441.301 (c)(1)(vi), pertaining to both the conflict of interest and the exception.

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. §1396n(c) and The Social Security Act, §1915(c).

   42 C.F.R Section 441.301(c)(1)(vi)

   Olmstead v. L.C., 527 U.S. 581 (1999),

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2019);

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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.

   Persons affected by 8.485 include waiver members who are Elderly, Blind, or Disabled. Persons affected by 8.553 include Medicaid recipients who reside in nursing homes, Intermediate Care Facilities for Individuals with Intellectual and Developmental Disabilities (ICF-IDD), or Regional Centers, who are willing to participate and have expressed interest in moving to a home- and community-based setting, and who are eligible for Home and Community Based Services. Eligible persons on the respective waivers may also qualify for transition services to develop or sustain independence during changes in circumstance.

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

   Striking from 8.485.61.B the language pertaining to persons living with AIDs will result in the provision more accurately listing the clients who meet the target group definition.

   By revising the numbering format of the needs based requirements within 8.553.2, the rule will represent a clearer framework of the general needs based criteria as it applies to multiple services within 8.553 vis a vis the specific needs based criteria as it applies to specific services within 8.553.

   By revising the respective sections of CCR 8.553 pertaining to conflict of interest, the Department will fully align the services' conflict of interest requirements with Federal Law C.F.R. 441.301 (c)(1)(vi).

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

   The Department proposes to remove the language concerning the eligibility of a of persons living with AIDS, as there is no longer a statutory basis for those persons to be eligible for that waiver. In removing this language, the state would avoid complications and costs arising across matters of law, administration, delivery, and persons' understanding of which resources and services for which they are eligible and may access 8.485.61 (B).

By revising the numbering format of the needs based requirements within 8.553.2, the rule will represent a clearer framework of the general needs based criteria as it applies to multiple services within 8.553 vis a vis the specific needs based criteria as it applies to specific services within 8.553.

The service provisions of in 8.553 do not include the exception language in the federal regulation., C.F.R. 441.301(c)(1)(vi). Without the exception language, the rule provisions conflict with federal law. To align with Federal law requirement to Department must include the exception language with the conflict-free requirement to ensure a full representation of the scope of the extent to which conflict protections do and do not apply. Materially, these provisions fail to include the provision's geographic incapacity exception to conflict free case management and the exception's protections and processes. Representing a preclusion of conflict without its exception could be interpreted, literally, as eliminating a Federally required exception or that such an exception does not exist. It is important to protect the integrity of the process through which the client has the fullest choice of providers and the fullest autonomy in determining their service plan and service access to suit their individualized needs—with protections against other party interests that may influence their services. However, clients in geographically isolated areas might only have access to service provision and case management through one entity. In such cases, the exception from conflict preclusions is important; without the exclusion, that client may not be able to access either services or case management.

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

   The costs and benefits of the rule revisions have been stated in 2 and 3 above. Further, failing to align the conflict of interest provisions of 8.553 with federal law may result in repeal of the rule.

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

   N/A

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.

   N/A

8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED (HCBS-EBD) GENERAL PROVISIONS

8.485.60 ELIGIBLE PERSONS

.61 HCBS-EBD services shall be offered to persons who meet all of the eligibility requirements below provided the individual can be served within the capacity limits in the federal waiver:

A. Financial Eligibility

Clients shall meet the eligibility criteria as stated at Section 8.100. Clients must also meet criteria specified in the Colorado Department of Human Services Income Maintenance Staff Manual, 9 CCR 2503-1, (2018)., ~~which is hereby incorporated by reference. The incorporation of 9 CCR 2503-1 excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. The Colorado Department of Human Services will provide Certified copies of incorporated materials are provided at cost upon request~~ reference

B. Level of Care and Target Group

Clients who have been determined to meet the level of care and target group criteria shall be certified by a Single Entry Point agency as eligible for HCBS-EBD. The Single Entry Point agency shall only certify HCBS-EBD eligibility for those clients:

1. Determined by the Single Entry Point agency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult~~, or persons living with AIDS as defined at Section 8.400.16~~; and

2. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11 through 8.401.15; or

3. Determined by a formal level of care assessment to require the level of care available in a hospital;

4. A length of stay shall be assigned by the Single Entry Point agency for approved admissions, according to guidelines at Section 8.402.60.

C. Receiving HCBS-EBD Services

1. Only clients who receive HCBS-EBD services, or who have agreed to accept HCBS-EBD services as soon as all other eligibility criteria have been met, are eligible for the HCBS-EBD program.

2. Case management is not a service and shall not be used to satisfy this requirement

3. Desire or need for home health services or other Medicaid services that are not HCBS-EBD services, as listed at Section 8.485.30, shall not satisfy this eligibility requirement

4. HCBS-EBD clients who have received no HCBS-EBD services for one month must be discontinued from the program.

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD services while residing in such institutions unless the single entry point agency determines the client is eligible for EBD as described in Section 8.486.33.

2. A client who is already an HCBS-EBD recipient and who enters a hospital for treatment may not receive HCBS-EBD services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the client from the HCBS-EBD program.

3. A client who is already an HCBS-EBD recipient and who enters a nursing facility may not receive HCBS-EBD services while in the nursing facility.

   (a) The case manager must terminate the client from the HCBS-EBD program if Medicaid pays for all or part of the nursing facility care, or if there is a Utilization Review Contractor-certified ULTC-100.2 for the nursing facility placement, as verified by telephoning the Utilization Review Contractor.

   (b) A client receiving HCBS-EBD services who enters a nursing facility for respite care as a service under the HCBS-EBD program shall not be required to obtain a nursing facility ULTC-100.2, and shall be continued as an HCBS-EBD client in order to receive the HCBS-EBD service of respite care in a nursing facility.

E. Cost-effectiveness

Only clients who can be safely served within cost containment, as defined at Section 8.485.50, are eligible for the HCBS-EBD program.

F. Waiting List

Persons who are determined eligible for services under the HCBS-EBD waiver, who cannot be served within the capacity limits of the federal waiver, shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the person's placement on the waiting list shall be the date on which eligibility for services under the HCBS-EBD waiver was initially determined.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the following priorities:

   a. Clients being deinstitutionalized from nursing facilities.

   b. Clients being discharged from a hospital who, absent waiver services, would be discharged to a nursing facility at a greater cost to Medicaid.

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

   d. Clients with high ULTC 100.2 scores who are at risk of imminent nursing facility placement.

8.553 LIFE SKILLS TRAINING, HOME DELIVERED MEALS, PEER MENTORSHIP, & TRANSITION SETUP SERVICES

8.553.2 SERVICE ACCESS AND AUTHORIZATION

A. To establish eligibility for Life Skills Training, Home Delivered Meals, or Peer Mentorship, the client must satisfy two sets of criteria: general criteria for accessing any of the three services, and criteria unique to each particular service. The client's Case Manager must not authorize Life Skills Training, Home Delivered Meals, or Peer Mentorship to continue for more than 365 days. The Department, in its sole discretion, may grant an exception based on extraordinary circumstances:

1. To be eligible for Life Skills Training, Home Delivered Meals, or Peer Mentorship, the client must satisfy the following general criteria:

    a. The client is transitioning from an institutional setting to a home and ~~community based~~community-based setting,~~;~~ or from any change in life circumstance,~~;~~ ~~and~~

    b. The client demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and

    c. The client demonstrates that they need the service to establish community supports or resources where they may not otherwise exist.

2. To be eligible for Life Skills Training (LST), Home Delivered Meals, and Peer Mentorship, the client must participate in an assessment and satisfy the criteria unique to each particular service the client wishes to access. ~~:~~

    a. To obtain approval for ~~Life Skills Training~~LST ~~(LST),~~ the client must demonstrate the following needs, which must be documented in the client's Service Plan:

        i. The client demonstrates a need for training designed and directed with the member to develop and maintain his/her ability to sustain himself/herself physically, emotionally, socially and economically in the community;

        ii. The client identifies skills for which training is needed and demonstrates that without the skills, the client risks his/her health, safety, or ability to live in the community;

        iii. The client demonstrates that without training he/she could not develop the skills needed; and

        ~~iv.~~ The client demonstrates that with training he/she has ability to acquire these skills or services necessary within 365 days.

        iv.

        v. Life Skills Training ~~LST~~ is available in the HCBS-CMHS Waiver under Section 8.509~~.12.A.12~~, the HCBS-EBD Waiver under Section 8.485~~.31.M~~; the HCBS-SCI Waiver under Section 8.517~~.1.A.13~~; and the HCBS-SLS Waiver under Section 8.500.9~~4.A.20~~.

    b. To obtain approval for Home Delivered Meals~~,~~, the client must demonstrate a need for the service, as follows~~:~~:

        i. The client demonstrates a need for nutritional counseling, meal planning, and preparation;

        ii. The client shows documented dietary restrictions or specific nutritional needs;

iii. The client lacks or has limited access to outside assistance, services, or resources through which he/she can access meals with the type of nutrition vital to meeting his/her dietary restrictions or special nutritional needs;

iv. The client is unable to prepare meals with the type of nutrition vital to meeting his/her dietary restrictions or special nutritional needs;

v. The client's inability to access and prepare nutritious meals demonstrates a need-related risk to health, safety, or institutionalization; and

vi. The assessed need is documented in the client's Service Plan as part of their acquisition process of gradually becoming capable of preparing their own meals or establishing the resources to obtain their needed meals.

