DO NOT PUBLSIH THIS PAGE

Title of Rule: MSB 21-06-08-A, A Revision to the Medical Assistance Long-term Services and Supports HCBS Benefit Rule Concerning Expanding Electronic Monitoring to include Remote Supports, to revise Section 8.488.
Rule Number: MSB 21-06-08-A
Division / Contact / Phone: BSMD/ Courtney Montes/ 5066

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 21-06-08-A, A Revision to the Medical Assistance Long-term Services and Supports HCBS Benefit Rule Concerning Expanding Electronic Monitoring to include Remote Supports, to revise Section 8.488.

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) 8.488

   Sections(s) MSB 21-06-08-A, 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 8.488 with the proposed text beginning at 8.488 through the end of 8.488.50. Replace the current text at 8.500.94.A beginning at 8.500.94.A through 8.500.94.A.22. Replace the current text at 8.500.94.B with the proposed text beginning at 8.500.94.B.17 through the end of 8.500.94.B.22. This rule is effective January 10, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLSIH THIS PAGE

Title of Rule: MSB 21-06-08-A, A Revision to the Medical Assistance Long-term Services and Supports HCBS Benefit Rule Concerning Expanding Electronic Monitoring to include Remote Supports, to revise Section 8.488.
Rule Number: MSB 21-06-08-A
Division / Contact / Phone: BSMD/ Courtney Montes/ 5066

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 Office of Community Living (OCL), Benefits and Services Management Division is requesting to revise the current Electronic Monitoring regulations, already included in five HCBS adult waivers, to include the addition of a Remote Supports component that will increase efficiencies, improve quality of care, and achieve cost savings. When hands-on care is not required, Remote Supports makes it possible for direct care staff to provide supervision, prompting, or instruction from a remote location. Examples of Remote Supports include technology for cooking safely, overnight support, medication adherence, fall detection, and wandering. The Department must add a service definition and regulations for the operation of Remote Supports. The addition of regulations will give members and providers regulatory parameters for how Remote Supports can be utilized in HCBS to maintain service integrity and ensure member's health and safety.

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 441.300

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Sections 25.5-6-303, 25.5-6-307, C.R.S. (2021);

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

DO NOT PUBLSIH THIS PAGE

Title of Rule: MSB 21-06-08-A, A Revision to the Medical Assistance Long-term Services and Supports HCBS Benefit Rule Concerning Expanding Electronic Monitoring to include Remote Supports, to revise Section 8.488.
Rule Number: MSB 21-06-08-A
Division / Contact / Phone: BSMD/ Courtney Montes/ 5066

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 to be affected are those that utilize Home and Community-Based Services under the Elderly Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Spinal Cord Injury (SCI), Brain Injury (BI), and Supported Living Services (SLS) waivers. Those that choose to utilize Remote Supports are anticipated to benefit from this rule. The proposed rules will also affect Medicaid providers and Case Management Agencies (CMAs) by codifying the implementation of Remote Supports.

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

   Quantitatively, offering a Remote Supports benefit has the potential to reduce HCBS expenditures by providing services at a lower cost than residential or in-person care. The Department anticipates a reduction in General Fund dollars by $348,345 in FY 21-22 and $1,045,040 in FY 22-23.

   Qualitatively, using technology instead of residential services can increase independence for members while ensuring safety and support, address workforce shortages by increasing provider efficiency, and improve access to care in rural areas. Increased independence for members is one of the major benefits of a Remote Supports benefit, allowing a person to live in their own home, without staff or with a reduced staff presence, and with more control of their living companions.

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.

   Through Long Bill SB 21 – 205 and SB 21-210, the Department received approval for the expansion of the Electronic Monitoring benefit, already authorized in select HCBS adult waivers (BI, SCI, SLS, CMHS, and EBD). Short term, the Department anticipates spending time developing training materials and providing technical

assistance to the case management agencies. Long term the Department anticipates a reduction in General Fund dollars by $348,345 in FY 21-22 and $1,045,040 in FY 22-23.

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

   The benefits of this action include: Using technology instead of residential services can increase independence for members while ensuring safety and support, address workforce shortages by increasing provider efficiency, improve access to care in rural areas, and reduce expenditures by providing services at a lower cost than residential care. Increased independence for members is one of the major benefits of a Remote Supports benefit, allowing a person to live in their own home, without staff or with a reduced staff presence, and with more control of their living companions. Offering a Remote Supports benefit has the potential to reduce HCBS expenditures by providing services at a lower cost than residential or in-person care. The Department anticipates a reduction in General Fund dollars by $348,345 in FY 21-22 and $1,045,040 in FY 22-23. HCBS services can be critical to preventing unnecessary hospitalizations or placement in a nursing facility however Remote Supports benefit offers the opportunity for members to receive high quality care and support without an in-person attendant.

   There are no benefits of inaction as this approval to implement Remote Supports is included in the Department's Budget Request and is approved by the Long Bill, SB 21-205.

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

   There do not appear to be any less costly methods or less intrusive methods for achieving the purpose of the proposed regulation changes. Remote Supports is a cost saving opportunity that allows members to have more choice and independence in their lives.

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 the purpose for the proposed rule.

8.488 ELECTRONIC MONITORING

8.488.10 DEFINITIONS

.11 BACKUP SUPPORT PERSON means the person who is responsible for responding in the event of an emergency or when a Client receiving Remote Supports otherwise needs assistance or the equipment used for delivery of Remote Supports stops working for any reason. Backup support may be provided on an unpaid basis by a family member, friend, or other person selected by the Client or on a paid basis by an agency provider.

.12 ELECTRONIC MONITORING SERVICES means electronic equipment or adaptations or other remote supports that are related to an eligible person's disability and/or that enable the person to remain at home, and includes the installation, purchase or rental of electronic monitoring devices which:

A. Eenable the ~~individual~~Client to secure help in the event of an emergency;

B. M~~m~~ay be used to provide reminders to the ~~individual~~Client of medical appointments, treatments, or medication schedules;

C. A~~a~~re required because of the ~~individual~~Client's illness, impairment or disability, as documented ~~on~~ in the department prescribed LOC Screen, ~~e ULTC 100 form and a~~and the Assessment, and Service Plan;

D. A~~a~~re essential to prevent institutionalization of the ~~individual~~Client; and.~~-~~

E. May allow an off-site direct service provider to monitor and respond to a Client's health, safety, and other needs using live communication.

.13~~2~~ ~~Electronic monitoring provider~~ELECTRONIC MONITORING PROVIDER means a provider agency as defined at ~~10 CCR 2505-10~~ S~~s~~ection ~~8.484.50.Q~~ 8.487 and Section 25.5-6-303. C.R.S., ~~which~~ that has met all the certification standards for electronic monitoring services specified ~~below~~ in Section 8.488.40.

.14 MONITORING BASE means the off-site location from which the Remote Supports Provider monitors the Client.

.15 REMOTE SUPPORTS mean the provision of support by staff at a Monitoring Base who are engaged with a Client to monitor and respond to the Client's health, safety, and other needs through technology/devices with the capability of live two-way communication.