~~vi.~~ Home Delivered Meals is available in the HCBS-BI Waiver under Section 8.515; the HCBS-CMHS Waiver under Section 8.509; the HCBS-DD Waiver under Section 8.500; the HCBS-EBD Waiver under Section 8.485; the HCBS-SCI Waiver under Section 8.517; and the HCBS-SLS Waiver under Section 8.500.9.

vii. ~~Home Delivered Meals are available in the HCBS-BI Waiver under Section 8.515.2.A.7; the HCBS-CMHS Waiver under Section 8.509.12.A.5; the HCBS-DD Waiver under Section 8.500.5.A.4; the HCBS-EBD Waiver under Section 8.485.31.E; the HCBS-SCI Waiver under Section 8.517.1.A.5; and the HCBS-SLS Waiver under Section 8.500.94.A.7.~~

c. To obtain approval for Peer Mentorship, a client must demonstrate:

i. A~~a~~ need for soft skills, insight, or guidance from a peer;

ii. T~~t~~hat without this service he/she may experience a health, safety, or institutional risk; and

~~iii.~~ T~~T~~here are no other services or resources available to meet the need.

iii.

iv. Peer Mentorship is available in the HCBS-BI Waiver under Section 8.515; the HCBS-CMHS Waiver under Section 8.509; the HCBS-EBD Waiver under Section 8.485; the HCBS-SCI Waiver under Section 8.517; the HCBS-DD Waiver under Section 8.500; and the HCBS-SLS Waiver under Section 8.500.9.

~~Peer Mentorship is available in the HCBS-BI Waiver under Section 8.515.2.A.11; the HCBS-CMHS Waiver under Section 8.509.12.A.9; the~~

~~HCBS-EBD Waiver under Section 8.485.31.J; the HCBS-SCI Waiver under Section 8.517.1.A.10; the HCBS-DD Waiver under Section 8.500.5.A.6; and the HCBS-SLS Waiver under Section 8.500.94.A.11.~~

8.553.3 LIFE SKILLS TRAINING (LST)

C. PROVIDER QUALIFICATIONS

1. The provider agency furnishing services to waiver clients shall abide by all general certification standards, conditions, and processes established for the client's respective waiver: HCBS-CMHS, -EBD, or -SCI waivers in Section 8.487; HCBS-SLS waiver in Section 8.500.98.

2. In accordance with 42 C.F.R Section 441.301(c)(1)(vi), ~~the~~ ~~[~~p~~]~~roviders of LST ~~provider~~for the individual, or those who have an interest in or are employed by the provider of LST ~~provider~~, must not ~~be the same provider or agency that authorizes services or develops the client's Service Plan with the client; and~~~~authorthize~~authorize services or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to authorize services and/or develop person-centered plans in a geographic area also provides HCBS.

3. The agency must employ an LST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, or a degree within a relevant field; and

4. The agency must ensure any component of the LST plan that may contain activities outside the scope of the LST trainer's expertise or licensure must be created by an appropriately licensed professional acting within his/her scope of practice.

   a. The professional must hold a license with no limitations in the scope of practice appropriate to meet the client's LST needs. The following licensed professionals are authorized to furnish LST training:

      i. Occupational Therapist;

      ii. Physical Therapist;

iii. Registered Nurse;

iv. Speech Language Pathologist;

v. Psychologist;

vi. Neuropsychologist;

vii. Medical Doctor;

viii. Licensed Clinical Social Worker

ix. Licensed Professional Counselor; or

x. Board Certified Behavior Analyst (BCBA)

b. An appropriately licensed professional providing a component(s) of the LST plan may be an agency staff member, contract staff member, or external licensed and certified professionals who are fully aware of duties conducted by LST trainers.

5. An agency must maintain a Class A or B Home Care Agency License issued by the Colorado Department of Public Health and Environment if that agency chooses to provide training on Personal Care as defined in one of the following listed regulations: Personal Care in the HCBS-CMHS, -EBD, or -SCI waivers as defined at Section 8.489.10; Personal Care in the HCBS-SLS waiver as defined at Section 8.500.94.B.12.

6. The agency must employ one or more LST Trainers to directly support clients, one-on-one, by designing with the client an individualized LST program service plan and implementing the plan for the client's training.

a. An individual is qualified to be an LST trainer only if he/she is:

i. A licensed health care professional with experience in providing functionally based assessments and skills training for individuals with disabilities;

ii. An individual with a Bachelor's degree and 1 year of experience working with individuals with disabilities;

iii. An individual with an Associate's degree in a social service or human relations area and 2 years of experience working with individuals with disabilities;

iv. An individual currently enrolled in a degree program directly related to special education, occupational therapy, therapeutic recreation, and/or teaching with at least 3 years of experience providing services similar to LST services;

v. An ~~Individual~~ individual with 4 years direct care experience teaching or working with needs of individuals with disabilities; or

vi. An individual with 4 years of lived experience transferable to training designed and directed with the member to develop and maintain his/her ability to sustain himself/herself physically, emotionally, socially and economically in the community; and the provider must ensure that this individual receives member-specific training sufficient to enable the individual to competently provide LST to the client consistent with the LST Plan and the overall Service Plan.

a) For anyone qualifying as a trainer under thi-s criteria, the provider must ensure that the trainer receives additional member-specific training sufficient to enable him/her to competently provide LST to the client that is consistent with the LST Plan.

b. Prior to delivery of and reimbursement for any services, LST trainers must complete the following trainings:

i. Person-centered support approaches;

ii. HIPAA and client confidentiality;

iii. Basics of working with the population to be served;

iv. On-the-job coaching by the provider or an incumbent LST trainer on the provision of LST training;

v. Basic safety and de-escalation techniques;

vi. Community and public resource availability; and

vii. Recognizing emergencies and knowledge of emergency procedures including basic first aid, home and fire safety.

c. The provider must insure that staff acting as LST trainers receive ongoing training within 90 days of unsupervised contact with a client, and no less than once annually, in the following areas:

i. Cultural awareness;

ii. Updates on working with the population to be served; and

iii. Updates on resource availability.

d. The provider employing an LST Trainer must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment as an LST Trainer. The provider shall not employ or contract with

any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients. All costs related to obtaining a criminal background check shall be borne by the provider.

8.553.4 HOME DELIVERED MEALS

D. PROVIDER STANDARDS

1. A licensed provider enrolled with Colorado Medicaid to provide Home Delivered Meal services Must be a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and holding a Certificate of Good Standing to do business in Colorado.

2. Must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, BI, or -SCI waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98.

3. Must hold a Retail Food license, and must maintain Food Handling licenses for staff delivering meals. All licenses must be current, with no limitations.

4. Must maintain a Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN) on staff or under contract.

5. In accordance with 42 C.F.R Section 441.301(c)(1)(vi), ~~the~~ providers of Home Delivered Meals ~~provider~~for the individual, or those who have an interest in or are employed by the provider of Home Delivered Meals for the individual, must not ~~be the same provider or agency that provides case management to the client or that develops the client's Service Plan with the client~~provide case management or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management and/or develop person-centered service plans in a geographic area also provides HCBS.

6. The provider furnishing Home Delivered Meals services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment who would be tasked with furnishing Home Delivered Meals services. The provider shall not employ or contract with any person convicted of an offense that could

pose a risk to the health, safety, and welfare of clients. All costs related to obtaining a criminal background check shall be borne by the provider.

8.553.5 PEER MENTORSHIP

C. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Peer Mentorship services if:

   a. The provider is a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State and holding a Certificate of Good Standing to do business in Colorado; ~~and~~

   b. The provider conforms to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, -BI, or -SCI waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98; ~~and~~

   c. The provider has a is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the provider's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; and

   d. The provider cooperates with CDPHE compliance and complaint surveys, and obeys all CDPHE policies, regulations and directives regarding licensure.

   e. In accord with 42 CFR 441.301(c)(1)(vi), providers of Peer Mentorship for the individual, or those who have an interest in or are employed by the provider of Peer Mentorship for the individual, must not provide case management, authorize services, or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management, authorize services, and/or develop person-centered service plans in a geographic area also provides HCBS.

f. Peer Mentorship shall not be provided by a peer who receives programming from the same residential location, day program location, or employment location as the client.

~~In accord with 42 CFR 441.301(c)(1)(vi), providers ofthe Peer Mentorship providerfor the individual, or those who have an interest in or are employed by the provider of Peer Mentorship providerfor the individual, must not be the same provider or agency that provides case management to the member, authorizes services for the member, or develops the client's Service Planprovide case management, authorize services, or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management, authorize services, and/or develop person-centered service plans in a geographic area also provides HCBS.~~

~~Peer Mentorship shall not be provided by a peer who receives programming from the same residential location, day program location, or employment location as the client.~~

2. The provider must ensure services are delivered by a peer mentor staff who:

a. Has lived experience transferable to support a member with acclimating to community living through providing them member advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the member's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

b. Is qualified to furnish the services customized to meet the needs of the client as described in the Service Plan;

c. Does not receive programming from the same residential location or day program location as the client; and~~.~~

d~~c~~. Has completed training from the provider agency consistent with core competencies and training standards presented to agencies by the Department at Peer Mentorship provider agency training. Core competencies are:

i. Understanding boundaries;

ii. Setting and pursuing goals;

iii. Advocacy for Independence Mindset;

iv. Understanding of Disabilities, both visible and non-visible, and how they intersect with identity; and

v. Person-Centeredness.

~~d. Does not receive programming from the same residential location or day program location as the client.~~

3. The provider of peer mentorship services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment as a Peer Mentor, and on all staff who interface with Medicaid clients. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients. All costs related to obtaining a criminal background check shall be borne by the provider.

4. The provider must ensure that no staff member having contact with clients is substantiated in the Colorado Adult Protection Services (CAPS) registry for mistreatment of an at-risk adult.

8.553.6 TRANSITION SETUP

D. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Transition Setup services if:

   a. The provider is a legally constituted domestic or foreign business entity registered with the Colorado Secretary of State Colorado and holding a Certificate of Good Standing to do business in Colorado; and

   b. The provider is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations.~~; and~~

2. The provider must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, -BI, or -SCI waivers in the Department's rule at Section 8.487; HCBS-DD waiver in the Department's rule at Section 8.500.9; HCBS-SLS waiver in the Department's rule at Section 8.500.98; and

3. In accord with 42 C.F.R Section 441.301(c)(1)(vi), providers of~~the~~ Transition Setup ~~provider~~for the individual, or those who have an interest in or are employed by the provider of Transition Setup ~~provider~~for the individual, must not ~~be the same provider or agency that provides case management to the client, authorizes services for the client, or~~

~~develops the client's Service Plan with the client~~provide case management, authorize services, or develop the person-centered service plan, except when the State demonstrates that the only willing and qualified entity to provide case management, authorize services, and/or develop person-centered service plans in a geographic area also provides HCBS.

4. The provider of Transition Setup services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment that would involve direct contact with Medicaid clients. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients. All costs related to obtaining a criminal background check shall be borne by the provider.

5. The provider shall ensure the product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning MAGI Medical Assistance rule updates, Sections 8.100.1,8100.3 and 8.100.4
Rule Number: MSB 19-08-05-A
Division / Contact / Phone: Office of Medicaid Operations / Ana Bordallo / 3038663558

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 19-08-05-A, Revision to the Medical Assistance Rule concerning MAGI Medical Assistance rule updates, Sections 8.100.1,8100.3 and 8.100.4
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) 8.100.1,8.100.3 and 8.100.4, 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 8.100.1 with the proposed text beginning at 8.100.1 through the end of 8.100.1. Replace the current text at 8.100.3.K with the proposed text beginning at 8.100.3.K through the end of 8.100.3.K.11. Replace the current text at 8.100.4.C with the proposed text beginning at 8.100.4.C through the end of 8.100.4.C.5. Replace the current text at 8.100.4.I with the proposed text beginning at 8.100.4.I.5 through the end of 8.100.4.I.5. This rule is effective December 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning MAGI Medical Assistance rule updates, Sections 8.100.1,8100.3 and 8.100.4
Rule Number: MSB 19-08-05-A
Division / Contact / Phone: Office of Medicaid Operations / Ana Bordallo / 3038663558

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule change will amend 10 CCR 2505-10 sections 8.100.1,8.100.3 and 8.100.4 based on 42 C.F.R 435.603 as this pertains to the Modified Adjusted Gross Income (MAGI)-based methodologies. Most of the revisions stem from the Tax Cuts and Jobs Act, which eliminated some allowable deductions and modifications to alimony rules. Among these changes are certain exclusions to the current policy regarding allowable deductions to calculate the adjusted gross income, such as tuition and fees, moving expenses, and alimony paid out. There will also be newly added deductions such as pre-tax retirement accounts, education expenses and flexible spending accounts to calculate an individuals adjusted gross income to determine MAGI- Medical Assistance. Other revisions to the current policy are on excludable income types such as a difficulty of care payment and alimony received to determine eligibility for MAGI-Medical Assistance programs. Lastly, added clarification will be added to our rules for a child/tax dependent who is applying for benefits and who lives with someone other than a parent, if they have income, their income will be used to determine their eligibility.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR 435.603, Section 36B(d)(2) of the Internal Revenue Code, Section 1902(e)(14) of the Act, Section 131 of the Internal Revenue Code, Title 26 U.S.Code 62 , Tax cuts and Jobs Act(Pub.L. No. 115-123,:BBA of 2018)

State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2019);

Initial Review	**10/11/19**	Final Adoption	**11/08/19**
Proposed Effective Date	**12/30/19**	Emergency Adoption	

DOCUMENT #11

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning MAGI Medical Assistance rule updates, Sections 8.100.1,8100.3 and 8.100.4
Rule Number: MSB 19-08-05-A
Division / Contact / Phone: Office of Medicaid Operations / Ana Bordallo / 3038663558

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 proposed rule will impact applicants/members who are applying or enrolled in a MAGI-Medical Assistance program. This rule update will benefit applicants/members who become eligible for benefits by helping to lower their adjusted gross income when determining eligibility for MAGI Medical Assistance.

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

   The proposed rule will help to determine eligibility correctly by using the appropriate allowable deductions to calculate an applicants/members adjusted gross income for MAGI-Medical Assistance programs.

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

   The Department does not anticipate any major changes to eligibility determinations; therefore the Department is not anticipating any costs or impact on state revenues as a result of the implementation of this rule.

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

   There are no costs to implementing these rules changes as these rule changes have minimal impact on eligibility. The Department will benefit from these rule changes as they will put the Department in compliance with federal regulations. Inaction will result in the Department not being in compliance with federal regulations. There is not any clear benefit to inaction.

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

The Department does not anticipate these rule changes causing any impact to costs, therefore there is no less costly method to achieve this rule change.

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

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

8.100 MEDICAL ASSISTANCE ELIGIBILITY

8.100.1 Definitions

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

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

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

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

Achieving a Better Life Experience (ABLE) accounts – Special savings accounts that are set up by (or for) certain individuals with disabilities in a qualified ABLE program that are exempt for eligibility. They can be established by any state's qualified ABLE Program. Colorado's ABLE program is administered by the Department of Higher Education.

Adjusted Gross Income (AGI)-means" gross income", as defined in federal tax rules, minus certain adjustments prescribed in the federal tax rules to derive the "Adjusted Gross Income" line on the tax return. These -adjustments from gross income are taken before the taxpayer takes his or her Schedule A deductions or Standard Deduction.

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

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

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

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

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

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

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

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

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive

Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

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

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

Burial Spaces are burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the individual or are held for his or her use, including necessary and reasonable improvements or additions to or upon such burial spaces such as: vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

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

Caretaker Relative is a person who is related to the dependent child or any adult with whom the dependent child is living and who assumes responsibility for the dependent child’s care.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Community Spouse is the spouse of an institutionalized spouse.

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

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

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

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

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

Difficulty of Care Payments is a payment to an applicant or ~~/~~member~~individual~~ as compensation for providing live-in home ~~additional~~ care to an individual ~~-~~who qualifies for foster care or Home and Community Based Services (HCBS) waiver program and lives in the home of the care recipient~~provider~~. This additional care must be required due to a physical, mental, or emotional handicap~~- suffered by the foster care individual~~.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PACE - Program of All-inclusive Care for the Elderly is a unique, capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive

medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SGA – Substantial Gainful Activity is defined by the Social Security Administration. SGA is the term used to describe a level of work activity and earnings. Work is “substantial” if it involves performance of significant physical or mental activities or a combination of both, which are productive in nature. For work activity to be substantial, it does not need to be performed on a full-time basis. Work activity performed on a part-time basis may also be substantial gainful activity. “Gainful” work activity is work performed for pay or profit; or work of a nature generally performed for pay or profit; or work intended for profit, whether or not a profit is realized.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.K. Consideration of Income

1. Income or resources of an alien sponsor or an alien sponsor's spouse shall be countable to the sponsored alien effective December 19, 1997. Forms used prior to December 19, 1997, including but not limited to forms I-134 or I-136 are legally unenforceable affidavits of support. The attribution of the income and resources of the sponsor and the sponsor's spouse to the alien will continue until the alien becomes a U.S. citizen or has worked or can be credited with 40 qualifying quarters of work, provided that an alien crediting the quarters to the applicant/client has not received any public benefit during any creditable quarter for any period after December 31, 1996.

    a. Exception: When the sponsored alien is a pregnant woman or a child the income or resources of an alien sponsor or an alien sponsor's spouse will not be countable to the sponsored alien.

2. Income, in general, is the receipt by an individual of a gain or benefit in cash or in kind during a calendar month. Income means any cash, payments, wages, in-kind receipt, inheritance, gift, prize, rents, dividends, interest, etc., that are received by an individual or family.

3. Earned income is payment in cash or in kind for services performed as an employee or from self-employment.

4. Earned in kind income shall be income produced as a result of the performance of services by the applicant/client, for which he/she is compensated in shelter or other items in lieu of wages.

5. Received means "actually" received or legally becomes available, whichever occurs first; the point at which the income first is available to the individual for use. For example, interest income on a savings account is counted when it is credited to the account.

6. All Home Care Allowance (HCA) income paid to a Medical Assistance applicant or ~~/~~member~~client~~ by the HCA recipient to provide home care services is countable earned income.