.16 REMOTE SUPPORTS PROVIDER means the agency provider selected by the Client as the provider of Remote Supports.

.17 SENSOR means equipment used to notify the Remote Supports Provider of a situation that requires attention or activity which may indicate deviations from routine activity and/or future needs. Examples include, but are not limited to, seizure mats, door sensors, floor sensors, motion detectors, heat detectors, and smoke detectors.

8.488.20 INCLUSIONS

.21 Electronic M~~m~~onitoring S~~s~~ervices shall include personal emergency response systems, medication reminder systems, Remote Supports, or other devices which comply with the

definition above and are not included in the non-benefit items below at 10 CCR 2505-10 section 8.488.301.

A. Remote Supports services shall include but are not limited to the following technology options:
1. Motion sensing system;
2. Radio frequency identification;
3. Live audio feed;
4. Web-based monitoring system; or,
5. Another device that facilitates two-way communication.

B. Remote Supports includes the following general provisions:
1. Remote Supports shall only be approved when it is the Client's preference and will reduce the need for in-person care.
21. AThe Client, their case manager, and the selected Remote Supports provider shall determine whether Remote Supports is sufficient to ensure the Client's health and welfare.
32. Remote Supports shall be provided in real time, not via a recording, by awake staff at a Monitoring Base using the appropriate technology. While Remote Support is being provided, the Remote Support staff shall not have duties other than the provision of Remote Supports provision.

8.488.30 EXCLUSIONS, RESTRICTIONS AND NON-BENEFIT ITEMS

.31 Electronic Mmonitoring Sservices shall be authorized only for individualClients who live alone, or who are alone for significant parts of the day, or whose only companion for significant parts of the day is too impaired to assist in an emergency, and who would otherwise require extensive supervision.

A. Remote Supports shall not be utilized for Clients who reside in any congregate or HCBS provider owned setting.

.32 Electronic Mmonitoring Sservices shall be authorized only for individualClients who have the physical and mental capacity to utilize the particular system requested for that individualClient.

.33 Electronic Mmonitoring Sservices shall not be authorized under HCBS if the service or device is available as a state plan Medicaid benefit.

.34 The following are not benefits of electronic monitoring services:

A. Augmentative communication devices and communication boards;

B. Hearing aids and accessories;

C. Phonic ears;

D. Environmental control units, unless required for the medical safety of a client living alone unattended; or as part of Remote Supports;

E. Computers and computer software when not unrelated to the provision of Remote Supports;

F. Wheelchair lifts for automobiles or vans;

G. Exercise equipment, such as exercise cycles;

H. Hot tubs, Jacuzzis, or similar items.

8.488.40 CERTIFICATION STANDARDS FOR ELECTRONIC MONITORING SERVICES

.41 Electronic monitoring providers shall conform to all general certification standards and procedures at ~~10 CCR 2505-10 s~~Section 8.487, HCBS-EBD WAIVER PROVIDER AGENCIES.

.42 In addition, electronic monitoring providers shall conform to the following standards for electronic monitoring services:

A. All equipment, materials or appliances used as part of the electronic monitoring service shall carry a UL (Underwriter's Laboratory) number or an equivalent standard. All telecommunications equipment shall be FCC registered.

B. All equipment, materials or appliances shall be installed by properly trained individuals ~~individuals~~, and the installer and/or provider of electronic monitoring shall train the C~~c~~lient in the use of the device. ~~.~~

C. All equipment, materials or appliances shall be tested for proper ~~for~~ functioning at the time of installation, and at periodic intervals thereafter, and be maintained based on the manufacturer's recommendations. ~~.~~Any malfunction shall be promptly ~~repaired~~repaired, and equipment shall be replaced when necessary, including buttons and batteries.

D. All telephone calls generated by electronic monitoring equipment shall be toll-free and all C~~c~~lients shall be allowed to run unrestricted tests on their equipment.

.43 In addition, Remote Supports Providers shall conform to the following additional standards for provision of Remote Supports services:

A. When Remote Supports includes the use of live audio and/or video equipment that permits a Remote Supports Provider to view activities and/or listen to conversations in the residence, the Client who receives the service and each person who lives with the Client shall consent in writing after being fully informed of what Remote Support entails including, but not limited to:

1. The Remote Supports Provider will observe their activities and/or listen to their conversations in the residence;

2. ~~Where~~The location in the residence where the Remote Supports service will take place; and,

3. Whether or not ~~recordings will be made~~ the Remote Supports provider will record audio and/or video.

4. If the Client or a person who lives with the Client has a guardian, the guardian shall consent in writing. The Client's Case Manager and Remote Supports Provider shall keep a copy of each signed consent form.

B. The Remote Support Provider shall provide a Client who receives Remote Supports with initial and ongoing training on how to use the Remote Supports system(s)

C. The Remote Supports Provider shall provide initial and ongoing training to its staff to ensure they know how to use the Monitoring Base System.

D. The Remote Supports provider shall have a backup power system (such as battery power and/or generator) in place at the Monitoring Base in the event of electrical outages. The Remote Supports Provider shall have ~~other~~additional backup systems and additional safeguards in place which shall include, but are not limited to, contacting the Backup Support Person in the event the Monitoring Base System stops working for any reason.

E. The Remote Support Provider shall have an effective system for notifying emergency personnel in the event of an emergency.

F. If a known or reported emergency involving a Client arises, the Remote Supports Provider shall immediately assess the situation and call emergency personnel first, if that is deemed necessary, and then contact the Backup Support Person. The Remote Supports Provider shall maintain contact~~stay engaged~~ with the Client during an emergency until emergency personnel or the Backup Support Person arrives.

G. The Backup Support Person shall verbally acknowledge receipt of a request for assistance from the Remote Supports Provider. Text messages, email, or voicemail messages will not be accepted as verbal acknowledgment.

H. When a Client requests in-person assistance, ~~T~~the Backup Support Person shall arrive at the Client's location within a reasonable amount of time (to be specified in documentation maintained by the Remote Support Provider ~~when a request for in-person assistance is made~~.

I. When a Client needs assistance, but the situation is not an emergency, the Remote Supports provider shall:

1. Address the situation~~-~~ from the Monitoring Base, or, ~~,~~
2. Contact the Client's Backup Support Person ~~for a Client~~ if necessary.

J. The Remote Support Provider shall maintain detailed and current written protocols for responding to a Client's needs, including contact information for the Backup Support Person to provide assistance ~~when necessary~~.

K. The Remote Support Provider shall maintain documentation of the protocol to be followed should the Client request that the equipment used for delivery of Remote Supports be turned off.

L. The Remote Supports Provider shall maintain daily service provision documentation that shall include the following:

1. Type of Service,

2. Date of Service,

3. Place of Service,

4. Name of Client receiving service,

5. Medicaid identification number of Client receiving service,

6. Name of Remote Supports Provider,

7. Identify the Backup Support Person and their contact information, if/when utilized.

8. -Begin and end time of the Remote Supports service,

9. Begin and end time of the Remote Supports service when a Backup Support Person is needed on site,

10. Begin and end time of the Backup Support Person when on site, whether paid or unpaid,

11. Number of units of ~~the delivered~~ Remote Supports service delivered per calendar day,

12. Description and details of the outcome of providing Remote Supports, and any new or identified needs that are outside of the individual's current Service Plan~~Support Plan~~, which shall be communicated to the individual's case manager.