    ~~a. Exception: When a HCA recipient lives in the home of the Medical Assistance applicant/client, HCA payments made to the Medical Assistance applicant/client for providing home care services to the HCA recipient is not countable income for the purpose of calculating the Medical Assistance applicant/client's MAGI-based income.~~

7. An applicant or member who is a live-In home care provider to a care recipient receiving a Difficulty of Care Payment and who is being determined for a MAGI Medical Assistance program,

must meet the following requirements for Difficulty of Care payments to be excluded as countable income:

a. The care provider receiving payments for personal care or supportive services provided to a care recipient must live full-time in the same home with the care recipient; and

b. The care recipient must either

i) receiving personal care /or supportive services must be enrolled in Long Term Service Supports (LTSS), with additional services through a Home-Based Services (HCBS) waiver program; or

ii) The care recipient must be enrolled in the Buy-In Program for Working Adults with Disabilities, and receive additional services through the Home and Community Based Services (HCBS) waiver program.

c. ~~———~~Exception: ~~-~~Difficulty of Care Payments are not excluded if the payments are for more than 10 qualified foster individuals under the age of 19 or 5 qualified foster individuals who are over the age of 19.

8~~7~~. Participation in the Workforce Investment Act (WIA) affects eligibility for Medical Assistance as follows:

a. Wages derived from participation in a program carried out under WIA (work experience or on-the-job training) and paid to a caretaker relative is considered countable earned income.

b. Training allowances granted by WIA to a dependent child or a caretaker relative of a dependent child to participate in a training program is exempt.

c. Wages derived from participation in a program carried out the under Workforce Investment Act (WIA) and paid to any dependent child who is applying for or receiving Medical Assistance are exempt in determining eligibility for a period not to exceed six months in each calendar year.

9~~8~~. An individual involved in a profit making activity as a sole proprietor, partner in a partnership, independent contractor, or consultant shall be classified as self-employed.

a. To determine the net profit of a self-employed applicant/client deduct the cost of doing business from the gross income. These business expenses include, but are not limited to:

i) the rent of business premises,

ii) wholesale cost of merchandise,

iii) utilities,

iv) taxes,

v) labor, and

vi) upkeep of necessary equipment.

b. The following are not allowed as business expenses:

i) Depreciation of equipment;

1) Exception: For the purpose of calculating MAGI-based income, depreciation of equipment is an allowable business expense if the equipment is not used for capital improvements.

ii) The cost of and payment on the principal of loans for capital asset or durable goods;

iii) Personal expenses such as personal income tax payments, lunches, and transportation to and from work.

c. Appropriate allowances for cost of doing business for Medical Assistance clients who are licensed, certified or approved day care providers are (1) $ 55 for the first child for whom day care is provided, and (2) $ 22 for each additional child. If the client can document a cost of doing business which is greater than the amounts above set forth, the procedure described in A, shall be used.

d. When determining self employment expenses and distinguishing personal expenses from business expenses it is a requirement to only allow the percentage of the expense that is business related.

10~~9~~. Self-employment income includes, but is not limited to, the following:

a. Farm income - shall be considered as income in the month it is received. When an individual ceases to farm the land, the self-employment deductions are no longer allowable.

b. Rental income - shall be considered as self-employment income only if the Medical Assistance client actively manages the property at least an average of 20 hours per week.

c. Board (to provide a person with regular meals only) payment shall be considered earned income in the month received to the extent that the board payment exceeds the maximum food stamp allotment for one-person household per boarder and other documentable expenses directly related to the provision of board.

d. Room (to provide a person with lodging only) payments shall be considered earned income in the month received to the extent that the room payment exceeds documentable expenses directly related to the provision of the room.

e. Room and board payments shall be considered earned income in the month received to the extent that the payment for room and board exceeds the food stamp allotment for a one-person household per room and boarder and documentable expenses directly related to the provision of room and board.

11~~0~~. Unearned income is the gross amount received in cash or kind that is not earned from employment or self-employment. Unearned income includes, but is not limited to, the following:

a. Pensions and other period payments, such as:

i) Private pensions or disability benefits

1) Exception: Refer to section 8.100.4 for treatment of private disability benefits for MAGI Medical Assistance.

ii) Social Security benefits (Retirement, survivors, and disability)

iii) Workers' Compensation payments

iv) Railroad retirement annuities

v) Unemployment insurance payments

vi) Veterans benefits other than Aid and Attendance (A&A) and Unusual Medical Expenses (UME).

vii) Alimony and support payments

viii) Interest, dividends and certain royalties on countable resources

8.100.4 MAGI Medical Assistance Eligibility [Eff. 01/01/2014]

8.100.4.A. MAGI Application Requirements

1. Persons requesting a MAGI Medical Assistance category need only to complete the Single Streamlined Application.

2. Parents and Caretaker Relatives, Pregnant Women, Children, and Adults may apply for Medical Assistance at sites other than the County Department of Social Services, including eligibility sites and Certified Application Assistance Sites (CAAS). The Department shall approve these sites to receive and initially process these applications. The application used shall be the Single Streamlined Application. The eligibility site shall determine eligibility.

3. The eligibility sites shall refer Medical Assistance clients who are pregnant and/or age 20 and under to EPSDT offices (designated by the Department) by:

    a. Copying the page of the Single Streamlined Application that includes the EPSDT benefit questions. The eligibility site will then forward this page to the EPSDT office within five working days from the date of application approval; or by:

    b. Means of secure, electronic data transfer approved by the Department

8.100.4.B. MAGI Category Verification Requirements

1. Minimal Verification – At minimum, applicants seeking Medical Assistance shall provide all of the following:

    a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, unless they qualify for an exception listed in 8.100.3.I.1.b. Individuals who qualify for an exception must not be required to provide an SSN.

b. Verification of citizenship and identity as outlined in section 8.100.3.H under Citizenship and Identity Documentation Requirements.

c. Earned Income: Income shall be self-attested by an applicant and verified through an electronic data source. Individuals who provide self-attestation of income must also provide a Social Security Number for wage verification purposes.

If earned income is not or cannot be self-attested, it shall be verified by wage stubs, tax documents, written documentation from the employer stating the employee's gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

Estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

d. Unearned income: Unearned income can be self-attested by an applicant. Certain types of unearned income, such as unemployment and survivor benefits may be verified through electronic data sources.

e. Verification of Legal Immigrant Status: Immigration status can be self-declared by an applicant applying for Medical Assistance, to determine eligibility for full Medical Assistance benefits. This declaration of legal immigration status will be verified through the Verify Lawful Presence (VLP) interface. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) program to verify legal immigration status. See section 8.100.3.G for a description of the VLP interface. If status cannot be verified, or if the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

2. Additional Verification: No other verification shall be required of the client unless information is found to be questionable on the basis of fact.

3. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

4. Information that exists in another case record or in CBMS shall be used by the eligibility site to verify those factors that are not subject to change, if the information is reasonably accessible.

5. The criteria of age and relationship can be declared by the client unless questionable. If questionable, these criteria can be established with information provided from:

a. official papers such as: a birth certificate, order of adoption, marriage license, immigration or naturalization papers; or

b. records or statements from sources such as: a court, school, government agency, hospital, or physician.

6. Establishing that a dependent child meets the eligibility criteria of:

a. age, if questionable requires (1) viewing the birth certificate or comparably reliable document at eligibility site discretion, and (2) documenting the source of verification in the case file and CBMS case comments;

b. living in the home of the caretaker relative, if questionable requires (1) viewing the appropriate documents which identify the relationship, (2) documenting these sources of verification in the case file and CBMS case comments.

8.100.4.C. MAGI Methodology for Income Calculation

1. For an in depth treatment of gross income, refer to 26 U.S.C. § 61, which is hereby incorporated by reference. The incorporation of 26 U.S.C. § 61 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request. Except as otherwise provided, pursuant to 26 U.S.C. § 61 gross income means all income from all derived sources, The Modified Adjusted Gross Income calculation for the purposes of determining a household's financial eligibility for Medical Assistance shall consist of, but is not limited to, the following:

a. Earned Income:

i) Wages, salaries, tips;

ii) Gross income derived from business;

iii) Gains derived from dealings in property;

iv) Distributive share of partnership gross income (not a limited partner);

v) Compensation for services, including fees, commissions, fringe benefits and similar items; and

vi) Taxable private disability income.

b. Unearned Income:

i) Interest (includes tax exempt interest);

ii) Rents;

iii) Royalties;

iv) Dividends;

v) Alimony ~~payments~~ received counts as unearned income if the divorce or legal separation is executed on or before December 31, 2018. Alimony received will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019~~.~~ ~~made directly to the household from a non-household member and separate maintenance payments~~ ;

vi) Pensions and annuities;

vii) Income from life insurance and endowment contracts;

viii) Income from discharge of indebtedness;

ix) Income in respect of a decedent; ~~and~~

x) Income from an interest in an estate or trust;~~.~~

xi) Social Security (SSA) income; and

xii) Distributive share of partnership gross income (limited partner).

c. Additional Income: In addition to the types of income identified in section 8.100.4.C.1.a-b., the following income is included in the MAGI calculation.

i) Any tax exempt interest income.

ii) Untaxed foreign wages and salaries.

iii) Social Security Title II Benefits (Old Age, Disability and Survivor's benefits).