8.488.50 REIMBURSEMENT METHOD FOR ELECTRONIC MONITORING

.51 Payment for E~~e~~lectronic M~~m~~onitoring S~~s~~ervices shall be the lower of the billed charges or the prior authorized amount.

.52 For Electronic Monitoring, excluding Remote Supports, t~~T~~he unit of reimbursement shall be one unit per service for non-recurring services, or one unit per month for services recurring monthly.

.53 For Remote Supports, the unit of reimbursement shall ~~be~~ include one unit per installation/equipment purchase and/or the units as designated on the Department's fee schedule and/or billing manuals for ongoing Remote Supports service.

.5~~4~~2 Effective 2/1/99, there shall be no reimbursement under this section for E~~e~~lectronic M~~m~~onitoring S~~s~~ervices provided in uncertified congregate facilities.

8.500.94 HCBS-SLS WAIVER SERVICES

8.500.94.A. SERVICES PROVIDED

1. Assistive Technology
2. Behavioral Services
3. Day Habilitation services and supports
4. Dental Services
5. Health Maintenance

6. Home Accessibility Adaptations

7. Home Delivered Meals

8. Homemaker Services

9. Life Skills Training (LST)

10. Mentorship

11. Non-Medical Transportation

12. Peer Mentorship

13. Personal Care

14. Personal Emergency Response System (PERS)

15. Professional Services, defined below in 8.500.94.B.14

16. Respite

17. Remote Supports

~~17~~18. Specialized Medical Equipment and Supplies

~~18~~19. Supported Employment

~~19~~20. Transition Setup

~~20~~21. Vehicle Modifications

~~21~~22. Vision Services

8.500.94.B The following services are available through the HCBS-SLS waiver within the specific limitations as set forth in the federally approved HCBS-SLS waiver.

17. Remote Supports means services as defined at Section 8.488 ~~within Electronic Monitoring.~~

18. Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the Client's disability and that enable the Client to increase the Client's ability to perform activities of daily living or to safely remain in the home and community. Specialized medical equipment and supplies include:

a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. Specially designed clothing for a Client if the cost is over and above the costs generally incurred for a Client's clothing;

c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-SLS waiver.

d. The following items are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement:

i) Items that are not of direct medical or remedial benefit to the Client are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement. These include but are not limited to; vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

~~18~~19. Supported Employment services includes intensive, ongoing supports that enable a Client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the Client's disabilities needs supports to perform in a regular work setting.

a. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development and assisting the Client to locate a job or job development on behalf of the Client.

b. Supported employment may be delivered in a variety of settings in which Clients interact with individuals without disabilities, other than those individuals who are providing services to the Client, to the same extent that individuals without disabilities employed in comparable positions would interact.

c. Supported employment is work outside of a facility-based site, that is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities,

d. Supported employment is provided in community jobs, enclaves or mobile crews.

e. Group employment including mobile crews or enclaves shall not exceed eight Clients.

f. Supported employment includes activities needed to sustain paid work by Clients including supervision and training.

g. When supported employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a Client as a result of the Client's disabilities.

h. Documentation of the Client's application for services through the Colorado Department of Labor and Employment Division for Vocational Rehabilitation shall be maintained in the file of each Client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. Section 1400, et seq.).

i. Supported employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

j. Supported employment shall not take the place of nor shall it duplicate services received through the Division for Vocational Rehabilitation.

k. The limitation for supported employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of supported employment and shall not be reimbursed:

i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a Client's supported employment.

~~19~~20. Transition Setup as defined at Section 8.553.1.

~~20~~21. Vehicle modifications are adaptations or alterations to an automobile or van that is the Client's primary means of transportation; to accommodate the special needs of the Client; are necessary to enable the Client to integrate more fully into the community; and to ensure the health and safety of the Client.

a. Upkeep and maintenance of the modifications are allowable services.

b. Items and services specifically excluded from reimbursement under the HCBS Waiver include:

i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the Client,

ii) Purchase or lease of a vehicle, and

iii) Typical and regularly scheduled upkeep and maintenance of a vehicle.

c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall 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-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.

~~21~~22. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a Client who is at least 21 years of age

a. Lasik and other similar types of procedures are only allowable when:

b. The procedure is necessary due to the Client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and

c. Prior authorized in accordance with Operating Agency procedures.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Adult Dental Annual Limit Maximum, Section 8.201.6
Rule Number: MSB 21-07-07-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 21-07-07-A, Revision to the Medical Assistance Act Rule concerning Adult Dental Annual Limit Maximum

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) 8.201.6, 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 8.201.6 with the proposed text beginning at 8.201.6 through the end of 8.201.6, This rule is effective January 10, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Adult Dental Annual Limit Maximum, Section 8.201.6
Rule Number: MSB 21-07-07-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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 extends the maximum adult dental annual benefit of $1,500 indefinitely per Senate Bill 21-211. SB21-211 restores the $1,500 maximum adult dental annual benefit that was reduced to $1,000 by the 2020 Long Bill (HB20-1360), and House Bill 20-1361, beginning when the higher federal match afforded through the federal "Families First Coronavirus Response Act", Pub.L. 116-127 (FFCRA) expires. The adult dental annual benefit is currently maintained at $1500 with the FFCRA higher match. This rule will maintain the $1,500 after the FFCRA higher federal match expires.

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 § 440.100 (2020)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

   C.R.S. § 25.5-5-202(1)(w) (2020)

Initial Review	**10/08/21**	Final Adoption	**11/12/21**
Proposed Effective Date	**01/10/22**	Emergency Adoption	

DOCUMENT #06

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Adult Dental Annual Limit Maximum, Section 8.201.6
Rule Number: MSB 21-07-07-A
Division / Contact / Phone: Health Programs Office / Russ Zigler / 303-866-5927

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.

   Adult members will be affected by this rule and will benefit from the adult dental annual limit remaining at $1,500.

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 adult dental annual limit will remain at $1,500 after the Families First Coronavirus Response Act (FFCRA) higher federal match expires rather than being reduced to $1,000.

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

   There are no costs to the Department to implement the proposed rule, as the Department will maintain the current annual limit. HB 20-1361 required the Department to reduce the limit to $1,000 after the end of the public health emergency and reduced the Department's appropriations in FY 2020-21 and FY 2021-22 accordingly. SB 21-211 eliminated that requirement and increased the Department's appropriations. Between the two bills, there was no change to the Department's funding.

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

   There are no probable costs to the proposed rule. The benefit of the proposed rule is maintaining the $1,500 adult dental annual limit after the FFCRA higher federal match expires. The cost of inaction is failure to align Department rule with state statute. There are no benefits to inaction.

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

There are no less costly methods or less intrusive methods for aligning Department rule with state statute.

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 aligning Department rule with state statute.

8.201 ADULT DENTAL SERVICES

8.201.6 ANNUAL LIMITS

1. Beginning July 1, 2019, dental services for Adult Clients age 21 years and older shall be limited to a total of $1,500 per Medicaid Adult Client per state fiscal year. An Adult Client may make personal expenditures for any dental services that exceed the $1,500 annual limit.

~~2.~~ ~~Effective April 1, 2021, or beginning when the higher federal match afforded through the federal "Families First Coronavirus Response Act", Pub.L. 116-127, or any amendment thereto, expires, whichever is later, and continuing through June 30, 2022, the dental services for Adult Clients age 21 years and older shall be limited to a total of $1,000 per Medicaid Adult Client per state fiscal year. An Adult Client may make personal expenditures for any dental services that exceed the $1,000 annual limit.~~

~~3~~2. The complete and partial dentures benefit shall be subject to prior authorization and shall not be subject to the annual maximum for dental services for Adult Clients age 21 years and older. Although the complete and partial dentures benefit is not subject to the annual maximum for the adult dental services, it shall be subject to a set Medicaid allowable rate.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assitance Rule concerning Provider Participation, Section 8.130
Rule Number: MSB 21-07-20-B
Division / Contact / Phone:Medicaid Operations / Jolene Guignet/ 6948

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 21-07-20-B, Revision to the Medical Assitance Rule concerning Provider Participation, Section 8.130

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) 8.130, 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 8.130 with the proposed text beginning at 8.130 through the end of 8.130. This rule is effective January 10, 2022.

*to be completed by MSB Board Coordinator

Title of Rule: Revision to the Medical Assitance Rule concerning Provider Participation, Section 8.130
Rule Number: MSB 21-07-20-B
Division / Contact / Phone:Medicaid Operations / Jolene Guignet/ 6948

STATEMENT OF BASIS AND PURPOSE

1. This revision is necessary to provide additional guidance on the expectations of all providers and to specifically outline the provider inactivation procedure.

2. Federal authority for the Rule, if any:

   42 CFR § 431.17; 42 CFR § 431.20; 42 CFR § 455.400

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

Title of Rule: Revision to the Medical Assitance Rule concerning Provider Participation, Section 8.130
Rule Number: MSB 21-07-20-B
Division / Contact / Phone:Medicaid Operations / Jolene Guignet/ 6948

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 change to the current rule will impact providers, as it allows for their provider participation agreements to be inactivated in certain situations. They have been afforded an ability to cure before the inactivation and appeal rights. This process is created to help the Department keep our enrollment records clean, giving us the ability to inactivate providers who are not billing.

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

   An inactivated provider may have to reapply if they are inactivated and pay the application fee. However, they are provided opportunities to cure before this will occur and they have to pay a new fee.

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 additional costs.

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

   The benefit to HCPF is great as we can keep our enrollment records clean by removing inactive providers. There is little cost to the department and any provider.

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

   There is no cost to the department and low cost to the provider.

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

8.130 PROVIDER PARTICIPATION

Providers will not discriminate based on race, color, religion, age (except as provided by law), sex, marital status, political affiliation, disability, or national origin. on the basis of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability.

8.130.1 DEFINITION DEFINITIONS

A. "Advanced Directive" means a written instruction, such as a Living Will or Durable Power of Attorney for health care, recognized under state law, whether statutory or as recognized by the courts of the state, that relates to the provision of medical care when the individual is incapacitated.

B. "Agent" means any person who has been delegated the authority to obligate or act on behalf of a Provider.

C. "Change of Information" means any change in information contained in the Provider's current enrollment record with the Department, including, but not limited to, any change to a person or entity who holds a direct or indirect ownership interest in the Provider exceeding five percent and any change to the Provider's licensure, certification registration status, accreditation, bankruptcy status, address (including any change to location(s) where good and services are rendered), contact person, telephone number, email address, or criminal conviction disclosures within the scope of 42 CFR § 455.106.

D "Change of Ownership" means that a Provider has been issued a new tax identification number.

E.C. "Colorado Department of Health Care Policy and Financing" or "Department" means the Colorado State governmental agency responsible for the administration of the Medical Assistance Program Program, , Child Health Plan Plus, the old age pension health and medical care program, and the supplemental old age pension health and medical care program pursuant to Title XIX of the Social Security Act and Title 25.5 of the Colorado Revised Statutes. pursuant to Title XIX of the Social Security Act.

D. "Disclosing Provider" means a Medical Assistance Provider (other than an individual practitioner or group of practitioners), managed care entity, or fiscal agent under contract with the Department.

EF. "Inactivation" means a Provider's billing privileges have been stopped but can be restored upon resolution of the basis of inactivation.

F. "Indirect ownership interest" means an ownership interest in an entity that has direct or indirect ownership in the disclosing Provider.

G. "Managing employee" means a general manager, business manager, administrator, director, or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the day-to-day operation of an institution, organization, or agency.

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

IH. "Requesting Agency" means the United States US Department of Health and Human Services or its designees, the Department or its designees, the Colorado Department of Human Services or its

designees, or the Medicaid Fraud Control Unit or its designees, acting through their representatives who have written or ~~de facto designation as such~~other authorization to act on behalf of these agencies.

8.130.2 MAINTENANCE OF RECORDS

~~8.130.2.~~A. Each ~~provider~~Provider shall:

1. Maintain legible, complete, and accurate records necessary to establish that conditions of payment for ~~Medicaid~~Medical Assistance Program covered goods and services have been met, and to fully disclose the ~~nature and~~ basis for the type, frequency, extent, duration, and delivery of goods and/or services provided to ~~clients~~ Medical Assistance Program ~~Medicaid recipients~~members, including but not limited to:

   a. Billings~~.~~,

   ~~b.~~

   ~~c.~~b. Prior authorization requests~~.~~,

   c. All medical records, service reports, and orders prescribing treatment plans~~.~~,

   d. Records of goods prescribed, ordered for, or furnished to, ~~clients~~members, and unaltered copies of original invoices for such items~~.~~,

   e. Records of all payments received from the Medical Assistance ~~program.~~ ~~P~~Program, and

~~2. Maintain legible records, which fully substantiate or verify claims submitted for payment.~~

   f. Records required elsewhere in Section 8.000 et seq.

2. The records shall be created at the time the goods or services are provided.

~~8.130.2.~~B. Records of ~~providers~~Providers shall include employment records, including but not limited to shift schedules, payroll records, and time ~~-~~cards of employees.

~~8.130.2.~~C. ~~-~~ Providers who issue prescriptions shall keep in the patient's record, the date of each prescription and the name, strength, and quantity of the item prescribed.

~~8.130.2.~~D. Records must be maintained for seven~~ix~~ (76) years unless an additional retention period is required elsewhere in ~~10 C.C.R. 2505-10,~~ Section~~s~~ 8.000 et seq~~.~~., or in ~~the provider~~an individual Provider participation agreement.

~~8.130.2.~~E. Each ~~provider~~Provider shall retain any other records created in the regular operation of business that relate to the type and extent of goods and/or services provided (for example, superbills). All records must be legible, verifiable, and must comply with generally accepted accounting principles ~~and~~, auditing standards~~.~~, and all applicable state and federal laws, rules, and regulations.