d. The following are Income exclusions:

i) An amount received as a lump sum is counted as income only in the month received;~~.~~

ii) Scholarships, awards, or fellowship grants used for educational purposes and not for living expenses;~~.~~

iii) Child support received;

iv) Worker's Compensation;

v) Supplemental Security Income (SSI);

vi) Veteran's Benefits;

vii) American Indian/Alaskan Native income exceptions listed at 42 C.F.R. § 435.603(e) (2012) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 435.603(e) (2012) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

e. Allowable Deductions: For an in depth treatment of allowable deductions from gross income, please refer to 26 U.S.C. 62, which is hereby incorporated by reference. The incorporation of 26 U.S.C. 62 (2014) excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular

business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

The following deductions ~~are allowed to~~can be subtracted from an individual's taxable gross income, in order to calculate the Adjusted Gross Income (AGI) including (but not limited to):

i) Student loan interest deductions;

ii) Certain Self- employment expenses ~~(~~SEP, SIMPLE and qualified plans, and health insurance deductions~~)~~;

iii) Deductible part of self-employment tax;

iv) Health savings account deduction;

v) Certain b~~B~~usiness expenses of reservists, performing artist, and fee-basis government officials;

vi) ~~Certain R~~reimbursed expenses of employees;

vii) Moving expenses for active duty military who are moving due to a permanent change of station;

viii) IRA deduction: Regular Individual Retirement Account (IRA) contributions claimed on a federal income tax return and which does not exceed the IRA contributions limits;

ix) Penalty on early withdrawal of savings;

x) Domestic production activities deduction;

xi) Alimony paid can be deducted only if the divorce or legal separation is executed on or before ~~12/~~December 31, ~~/~~2018. It cannot be deducted if the divorce or separation is modified or executed on or after ~~1/~~January 1, ~~/~~20019. ~~outside the home~~;

xii) Certain educator expenses; and

xiii) Certain pre-tax contributions.

f. Income of children and tax dependents:

i) The income of a child who is included in the household of their natural, adopted, or step parent will not be included in the household income unless that child has income above the tax filing threshold.~~sufficient to require that the child file a tax return~~.

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a child is required to file taxes.

ii) The income of a person, other than a child or spouse, who expects to be claimed as a tax dependent will not be included in the household income of the taxpayer unless that tax dependent has income abovesufficient the tax filing thresholdto require that the tax dependent file a tax return.

1) Income from Title II Social Security benefits and Tier I Railroad benefits are excluded when determining if a tax dependent is required to file taxes.

ii) The income of a child or tax dependent who does not live with their natural, adopted, or step parent will always count towards the determination of their own eligibility, even if the child's or tax dependent's income is below the tax filing threshold.

2. Income verifications: When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see section 8.100.3.H.9.

a. Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 10%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall be determined ineligible due to income.

b. If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy shall be requested. If the applicant is unable to provide a reasonable explanation, paper documentation shall be requested.

i) The Department may request paper documentation only if the Department does not find income to be reasonably compatible and if the applicant does not provide a reasonable explanation or if electronic data are not available.

3. Self-Employment – If the applicant is self-employed the ledger included in the Single Streamlined Application shall be sufficient verification of earnings, unless questionable.

4. Budget Periods for MAGI-based Income determination – The financial eligibility of applicants for Medical Assistance shall be determined based on current or previous monthly household income and family size.

a. Applicants who are found financially ineligible based on current or previous monthly household income and family size, and whose household has earned income from self-employment, seasonal employment, and/or commission-based employment, shall have their financial eligibility determined using annualized self-employment, seasonal employment, and commission-based employment income.

5. If an applicant does not meet the financial eligibility requirements for Medical Assistance based on MAGI, but meets all other eligibility requirements, the applicant shall be found eligible for MAGI Medical Assistance if the applicant's income, as calculated using the methodology for determining eligibility for Advanced Premium Tax Credits or Cost Sharing Reductions through the marketplace, is below 100% of the federal poverty level.

8.100.4.D. Income Disregard

1. An income disregard equivalent to five percentage points of the Federal Poverty Level for the applicable family size will be subtracted from MAGI-based income.

   a. If an individual's MAGI-based countable income is above the income threshold for the applicable MAGI program under title XIX (Medicaid) or title XXI (CHP+) of the Social Security Act, the five percent (5%) disregard will be applied for each qualifying MAGI program as the last step to determine eligibility.

   b. If the countable income is below the income threshold for the applicable MAGI program, the individual is income eligible and the five percent (5%) disregard will not be applied to determine eligibility.

8.100.4.E. Determining MAGI Household Composition.

1. MAGI household composition is similar to, but not necessarily the same as a tax household. To determine MAGI household composition, the individual's relationship to the tax filer must be established as declared on the Single Streamlined Application.

   a. In the case of an applicant who expects to file a tax return for the taxable year in which an initial determination or renewal of eligibility is being made, and does not expect to be claimed as a tax dependent by anyone else, then the applicant's MAGI household shall consist of the following:

      i) The Tax-Filer;

      ii) The Tax-Filer's spouse if living in the home;

      iii) All persons whom the Tax-Filer expects to claim as a tax dependent on their personal income tax return

   b. In the case of an applicant who expects to be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the applicant's MAGI household shall be:

      i) The Tax Dependent;

      ii) The Tax-Filer and their spouse if living in the home;

      iii) The Tax-Filer's other tax dependents;

iv) The Tax Dependent's spouse, if living with the Tax Dependent.

c. The MAGI household of an applicant who expects to be claimed as a tax dependent is as outlined in 8.100.4.E.b above, except in the following circumstances:

i) The applicant expects to be claimed as a tax dependent by someone other than a spouse, biological, adoptive or step parent.

ii) The applicant is a child under 19 who is expected to be claimed by one parent as a tax dependent and is living with both parents, but the parents do not expect to file a joint tax return.

iii) The applicant is a child under 19 and who expects to be claimed as a tax dependent by anon-custodial parent.

d. If the applicant meets one of the exceptions in 8.100.4.E.c above or is a non-filer, household composition shall be determined using the following non-filer rules and the applicant's household shall consist of the following:

i) The applicant;

ii) The applicant's spouse who lives in the household;

iii) The applicant's natural, adopted, and step children under the age of 19, who live in the household; and

iv) In the case of applicants under the age of 19, the applicant's natural, adoptive, and step parents and natural, adoptive, and step siblings under age 19, who live in the household.

2. When a household includes a pregnant woman, regardless of the Medical Assistance category, the pregnant woman is counted as herself plus the number of children she is expected to deliver.

3. Married couples living together will each be included in the other's MAGI household regardless of whether or not they expect to file taxes jointly, separately or if one expects to be claimed as a tax dependent of the other.

4. If a child is claimed as a tax dependent by both parents who are married and who will file taxes jointly but one parent lives outside of the household due to separation or pending divorce, the child's household composition is determined by non-filer rules. The parent living outside of the household will not be counted as part of the household.

5. An individual who is both a tax dependent and a tax filer will be considered a tax dependent for the purpose of determining eligibility for Medical Assistance.

8.100.4.F. MAGI Category Presumptive Eligibility

1. A pregnant applicant may apply for presumptive eligibility for ambulatory services through Medical Assistance presumptive eligibility sites. A child under the age of 19may apply or have an adult apply on their behalf for presumptive eligibility for State Plan approved medical services through presumptive eligibility sites.

2. To be eligible for presumptive eligibility:

a. a pregnant woman shall have an attested pregnancy, declare that her household's income shall not exceed 185% of the federal poverty level (MAGI-equivalent) and declare that she is a United States citizen or a documented immigrant. Refer to the MAGI-Medicaid income guidelines chart available on the Department's website

b. a child under the age of 19 shall have a declared household income that does not exceed 133% of federal poverty level (MAGI-equivalent) and declare that the child is a United States citizen or a documented immigrant.

3. Presumptive eligibility sites shall be certified by the Department to make presumptive eligibility determinations. Sites shall be re-certified by the Department every 2 years to remain approved presumptive eligibility sites.

4. The presumptive eligibility site shall forward the application to the county within five business days.

5. The presumptive eligibility period begins on the date the applicant is determined eligible and ends with the earlier of:

a. The day an eligibility determination for Medical Assistance is made for the applicant(s); or

b. The last day of the month following the month in which a determination for presumptive eligibility was made.

6. A presumptive eligible client may not appeal the end of a presumptive eligibility period.

7. Presumptively eligible women and Medical Assistance clients may appeal the county department's failure to act on an application within 45 days from date of application or the denial of an application. Appeal procedures are outlined in the State Hearings section of this volume.

8.100.4.G. MAGI Covered Groups

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   a. A pregnant women’s eligibility period will end effective the earliest possible month, if the following occurs:

      i) Fails to provide a reasonable explanation or paper documentation when self-attested income is not reasonably compatible with income information from an electronic data source, by the end of the 90 day reasonable opportunity period. This exception only applies the first-time income is verified following an initial eligibility determination or an annual redetermination.

6. A lawfully admitted non-citizen who is pregnant and who has been in the United States for less than five years is eligible for Medical Assistance if she meets all of the other eligibility requirements specified at 8.100.4.G.5 and fits into one of the immigration categories listed in 8.100.3.G.1.g.iii.1-5 and 8.100.3.G.1.g.vi.1-15. This population is referenced as Legal Immigrant Prenatal.

7. A child whose mother is receiving Medical Assistance at the time of the child's birth is continuously eligible for one year. This population is referred to as “Eligible Needy Newborn”. This coverage also applies in instances where the mother received Medical Assistance to cover the

child's birth through retroactive Medical Assistance. The child is not required to live with the mother receiving Medical Assistance to qualify as an Eligible Needy Newborn.