~~8.130.2.~~F. Each entry in a medical record must be signed and dated by the individual providing the medical service or good. Stamped signatures are not acceptable.

~~8.130.2.~~G. ~~-~~ Providers utilizing electronic record-keeping may apply computerized signatures and dates to ~~the~~a medical record if their record-keeping systems guarantee the following security measures:

~~1.~~ 1.

Restrict application of an electronic signature to the specific individual identified by the signature. System security must prevent one person from signing another person's name.

2. Prevent alterations to authenticated (signed and dated) ~~reports~~records. If the ~~provider~~Provider chooses to supplement a previous entry, the system must only allow a new entry that explains the supplement. The ~~provider~~Provider must not be allowed to change the initial entry.

3. Printed or displayed electronic records must note that signatures and dates have been applied electronically.

~~8.130.2.~~H. At the discretion of the ~~requesting agency~~Requesting Agency, record verification may include, but will not be limited to, interviews with ~~providers~~Providers, employees of ~~providers~~Providers, billing services that bill on behalf of ~~providers~~Providers, and any member of a corporate structure that includes the ~~provider~~Provider as a member.

~~8.130.2.I. Nothing in Section 8.130 shall negate or modify any specific record keeping requirements contained in 10 C.C.R. 2505-10, Sections 8.000 et seq. or in individual provider agreements.~~

8.130.3 ADVANCE DIRECTIVES

~~8.130.3.A. Advanced Directive means a written instruction, such as a Living Will or Durable Power of Attorney for health care, recognized under state law, whether statutory or as recognized by the courts of the state, that relates to the provision of medical care when the individual is incapacitated.~~

~~8.130.3.B~~A. Providers shall provide adult ~~Medical Assistance program~~Medical Assistance Program ~~clients~~ members with written information about the individual's rights under state law to accept or refuse medical treatment, the right to formulate advance directives, and the ~~providers'~~Providers' policies regarding the implementation of such rights as follows:

1. Hospitals, at the time of the individual's admission as an inpatient.

2. Nursing facilities, at the time of the individual's admission as a resident.

3. Providers of home health care or personal care services, in advance of the individual coming under the care of the ~~provider~~Provider.

4. Hospice programs, at the time of initial receipt of hospice care by the individual from the program.

5. Health maintenance organizations, at the time of enrollment of the individual with the organization.

~~8.130.3.C~~B. The ~~provider~~Provider shall maintain written policies and procedures with respect to all adult individuals receiving medical or personal care by or through the ~~provider~~Provider ~~organization~~, which shall include:

1. Documentation in the individual's medical records indicating whether the individual has executed an advance directive.

2. Documentation that the individual will not be discriminated against, nor will the provision of care be conditioned on whether he/she has executed an advance directive.

~~1.~~ 3. Documentation ensuring compliance with requirements of state law respecting advanced directives.

4. Documentation in the individual's medical record substantiating the ~~provider's~~Provider's reason(s) for non-compliance with an advance directive based on conscience or professional ethics.

~~8.130.3.D~~C. Providers shall provide education for staff and the patient/~~client~~ member community on issues concerning advance directives.

8.130.35~~.~~ SCREENING FOR EXCLUDED EMPLOYEES AND CONTRACTORS

A. As a condition of enrollment and participation in the ~~medical assistance~~Medical Assistance ~~program~~Medical Assistance Program, each ~~provider~~Provider shall comply with the following requirements for screening for employees and contractors who have been excluded from participation in Medicaid and Medicare by the US Department of Health & Human Services Office of Inspector General:

1. Each ~~provider~~Provider shall utilize the US Department of Health & Human Services Office of Inspector General's List of Excluded Individuals/Entities (www.oig.hhs.gov) to determine if a prospective employee or newly signed contractor has been excluded from participation in ~~Medi~~a Medical Assistance Program~~caid~~.

a. Such screening should be performed within five (5) business days of the date on which the new employee was hired or new ~~contractor~~contract was signed.

2. Each ~~provider~~Provider shall screen its employees and contractors against the List of Excluded Individuals/Entities at least monthly to capture any exclusions or reinstatements that have occurred since the last search of the database.

3. If a ~~provider~~Provider determines that an employee or contractor of the ~~provider~~Provider has been excluded, then the ~~provider~~Provider shall report this to the Department within five (5) business days of the date of discovery.

4. Each screening must be documented in a manner that can be provided to the Department upon request.

B. Except as otherwise provided in federal law, if the ~~Medical Assistance program~~Medical Assistance Program pays for any goods or services furnished, ordered, or prescribed by an excluded individual or entity that is employed by or has contracted with a ~~provider~~Provider, such payment shall constitute an overpayment~~, as defined at 8.076.1.8.~~ and shall be subject to ~~the~~ overpayment recovery ~~provisions of~~, pursuant to Section 8.076.~~3.~~ Such ~~provider~~Provider may also be subject to sanctions by the Department, including the termination of the ~~provider~~Provider agreement, as described at 8.076.5., if the ~~provider~~Provider knew or should have known of the exclusion. The ~~provider~~Provider may also be subject to civil and monetary penalties imposed by the US Department of Health and Human Services.

1. To the extent that such amount can be traced, the amount of the overpayment shall include any funds expended by the ~~Medical Assistance program~~Medical Assistance Program to pay the excluded individual's or contractor's salary, expenses, or fringe benefits.

C.~~.~~ Subject to federal law and the Department's discretion, failure of ~~provider~~a Provider to comply with the screening requirements listed at Section 8.130.35.A. may constitute good cause sufficient to justify termination of the ~~provider~~Provider agreement, as described at 8.076.5.

8.130.4 ~~TERMINATION~~40 PROVIDER EMPLOYEE OR CONTRACTOR LICENSE VERIFICATIONS~~S~~

A. As a condition of participation in the Medical Assistance program, any Provider who provides or who has employees or contractors who provide services or supplies must ensure that, at the time services or supplies are provided, the Provider, the employee, or the contractor possesses the license, certification, or credential that is required in the State of Colorado to provide such services or supplies. ~~As a condition of participation in the Medical Assistance program, any Provider who has employees or contractors who provide services or supplies must ensure that, at the time services or supplies are provided, the employee or contractor possesses the license, certification, or credential that is required in the State of Colorado to provide such services or supplies.~~

8.130.45 REPORTING CHANGES

A. Within thirty-five (35) calendar days, Provider shall update the provider portal of the Department's Medicaid Management Information System (MMIS) with any Change of Information or Change in Ownership.

B. Failure by the Provider to notify the Department of any Change of Information or Change in Ownership in accordance with ~~this~~ section 8.130.45.A.:

1. May result in the denial, suspension, inactivation, or termination of the Provider agreement or contract.

~~—~~Does not exempt a Medical Assistance Program ~~Medicaid~~ Provider from compliance with 10 CCR 2505-3 and 10 CCR 2505-10.

2.

~~8.130.~~

~~Existing contracts shall be terminated if the provider fails to disclose requested information or if any person who has an ownership or control interest in the entity, or who is an agent or managing employee of the entity, has been convicted of a criminal offense related to that person's involvement in any program established under Medicare, Medicaid, or the Title XX services program. Person with an Ownership or Control Interest means a person, corporation, partnership, joint venture or other legal entity that:~~
~~A. Has an ownership interest equal to five percent or more in a Disclosing Entity, or~~
~~B. Has an indirect ownership interest equal to five percent or more in a Disclosing Entity, or~~
~~C. Has a combination of direct and indirect ownership interests equal to five percent or more in a Disclosing Entity, or~~
~~D. Owns an interest of five percent or more in any mortgage, deed of trust, note, or other obligation secured by the Disclosing Entity if that interest equals at least five percent of the value of the property or assets of the Disclosing Entity, or~~
~~E. Is an officer or director of a Disclosing Entity that is organized as a corporation, or~~
~~F. Is a partner in a Disclosing Entity that is organized as a partnership.~~
~~Convicted means that a federal, state, or local court, regardless of whether an appeal from that judgment is pending, has entered a judgment of conviction.~~

8.130.50 REQUIREMENT TO VERIFY ENROLLMENT OF MEMBER AT TIME OF SERVICE

A. A Provider shall verify and document that the member is enrolled in the applicable ~~Medical Assistance program~~Medical Assistance Program at the time the service is rendered.

B. A Provider shall verify that payments received are for medically necessary goods and services that were actually rendered, and that claims and encounters submitted for payment are true and correct.

8.130.60 PROVIDERS ARE RESPONSIBLE FOR ALL CLAIMS SUBMITTED

A. A Provider shall accept full legal responsibility for all claims submitted under the Provider's ~~Medical Assistance program~~Medical Assistance Program ID number to the ~~Medical Assistance program~~Medical Assistance Program, whether submitted by the Provider or submitted on the Provider's behalf.

1. A Provider shall comply with all federal and state civil and criminal statutes, regulations, and rules relating to the delivery of ~~benefits~~goods and services to eligible individuals, and to the submission of claims for such ~~benefits~~goods and services. A Provider's non-compliance may result in no payment for goods and services rendered.

B. A Provider shall furnish to the Department its National Provider Identifier (NPI) (if eligible for an NPI) and include the NPI on all claims submitted pursuant to Sections 8.125.8 and 8.126.3.

C. A Provider shall request payment only for those goods and services which are medically necessary, as such term is defined in Section 8.076.1.8. and in any other subsection of these rules defining medical necessity, and which are rendered personally by the Provider or rendered by qualified personnel under the Provider's direct and personal supervision.

1. A Provider shall submit claims only for those ~~benefits~~goods and services provided by health care personnel who meet the professional qualifications established by the State.

2. Any misrepresentation or falsification of a claim submitted by a Provider, or on a Provider's behalf, may subject the Provider to fines and/or imprisonment under state or federal law.

D. If at any time the Department determines that a Provider has failed to maintain compliance with any state or federal laws, rules, or regulations, the Provider may be suspended from participation in the ~~Medical Assistance program~~Medical Assistance Program, and may be subject to administrative actions authorized by federal or state law or regulation, criminal investigation, and/or prosecution.

8.130.70 COMPLIANCE WITH GUIDANCE

A. Providers must comply with all state and~~or~~ federal statutes, rules, regulations, and guidance.

B. Guidance includes, but is not limited to:

1. Department Billing Manual

2. Department Provider Bulletins

3. Department Memo Series

4. Uniform Service Coding Standards

5. Current Procedural Terminology (CPT) code set

6. Current Healthcare Common Procedure Coding System (HCPCS)

7. Current International Classification of Diseases (ICD)~~, Tenth Revision (ICD-10)~~

C. Failure to comply may subject the Provider to authorized administrative actions, civil investigation, and criminal investigation.

8.130.80 INACTIVATING PROVIDER AGREEMENTS

A. A Provider may have its Provider Participation Agreement inactivated and will no longer be able to bill for goods and services if any of the following occur:

1. The Provider's license, certification, or accreditation has expired or is subject to conditions or restrictions.

2. The Provider has failed to complete Provider revalidation.

3. The Provider is no longer eligible to participate as a Medical Assistance Program~~Medicaid~~ Provider or breaches the Provider agreement.

4. There is a Change of Ownership.

5. The Provider's business closes, or the business is nonoperational.

6. The Provider is deceased or retired.

7. The Provider is inactive and has not submitted any claims activity for 24 months.

B. The Provider will be sent written notice thirty (30) days prior to the inactivation, unless ~~be sent~~ otherwise required by federal or state statute, regulation, or rule.

1. The notice will detail the reason for the inactivation.

2. The notice will give the Provider the opportunity to dispute the inactivation.

C. If the Provider elects to dispute the inactivation, the Department must receive the Provider's written request to dispute the inactivation within thirty (30) calendar days of the date of the inactivation notice.

D. The Department will review the request and issue a determination on the inactivation which will include the Provider's right to file an appeal in accordance with Section 8.050.

E. The effective date of the inactivation may be backdated to the date of the occurrence described in Section 8.130.80.A.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Home and Community Based Services Final Settings Rule, Section 8.484
Rule Number: MSB 21-02-09-A
Division / Contact / Phone: COB Section / 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 21-02-09-A, Revision to the Medical Assistance Rule concerning the Home and Community Based Services Final Settings Rule, Section 8.484

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) OP Pages, 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 beginning at 8.484 through the end of 8.484.5.H. This rule is effective January 10, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Home and Community Based Services Final Settings Rule, Section 8.484
Rule Number: MSB 21-02-09-A
Division / Contact / Phone: COB Section / 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).
   In 2014, the federal Centers for Medicare & Medicaid Services (CMS) published a rule requiring Home- and Community-Based Services (HCBS) to be provided in settings that meet certain criteria. The criteria ensure that HCBS participants have access to the benefits of community living and live and receive services in integrated, non-institutional settings. These rules codify in regulation the federal requirements for all HCBS Waivers.

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:

   § 441.301(C)(4))

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

Initial Review **10/08/21** Final Adoption **11/12/21**
Proposed Effective Date **01/10/22** Emergency Adoption

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning the Home and Community Based Services Final Settings Rule, Section 8.484
Rule Number: MSB 21-02-09-A
Division / Contact / Phone: COB Section / 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.

   The proposed regulations will impact all HCBS members, approximately 55,000 individuals. All providers who accept Medicaid funding are required to comply with these rules. Member's will greatly benefit from the implementation of these rules by ensuring everyone gets the most out of community living, all services are provided in integrated settings, and the provision of services are person-centered. There may be costs incurred by providers in order to come into compliance with these regulations. For example, a provider may need to invest in locks for bedroom doors. The Department has engaged stakeholders throughout the process to understand the potential costs incurred from the implementation 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.

   The codification of the federal Final Settings Rule will have a significant, positive impact for our members. As noted, these regulations ensure services are delivered in an integrated, person-centered manner. A members' rights are outlined and protected within these regulations. If a right needs to be modified for some reason, informed consent must be given by the member or the guardian. These rules will ensure all providers follow these requirements and allows the oversight agency to survey on these requirements.