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

8.100.4.H. Needy Persons

1. Medical Assistance shall be provided to certain needy persons under 21 years of age, including the following:

a. Those receiving care in a Long Term Care Institution eligible for Medical Assistance reimbursement or receiving active treatment as inpatients in a psychiatric facility eligible for Medical Assistance reimbursement and whose household income is less than the MAGI needs standard for his/her family size when the client applies for assistance. Clients that are receiving benefits under this category and are still receiving active inpatient treatment in the facility at age 21 shall be eligible to age 22. This population is referenced as Psych <21.

b. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in foster care, in homes or private institutions or in subsidized adoptive homes. A child shall be the responsibility of the county, even if the child may be in a medical institution at that time. See Colorado Department of Human Services "Social Services Staff Manual" section 7 for specific eligibility requirements (12 CCR § 2509-1). 12 CCR § 2509-1 (2013) is hereby incorporated by reference. The incorporation of 12 CCR § 2509-1 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver CO 80203. Certified copies of incorporated materials are provided at cost upon request.

c. Those for whom the Department of Human Services is assuming full or partial financial responsibility and who are in independent living situations subsequent to being in foster care.

d. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's Alternatives to Foster Care Program and would be in foster care except for this program and whose household income is less than the MAGI needs standard for his/her family size.

e. Those for whom the Department of Human Services is assuming full or partial responsibility and who are removed from their home either with or without (court ordered) parental consent, placed in the custody of the county and residing in a county approved foster home.

f. Those for whom the Department of Human Services is assuming full or partial responsibility and who are receiving services under the state's subsidized adoption

program, including a clause in the subsidized adoption agreement to provide Medical Assistance for the child.

g. Those for whom the Department of Human Services is assuming full or partial financial responsibility on their 18th birthday or at the time of emancipation. These individuals also must have received foster care maintenance payments or subsidized adoption payments from the State of Colorado pursuant to article 7 of title 26, C.R.S. immediately prior to the date the individual attained 18 years of age or was emancipated. Eligibility shall be extended until the individual's 21st birthday for these individuals with the exception of those receiving subsidized adoption payments.

2. Medical Assistance shall be extended to certain needy persons until the end of the month of the individual's 26th birthday, including the following:

a. Those individuals that were formerly in foster care under the responsibility of the State or Tribe on their 18th, 19th, 20th or up to their 21st birthday and were receiving Medical Assistance.

i) This extension does not apply to youth that are receiving subsidized adoption payments or

ii) To youth that are enrolled in mandatory Medical Assistance.

b) Former Foster Care youth are not subject to either an income or resource test.

c) Former Foster Care youth's newborn shall be considered a needy newborn.

8.100.4.I. Transitional Medical Assistance and 4 Month Extended Medical Assistance

1. Eligibility for Transitional Medical Assistance shall be granted for twelve months (beginning with the first month of ineligibility) to individuals who are no longer eligible for the Parent/Caretaker Relative category due to a change in income.

The extension shall be applied to individuals who:

a. Were eligible for the Parent/Caretaker Relative category in at least three of the six months preceding the month in which the individual would have become ineligible, and

b. Are no longer eligible for coverage under the Parent/Caretaker Relative category because of new or increased income from employment or hours of employment

i) At least one Parent/Caretaker Relative must continue to be employed and cannot terminate employment without good cause. This does not need to be the same person for the whole period the family is receiving Transitional Medical Assistance.

2. Any dependent child or Parent/Caretaker Relative who was or becomes part of the Medical Assistance household after the individual has begun receiving Transitional Medical Assistance is eligible for the remaining months of Transitional Medical Assistance.

a. A dependent child in the household who received Medical Assistance through continuous eligibility, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance.

b. An individual in the household who received Medical Assistance, but is no longer eligible for Medical Assistance based on a redetermination, is eligible for the family's remaining months of Transitional Medical Assistance

3. To become or remain eligible for Transitional Medical Assistance:

a. The household must include a dependent child. If it is determined that the household no longer has a child living in the home, Transitional Medicaid Assistance shall discontinue at the end of the month in which the household does not include a dependent child.

b. If health insurance is available from the employer to the employee, at no cost to the Medical Assistance recipient, the client shall enroll in the insurance program.

4. When Transitional Medical Assistance ends the case will be reassessed for all other categories of Medical Assistance for which the family members may be eligible. A new application shall not be required for this process.

5. Eligibility for Medical Assistance shall be extended for four months (beginning with the first month of ineligibility) for certain families who become ineligible for Medical Assistance due solely or partially to the receipt of support income, such as alimony. The extension shall be applied for a family which receives assistance under Medical Assistance in at least three of the six months immediately preceding the month in which the family becomes ineligible for assistance. To be eligible for the four month Medical Assistance extension, the family shall meet all other eligibility criteria for Medical Assistance before the alimony income is applied-.

a. Alimony received will be countable income only if the divorce or legal separation is executed on or before December 31, 2018. Alimony will not be countable income if the divorce or legal separation is modified or executed on or after January 1, 2019.

8.100.4.J. Express Lane Eligibility

Express Lane Eligibility shall allow for automatic initiation of Medical Assistance enrollment by using available data and findings from other programs as listed below.

1. Free/Reduced Lunch Program

a. Recipients of the Free/Reduced Lunch Program who have submitted a Free/Reduced Lunch application at a participating school district-

i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

ii) Children who meet all necessary eligibility requirements as outlined in this volume shall be automatically enrolled.

iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity shall receive 90days of eligibility while awaiting this verification.

iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.

v) Eligibility is based on income declared on the Free/Reduced Lunch application as well as eligibility requirements outlined in this volume.

vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility will be evaluated using the Single Streamlined Application for Medical Assistance.

b. Recipients of the Free/Reduced Lunch Program who were not required to submit a Free/Reduced Lunch application at a participating school district-

i) Families who are automatically enrolled Free/Reduced Lunch recipient children shall not be forwarded to the Department for Express Lane Eligibility in compliance USDA confidentiality guidelines.

ii) These families must apply for Medical Assistance in order to give consent for request of benefits.

2. Direct Certification

a. Individuals who have submitted a Food Assistance or Colorado Works application

i) Families shall be given the option to opt into Medical Assistance coverage for their potentially eligible child.

ii) Children who meet all necessary eligibility requirements as outlined throughout 8.100.4 shall be automatically enrolled

iii) Children who meet all necessary eligibility requirements except verification of U.S. citizenship and identity will receive 90 days of eligibility while awaiting this verification.

iv) Any additionally required verification shall be requested from the client through CBMS prior to being automatically enrolled.

v) Eligibility is based on income declared on the Food Assistance or Colorado Works application as well as eligibility requirements outlined throughout this volume.

vi) If it would be found that a child does not satisfy an eligibility requirement for Medical Assistance, the child's eligibility shall be evaluated using the Single Streamlined Application for Medical Assistance.

vii) Individuals whose eligibility is not determined through Express Lane Eligibility can also submit a separate Single Streamlined Application for Medical Assistance to determine eligibility.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Increase of the Reimbursement Rate Reserved for Compensation of Direct Care Workers, Section 8.507
Rule Number: MSB 19-08-02-A
Division / Contact / Phone: Benefits and Services Management Division / Erin Thatcher / 303-866-5788

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 19-08-02-A, Revision to the Medical Assistance Rule concerning Increase of the Reimbursement Rate Reserved for Compensation of Direct Care Workers, Section 8.507
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) 8.507, 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 8.507 with the proposed text beginning at 8.507 through the end of 8.507.4.J. This rule is effective December 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Increase of the Reimbursement Rate Reserved for Compensation of Direct Care Workers, Section 8.507
Rule Number: MSB 19-08-02-A
Division / Contact / Phone: Benefits and Services Management Division / Erin Thatcher / 303-866-5788

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).

   This rule implements Section 25.5-6-1601 et seq., C.R.S. (2019) which requires the Department to request an 8.1% increase to the reimbursement rate for personal care and homemaker services in certain waivers. The statute establishes a minimum wage for the included services. The increased funding must be reserved and used to increase compensation of direct care workers providing the included services. The rule establishes the requirement for use of the funds, the reporting requirements, and the Department's ability to audit provider-reported information.

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:

   n/a

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2019);
   25.5-6-1601 et seq., C.R.S. (2019)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

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.

   SB19-238 requires changes to compensation for direct care workers providing personal care, homemaker, and In-Home Support Services (IHSS) for any waiver under which the service is an approved benefit. The statute excludes Consumer Directed Attendant Support Services (CDASS), Pediatric Personal Care, and Health Maintenance Activities in IHSS.

   The statute requires Home Care Agencies to pass-through 100% of a requested 8.1% rate increase as compensation to non-administrative employees providing the included services. There is a minimum wage established for employees providing the included services, set at $12.41 effective July 1, 2020. The statute also authorizes future wage passthroughs related to future rate increases, if received, in FY 2020-21.

   The statute requires Home Care Agencies to report compliance, and authorizes the Department to receive reports, audit reports, and recoup costs if the Home Care Agency is found to be out of compliance. Home Care Agencies will receive increased funding which must be used to increase compensation for direct care workers.

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

   The proposed rule requires Home Care Agencies to report their compliance. If a Home Care Agency does not comply with the rules, there may be penalties and recoupment.

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.

   SB19-238 provided the Department with resources to complete the auditing requirements needed for the implementation of this rule. No additional budgetary impact is expected from the implementation of this rule.

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

   The Department is mandated to promulgate rules per Section 25.5-6-16, C.R.S. (2019).

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

   The Department will utilize existing reporting tools and requirements as authorized by HB18-1407 for the implementation of SB19-238.

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

   The Department is mandated to promulgate rules per Section 25.5-6-1601 et seq., C.R.S. (2019).

8.507 INCREASE OF THE REIMBURSEMENT RATE RESERVED FOR COMPENSATION OF DIRECT CARE WORKERS

8.507.1 DEFINITIONS

Definitions below only apply to Section 8.507.

A. Compensation means any form of monetary payment, including bonuses, employer-paid health and other insurance programs, paid time off, payroll taxes that are proportionate to the increase in compensation, and all other fixed and variable benefits conferred on or received by all Direct Care Workers providing services as enumerated below.

B. Direct Benefit means compensation that is directly conferred onto Direct Care Workers for their sole benefit and does not include direct benefits to the Home Care Agency which may have an indirect benefit to the Direct Care Workers.

C. Direct Care Worker means a non-administrative employee of a Home Care Agency who assists persons receiving personal care, homemaking, and/or In-Home Support Services in the home or community.

D. Home Care Agency means any sole proprietorship, partnership, association, corporation, government or governmental subdivision or agency subject to the restrictions in Section 25-1.5-103 (1)(a)(II), C.R.S., not-for-profit agency, or any other legal or commercial entity that manages and offers, directly or by contract, skilled home health services or personal care services to a home care consumer in the home care consumer's temporary or permanent home or place of residence. For the purposes of this section, home care agency includes only agencies providing the waiver services listed in Section 8.507.2(A) without regard to whether the agency is licensed to provide such services.

E. Payroll tax means taxes that are paid or withheld by the employer on the employee's behalf such as Social Security tax, Medicare tax, and Medicare surtax.

F. Plan of Correction means a formal, written response from a Home Care Agency to the Department on identified areas of non-compliance with requirements listed at Section 25.5-6-1602-1603, C.R.S.

8.507.2 REIMBURSEMENT RATE INCREASE

A. Effective January 1, 2020, the Department increased reimbursement rates by eight and one-tenth percent which is to be reserved for compensation to Direct Care Workers above the rate of compensation that the Direct Care Workers received as of June 30, 2019. One hundred percent of the eight and one-tenth percent rate increase must be used as compensation for the Direct Care Workers. The following services delivered through Home and Community Based Waivers will receive the eight and one-tenth percent increase to reimbursement rates:

1. Homemaker Basic

2. Homemaker Enhanced

3. Personal Care

4. In-Home Support Services

    a. Exclusion: Health Maintenance Activities

B. Consumer Directed Attendant Support Services (CDASS) and Pediatric Personal Care are excluded from this Section 8.507

C. Items or expenses for which funding from the 2019-20 fiscal year reimbursement rate increase may not be used for, include, but are not limited to, the following:

1. Executive Salaries

2. Administrative Expenses

3. Human Resource Expenses

4. Information Technology

5. Oversight Expenses

6. Business Management Expenses

7. General Record Keeping Expenses

8. Budget and Finance Expenses

9. Workers' Compensation Insurance

10. Contract Staffing Agency Expenses

11. Employee Appreciation Events

12. Gifts

13. Activities not identifiable to a single program.

D. In the event that a Direct Care Worker was hired after June 30, 2019, the Home Care Agency shall use the lowest compensation paid to a Direct Care Worker of similar functions and duties as of June 30th, 2019. This is the base rate that the increased compensation will be applied to.

E. On and after July 1, 2020, the hourly minimum wage for Direct Care Workers providing personal care services, homemaker services, and In-Home Support Services is $12.41 per hour.

F. For any increase to the reimbursement rates for the above services that takes effect during the 2020-21 fiscal year, agencies shall use eighty-five percent of the funding to increase compensation for Direct Care Workers above the rate of compensation that the Direct Care Workers received as of June 30, 2020.

1. Home Care Agencies may use any remaining funding resulting from the reimbursement rate increase for general and administrative expenses, such as chief executive office salaries, human resources, information technology, oversight, business management, general record keeping, budgeting and finance, and other activities not identifiable to a single program.

G. Within sixty days after rate increases are approved, each Home Care Agency shall provide written notification to each Direct Care Worker who provides the above services of the compensation they are entitled to.

8.507.3 REPORTING REQUIREMENTS FOR DIRECT CARE WORKER RATE INCREASES

A. On or before December 31, 2020, and one (1) year thereafter, Home Care Agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-1602, C.R.S. were used to increase compensation for Direct Care Workers in the 2019-20 fiscal year. On or before December 31, 2021, Home Care Agencies must report and attest to the Department in detail how all of the increased funds received pursuant to Section 25.5-6-1602, C.R.S. were used to increase compensation for the 2020-21 fiscal year. If there is no reimbursement rate increase, Home Care Agencies must report and attest to the Department in detail how they~~it~~ maintained each Direct Care Worker's~~'~~ compensation for the 2020-21 fiscal year.

1. Home Care Agencies must report to the Department, in the manner prescribed by the Department, by December 31 of each year.

2. The Department has ongoing discretion to request information from Home Care Agencies demonstrating how it maintained increases in compensation for Direct Care Workers beyond the reporting period.

3. Failure to provide adequate and timely reports may result in recoupment of funds.

8.507.4 AUDITING REQUIREMENTS FOR DIRECT CARE WORKERS INCREASE FOR COMPENSATION

A. Each Home Care Agency shall keep true and accurate work records to support and demonstrate use of the funds. Such records shall be retained for a period of not less than three (3) years and shall be open to inspection by the Department and are made available to be copied by the Department or its authorized representatives at any reasonable time and as often as may be necessary.

B. Home Care Agencies shall submit to the Department upon request, only records showing that the funds received for the services listed in Section 8.507.2.A. were used as a compensation for Direct Care Workers, including but not limited to:

1. Federal Employment Forms

   a. W2 - Wage and Tax Statement

   b. W3 - Transmittal of Wage and Tax Statement

   c. 941 - Employer's Quarterly Federal Unemployment Tax Return

   d. 940 - Employer's Annual Federal Unemployment Tax Return

2. State Employment Forms

   a. UITR 1 – State Unemployment Insurance Tax Report

   b. UITR 1A - State Unemployment Insurance Tax Report Wage List

3. Business/Corporate Tax Returns

4. Independent Contractor Forms

   a. 1099's- Miscellaneous Income

   b. 1096 - Annual Summary and Transmittal of U.S. Information Returns

5. Payroll Records

a. Payroll Detail

b. Payroll Summary

6. Accounting Records

a. Chart of Accounts

b. General Ledger

c. Profit & Loss Statements

d. Check Register

7. Bank Statements

8. Timesheets

9. Benefits Records

a. Health Insurance Records

b. Other Insurance Records

c. Paid Time Off Records

D. The Department may recoup part or all of the funding resulting from the increase in the reimbursement rate if the Department determines that the Home Care Agency:

1. Did not use one hundred percent of any funding resulting from the rate increase to increase compensation for Direct Care Workers during fiscal year 2019-2020, as required by Section 25.5-6-1602(2), C.R.S.

2. Did not use eighty-five percent of the funding resulting from the rate increase to increase compensation for Direct Care Workers during fiscal year 2020-2021

3. Failed to track and report how it used any funds resulting from the increase in the reimbursement rate

E. If the Department makes a determination to recoup funding, the Department shall notify the Home Care Agency in writing of the Department's intention to recoup funds. The Home Care Agency has forty-five (45) days after issuance of the notice of the determination to complete any of the following actions:

1. Challenge the determination of the Department;

2. Provide additional information to the Department demonstrating compliance;

3. Submit a Plan of Correction to the Department.

F. The Home Care Agency must submit the Plan of Correction to the Department within forty-five (45) business days of the issuance of a written request from the Department. The Home Care Agency must notify the Department in writing, within five (5) business days of the receipt of the

written request from the Department, if it will not be able to submit the Plan of Correction by the due date. The Home Care Agency must explain the rationale for the delay and the Department may grant an extension, in writing, of the deadline for the Home Care Agency's compliance.

G. A Plan of Correction shall include, but not be limited to:

1. A detailed description of actions to be taken to resolve issues and supporting documentation demonstrating completion.

2. A detailed plan specifying the actions to be taken.

3. Employee(s) responsible for implementing the actions.

4. The implementation timeframes and date(s) for completion.

H. Upon receipt of the Plan of Correction, the Department will accept, request modifications, or reject the proposed Plan of Correction. Modifications or rejections will be accompanied by a written explanation. If a Plan of Correction is rejected, the Home Care Agency must resubmit a new Plan of Correction along with any requested documentation to the Department for review within five (5) business days of notification.