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 has partnered with the Department of Public Health and Environment on this project. There are no additional costs to CDPHE from these regulations. The work to conduct the surveys has already been incorporated into their existing workload.

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

The Department must implement these regulations otherwise we will be out of compliance with the federal regulations. By being out of compliance, there is a risk of losing the federal match on all HCBS services.

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

   There are no other methods to achieve our purpose. These regulations must be promulgated in order to remain in compliance with federal regulations.

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

   No alternative methods were considered.

8.483 ADULT FOSTER CARE - REPEALED

[Repealed effective April 2, 2007]

8.484 HOME- AND COMMUNITY-BASED SERVICES SETTINGS FINAL RULE~~HOME CARE ALLOWANCE - REPEALED~~

~~[Repealed effective April 2, 2007]~~

8.484.1 STATEMENT OF PURPOSE, SCOPE, AND ENFORCEMENT

8.484.1.A The purpose of this Section 8.484 is to implement the requirements of the federal Home- and Community-Based Services (HCBS) Settings Final Rule, 79 Fed. Reg. 2947 (2014), codified at 42 C.F.R. § 441.301(c)(4). These rules identify individual rights that are protected at settings where people live or receive HCBS. They also set out a process for modifying these rights as warranted in individual cases. These rules apply to all HCBS under all authorities, except where otherwise noted.

8.48~~4~~1.1.B This Section 8.484 is enforced pursuant to existing procedures, subject to the following transition period exceptions:

1. The following settings were presumed compliant during the transition period and remain covered by this presumption until March 17, 2023:

   a. Residential settings owned or leased by individuals receiving HCBS or their families (personal homes);

   b. Professional provider offices and clinics;

   c. Settings where children receive Community Connector services under the Children's Extensive Supports (CES) Waiver; and

   d. Settings where people receive individual Supported Employment services.

2. Any setting for which a Provider Transition Plan (PTP) has been submitted by December 30, 2021 may continue to transition toward compliance according to the schedule set forth in the PTP. This exception is to be narrowly construed and does not apply to other situations, such as, by way of illustration only, non-compliance:

   a. At case management agencies;

   b. At a setting for which a PTP was not submitted by December 30, 2021 for any reason;

   c. At a setting after the applicable deadline in the setting's PTP, with the deadline being (i) three months after the PTP was submitted unless adjusted with departmental approval and (ii) in no event after March 17, 2023; or

   d. Involving compliance issues that have been verified as resolved through the PTP process and therefore no longer subject to transition.

8.484.2 DEFINITIONS

8.484.2.A Age Appropriate Activities and Materials means activities and materials that foster social, intellectual, communicative, and emotional development and that challenge the individual to use their skills in these areas while considering their chronological age, developmental level, and physical skills.

8.484.2.B Covered HCBS means any Home- and Community-Based Service(s) provided under the Colorado State Medicaid Plan, a Colorado Medicaid waiver program, or a State-funded program administered by the Department. This category excludes Respite Services, Palliative/Supportive Care services provided outside the child's home under the Children with Life-Limiting Illness Waiver, and Youth Day Services under the CES Waiver.

8.484.2.C HCBS Setting means any physical location where Covered HCBS are provided.

1. HCBS Settings include, but are not limited to, Provider-Owned or -Controlled Non-residential Settings, Other Non-residential Settings, Provider-Owned or -Controlled Residential Settings, and Other Residential Settings.

2. If Covered HCBS are provided at a physical location to one or more individuals, the setting is considered an HCBS Setting, regardless of whether some individuals at the setting do not receive Covered HCBS. The requirements of this Section 8.484 apply to the setting as a whole and protect the rights of all individuals receiving services at the setting regardless of payer source.

8.484.2.D Informed Consent means the informed, freely given, written agreement of the individual (or, if authorized, their guardian or other legally authorized representative) to a Rights Modification. The case manager ensures that the agreement is informed, freely given, and in writing by confirming that the individual (or, if authorized, their guardian or other legally authorized representative) understands all of the information required to be documented in Section 8.484.5 and has signed the Department-prescribed form to that effect.

8.484.2.E Intensive Supervision means one-on-one (1:1), line-of-sight, or 24-hour supervision. Intensive Supervision is a Rights Modification if the individual verbally or non-verbally expresses that they do not want the supervision or if the supervision would be covered by the Department's processes for rights suspensions or restrictive procedures pursuant to the version of Sections 8.600.4, 8.604.3, and 8.608.1-2 in effect on December 30, 2021.

8.484.2.F Other Non-residential Setting means a physical location that is non-residential and that is not owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing non-residential services.

1. Other Non-residential Settings include, but are not limited to, locations in the community where Covered HCBS are provided.

8.484.2.G Other Residential Setting means a physical location that is residential and that is not owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing residential services.

1. Other Residential Settings include, but are not limited to, Residential Settings owned or leased by individuals receiving HCBS~~,~~ or their families (personal homes) and those owned or leased by relatives paid to provide HCBS unless such relatives are independent contractors of HCBS providers.

8.484.2.H Person-Centered Support Plan means a service and support plan that is directed by the individual whenever possible, with the individual's representative acting in a participatory role~~,~~ as needed, is prepared by the case manager under Sections 8.393.2.E or 8.519.11, identifies the supports needed for the individual to achieve personally identified goals, and is based on respecting and valuing individual preferences, strengths, and contributions.

8.484.2.I Plain Language means language that is understandable to the individual and in their native language, and it may include pictorial methods, if warranted;

8.484.2.J Provider-Owned or -Controlled Non-residential Setting means a physical location that is non-residential and that is owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing non-residential services.

1. Provider-Owned or -Controlled Non-residential Settings include, but are not limited to, provider-owned facilities where Adult Day, Day Treatment, Specialized Habilitation, Supported Community Connections, Prevocational Services, and Supported Employment Services are provided.

8.484.2.K Provider-Owned or -Controlled Residential Setting means a physical location that is residential and that is owned, leased, operated, or managed by an HCBS provider or by an independent contractor providing residential services.

1. Provider-Owned or -Controlled Residential Settings include, but are not limited to, Alternative Care Facilities (ACFs); Supported Living Program (SLP) and Transitional Living Program (TLP) facilities; group homes for adults with intellectual or developmental disabilities (IDD); Host Homes for adults with IDD; any Individual Residential Services and Supports (IRSS) setting that is owned or leased by a service provider or independent contractor of such a provider; and foster care homes, Host Homes, group homes, residential child care facilities, and Qualified Residential Treatment Programs (QRTPs) in which Children's Habilitation Residential Program (CHRP) services are provided.

8.484.2.L Restraint means any manual method or direct bodily contact or force, physical or mechanical device, material, or equipment that restricts normal functioning or movement of all or any portion of a person's body, or any drug, medication, or other chemical that restricts a person's behavior or restricts normal functioning or movement of all or any portion of their body. Physical or hand-over-hand assistance is a Restraint if the individual verbally or non-verbally expresses that they do not want the assistance or if the assistance is a safety or emergency control procedure or would be covered by the Department's processes for rights suspensions or restrictive procedures pursuant to the version of Sections 8.600.4, 8.604.3, and 8.608.1-2 in effect on December 30, 2021.