I. The Department shall notify the Home Care Agency in writing of its final determination after affording the Home Care Agency the opportunity to take the actions specified in Section 8.507.4.E. The Department shall recoup one hundred percent of the increased funding received but did not use for a direct benefit for non-administrative employee if the Home Care Agency:

1. fails to respond to a notice of determination of the Department within the time provided in Section 8.507.4.E;

2. is unable to provide documentation of compliance; or

3. the Department does not accept the Plan of Correction submitted by the service agency; or

4. Plan of Correction is not completed within the established timeframe pursuant to Section 8.507.4.I.

J. All recoveries will be conducted pursuant to Section 25.5-4-301, C.R.S. and Section 8.076.3.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Hospital Expenditure Report Data Collection, Section 8.4000
Rule Number: MSB 19-08-13-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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 19-08-13-A, Revision to the Medical Assistance Rule Concerning Hospital Expenditure Report Data Collection, Section 8.4000
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) 8.400, 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*

Insert the newly proposed text at 8.4000 beginning at 8.4000 through the end of 8.4002.C. This rule is effective December 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule Concerning Hospital Expenditure Report Data Collection, Section 8.4000
Rule Number: MSB 19-08-13-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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 recent adoption of House Bill 19-1001, Hospital Transparency Measures to Analyze Efficiency, codified at 25.5-4-402.8, C.R.S., requires the Department of Health Care Policy and Financing (the Department) to develop and publish a report on hospital uncompensated care costs titled the Hospital Expenditure Report. To accomplish this, hospitals are required to report audited financial statements, Medicare Cost Reports, and additional self-reported data (utilization, financial, and physician and hospital acquisitions). The proposed rule provides definitions of key terms and details the data collection process including specifying the hospital statements to be collected.

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. (2019);
   25.5-4-402.8, C.R.S

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Rule Concerning Hospital Expenditure Report Data Collection, Section 8.4000
Rule Number: MSB 19-08-13-A
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REGULATORY ANALYSIS

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

   State licensed general and critical access hospitals will bear the cost of the proposed rule. This cost is mitigated by utilizing existing audited financial statements and Medicare Cost Reports that hospitals are already reporting. The Department, policy makers, and the general public will benefit from the rule by providing valuable information on hospital utilization and financial information on the Colorado hospital marketplace and individual hospitals.

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

   General and critical access hospitals may experience additional administrative labor hours dedicated to the submission and data reporting process.

   The proposed rule provides an alternative reporting submission (submission of the DATABANK program reports to the Colorado Hospital Association), which should ease the administrative burden for many hospitals.

   For hospitals who choose to use the Department reporting template for their reporting submission, hospitals can standardize their submission, providing the hospital with valuable year-over-year quantitative information for analysis.

   The resulting database and Hospital Expenditure Report will provide the Department, the Colorado Hospital Association, hospitals, policy makers, and the public with valuable information on hospital utilization and financial information on the Colorado hospital marketplace.

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

   No costs to the Department or any other agency are anticipated.

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

   The Department does not anticipate any additional costs from the proposed rule.

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

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule. The statute defines required documentation and data to be reported.

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

   The Department could rely on the statute as a lone means of authority for the data collection. However, the statute calls from some rulemaking and rulemaking is needed to define key terms and describe data collection requirements. Specifically the statute does not provide enough detail for data collection process to be useful to hospitals, nor does the statute provide enough detail to ensure that the data collected is consistent.

   The proposed rule provides essential details missing from the statute: explicit hospital exemption, direction on the submission process, alternatives to the reporting submission, and directions on what to do if statements or reporting is unavailable for submission. The proposed rule also adds specifications on the statements to be collected, ensuring that hospitals provide meaningful and comparable data.

8.4000

PURPOSE: To supply data for the Hospital Expenditure Report, which is an annually prepared written report detailing uncompensated hospital costs and the different categories of expenditures, by major payer group, made by hospitals in the state.

8.4001 DEFINITIONS

"Certified Financial Statements" means financial statements, along with accompanying notes, that have been prepared in accordance with Generally Accepted Accounting Principles and that have been audited by an independent certified public accountant(s) in accordance with generally accepted auditing standards.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"DATABANK Program" means the Colorado Hospital Association program that collects hospital utilization and financial data.

"Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described at § 25.5-4-402.4(7), C.R.S..

"General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

"Health System" is a larger corporation or an organizational structure that owns, contains, or operates more than one hospital.

"Long Term Care Hospital" means a General Hospital that is certified as a long-term care hospital by the Colorado Department of Public Health and Environment.

"Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS, and the annual required submission of worksheets and schedules by Medicare certified providers used for Medicare reimbursement.

"Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

"Rehabilitation Hospital" means an inpatient rehabilitation facility.

8.4002 RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS

8.4002.A STATEMENT SUBMISSION

1. For the purposes of compiling historic data for the Hospital Expenditure Report, all General Hospitals and Critical Access Hospitals shall submit Certified Financial Statements and Medicare Cost Reports for all fiscal periods ending after January 1, 2012 through the most recently available fiscal period.

    a. Hospitals shall submit within fifteen (15) days of the effective date of this rule.

2. For the purposes of ongoing data compilation for the Hospital Expenditure Report, all General Hospitals and Critical Access hospitals shall submit their Certified Financial Statements and Medicare Cost Reports.

    a. Hospitals shall submit a Certified Financial Statement within 120 days after the end of its fiscal year, unless the Department grants an extension in writing in advance of that date.

    ~~The Department shall inform hospitals of the fiscal period(s) of the request.~~

    b. Hospitals shall submit annual Medicare Cost Reports to the Department within thirty (30) ~~calendar~~ days after ~~receiving the request or on the stated due date, whichever is later~~submitting them to CMS.

3. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from submitting Certified Financial Statements and Medicare Cost Reports~~statement submission~~.

4. For a hospital that operates within a Health System or other corporate structure, and is normally included in the Health System or other corporate structure's Certified Financial Statements

    a. The hospital may submit the Health System or other corporate structure's Certified Financial Statements if the statements separately identify the financial information for each licensed hospital operating in the state including:

        i. A statement of operations.

        ii. A balance sheet.

        iii. If available, a statement of changes in net assets (or equity).

        iv. If available, a statement of cash flows.

    b. For hospitals in which the consolidated Certified Financial Statements do not separately identify the financial information for each licensed hospital operating in the state, then the hospital shall submit the financial statements that were submitted with its Medicare Cost Report~~.~~ shall submit a reconciliation of the consolidated financial statement and hospital-specific revenue and expenses reported on the Medicare Cost Report pursuant to the federal centers for Medicare and Medicaid services provider reimbursement manual form 339.

5. If total revenues and total expenses on the submitted financial statements differ from the Medicare Cost Report, the hospital shall submit a reconciliation.

6. A hospital may choose to submit a written explanation of operating, investing, or financing decisions that impact the interpretation of the Certified Financial Statements or Medicare Cost Report.

7. A hospital may choose to submit a written explanation detailing changes in reporting methodology between fiscal periods that would impact the interpretation of the statements and what period may be affected. Examples of reporting methodologies that could change include:

    a. Measurements of financial assets and liabilities.

    b. Recording of retirement benefit plans.

    c. Recording of income tax expense.

d. Rates of depreciation.

8. The Department is not responsible for the review and authentication of the Certified Financial Statements and the Medicare Cost Report. The authentication of the submitted Certified Financial Statements and the Medicare Cost Report is the responsibility of the hospital or Health System.

9. Submissions shall be certified by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

8.4002.B REPORTING SUBMISSION

1. For the purposes of compiling historic data for the Hospital Expenditure Report, hospitals shall report utilization and financial information for fiscal periods ending after January 1, 2012 through the most recently available fiscal period if such information is available. The Department shall make available or distribute a data reporting template to all hospitals.

    a. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by C.R.S. § 25.5-4-402.8(2)(b)(III).~~.~~

    b. The Department may allow hospitals to submit data submitted to the DATABANK Program as an alternative to the Department's reporting template. The Department shall instruct hospitals what is an acceptable DATABANK Program submission.

    c. Hospitals shall return the completed reporting template to the Department within fifteen (15) ~~calendar~~ days after receiving the request or on the stated due date, whichever is later.

2. For the purposes of ongoing data compilation for the Hospital Expenditure Report, hospitals shall report utilization and financial information on the hospital for the requested fiscal year. The Department shall make available or distribute a data reporting template to all hospitals.

    a. The Department shall inform hospitals of the fiscal period of the request.

    b. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each reported data field, which will include at a minimum those items required by C.R.S. § 25.5-4-402.8(2)(b)(III).~~.~~

    c. Hospitals shall return the completed reporting template to the Department within thirty (30) ~~calendar~~ days after receiving the request or on the stated due date, whichever is later.

3. Hospitals shall submit a roll-forward schedule detailing the changes in property, plant, and equipment balances from the beginning to the end of the reporting period.

    a. Changes shall be appropriately categorized as either purchases, other acquisitions, sales, disposals, depreciation expense or other changes. Significant amounts categorized as other changes should be separately described. The roll-forward schedule should provide details of changes by property, plant, and equipment category including, but not limited to land, buildings, buildings – accumulated depreciation, building improvements, building improvements – accumulated depreciation, leasehold improvements – leasehold improvements – accumulated depreciation, equipment, equipment – accumulated depreciation, other and other – accumulated depreciation. The

beginning and ending balances on the roll-forward schedule should agree to the respective balance sheet.

4. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the reporting submission.

5. The Department shall determine the reasonableness of the data submitted by comparing it to the submitted Certified Financial Statement.

6. Submissions shall be certified by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.

8.4002.C DEPARTMENT REPORTING & TRANSPARENCY

1. The Department is responsible for the compilation of the hospital submissions.

1. The Department shall consult with the Enterprise Board on the structure and format of the Hospital Expenditure Report at the Enterprise Board meetings.

2. The Department shall share the hospital's data in the Hospital Expenditure Report and a copy of the report with the hospital a minimum of fifteen (15) ~~calendar~~ days before the report is publicly available or issued to the Enterprise Board.

3. After the collection and review of the data submission, a machine-readable format of the hospital data shall be made available to the statewide hospital association at no cost to the association.