8.484.2.M Restrictive or Controlled Egress Measures means devices, technologies, or approaches that have the effect of restricting or controlling egress or monitoring the coming and going of individuals. The following measures are deemed to have such an effect and are Restrictive or Controlled Egress Measures: locks preventing egress; audio monitors, chimes, motion-activated bells, silent or auditory alarms, and alerts on entrances/exits at residential settings; and wearable devices that indicate to anyone other than the wearer their location or their presence/absence within a building. Other measures that have the effect of restricting or controlling egress or monitoring the coming and going of individuals are also Restrictive or Controlled Egress Measures.

8.484.2.N Rights Modification means any situation in which an individual is limited in the full exercise of their rights.

1. Rights Modifications include, but are not limited to:

a. the use of Intensive Supervision if deemed a Rights Modification under the definition in Section 8.484.2.E above;

b. the use of Restraints;

c. the use of Restrictive or Controlled Egress Measures;

d. modifications to the other rights in Section 8.484.3 (basic criteria applicable to all HCBS Settings) and Section 8.484.4 (additional criteria for HCBS Settings);

e. any provider actions to implement a court order limiting any of the foregoing individual rights;

f. rights suspensions under Section 25.5-10-218(3), C.R.S.; and

g. all situations formerly covered by the Department's processes for rights suspensions or restrictive procedures pursuant to the version of Sections 8.600.4, 8.604.3, and 8.608.1-2 in effect on December 30, 2021.

2. Modifications to the rights to dignity and respect, the rights in Sections 8.484.3.A.6-11 (covering such matters as person-centeredness; civil rights; freedom from abuse; and Plain-Language explanations of rights, dispute resolution policies, and grievance/complaint procedures), and the right to physical accessibility are not permitted.

3. For children under age 18, a limitation or restriction to any of the rights in Sections 8.484.3 and 8.484.4 that is typical for children of that age, including children not receiving HCBS, is not a Rights Modification. Consider age-appropriate behavior when assessing what is typical for children of that age. If the child is not able to fully exercise the right because of their age, then there is no need to pursue the Rights Modification process under Section 8.484.5. However, if the proposed limitation or restriction is above and beyond what a typically developing peer would require, then it must be handled as a Rights Modification under Section 8.484.5.

8.484.3 BASIC CRITERIA APPLICABLE TO ALL HCBS SETTINGS

8.484.3.A All HCBS Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as indicated in their Person-Centered Support Plan, subject to the Rights Modification process in Section 8.484.5:

1. The setting is integrated in and supports full access of individuals to the greater community, including opportunities to seek employment and work in competitive integrated settings, control personal resources, receive services in the community, and engage in community life, including with individuals who are not paid staff/contractors and do not have disabilities, to the same degree of access as individuals not receiving HCBS.

a. Individuals are not required to leave the setting or engage in community activities. Individuals must be offered and have the opportunity to select from Age Appropriate Activities and Materials both within and outside of the setting.

b. Integration and engagement in community life includes supporting individuals in accessing public transportation and other available transportation resources.

c. Individuals receiving HCBS are not singled out from other community members through requirements of individual identifiers, signage, or other means.

d. Individuals may communicate privately with anyone of their choosing.

e. Methods of communication are not limited by the provider.

i. The setting must always provide access to shared telephones if it is a Provider-Owned or -Controlled Residential Setting and during business hours if it is a Provider-Owned or -Controlled Non-residential Setting.

ii. Individuals are allowed to maintain and use their own cell phones, tablets, computers, and other personal communications devices, at their own expense.

iii. Individuals are allowed to access telephone, cable, and Ethernet jacks, as well as wireless networks, in their rooms/units, at their own expense.

f. Individuals have control over their personal resources. If an individual is not able to control their resources, an assessment of their skills must be completed and documented in their Person-Centered Support Plan. The assessment and Person-Centered Support Plan must identify what individualized assistance the provider or other person will provide and any training for the individual to become more independent, based on the outcome of the assessment.

i. Providers may not insist on controlling an individual's funds as a condition of providing services and may not require individuals to sign over their Social Security checks or paychecks.

ii. A provider may control an individual's funds if the individual so desires, or if it has been designated as their representative payee under the Social Security Administration's (SSA's) policies. If a provider holds or manages an individual's funds, their signed Person-Centered Support Plan must:

a) Document the request or representative payee designation;

b) Document the reasons for the request or designation; and

c) Include the parties' agreement on the scope of managing the funds, how the provider should handle the funds, and what they define as "reasonable amounts" under Section 25.5-10-227, C.R.S.

iii. The provider must ensure that the individual can access and spend money at any time, including on weekends, holidays, and evenings, including with assistance or supervision if necessary.

2. The setting is selected by the individual from among setting options, including non-disability specific settings and an option for a private unit in a residential setting. The setting options are identified and documented in the Person-Centered Support Plan and

are based on the individual's needs, preferences, and, for residential settings, resources available for room and board.

3. The setting ensures an individual's rights of privacy, dignity, and respect, and freedom from coercion and restraint.

   a. The right of privacy includes the right to be free of cameras, audio monitors, and devices that chime or otherwise alert others, including silently, when a person stands up or passes through a doorway.

      i. The use of cameras, audio monitors, chimes, and alerts in (a) interior areas of residential settings, including common areas as well as bathrooms and bedrooms, and in (b) typically private areas of non-residential settings, including bathrooms and changing rooms, is acceptable only under the standards for modifying rights on an individualized basis pursuant to Section 8.484.5.

      ii. If an individualized assessment indicates that the use of a camera, audio monitor, chime, or alert in the areas identified in the preceding paragraph is necessary for an individual, this modification must be reflected in their Person-Centered Support Plan. The Person-Centered Support Plans of other individuals at that setting must reflect that they have been informed in Plain Language of the camera(s)/monitor(s)/chime(s)/alert(s) and any methods in place to mitigate the impact on their privacy. The provider must ensure that only appropriate staff/contractors have access to the camera(s)/monitor(s)/chime(s)/alert(s) and any recordings and files they generate, and it must have a method for secure disposal or destruction of any recordings and files after a reasonable period.

      iii. Cameras, audio monitors, chimes, and alerts on staff-only desks and exterior areas, cameras on the exterior sides of entrances/exits, and cameras typically found in integrated employment settings, generally do not raise privacy concerns, so long as their use is similar to that practiced at non-HCBS Settings. In provider-owned or -controlled settings, notice must be provided to all individuals that they may be on camera and specify where the cameras are located. If such devices have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to the Rights Modification requirements of Section 8.484.5.

      iv. Audio monitors, chimes, motion-activated bells, silent or auditory alarms, and alerts on entrances/exits at residential settings have the effect of restricting or controlling egress and are subject to the Rights Modification requirements of Section 8.484.5. If such devices on entrances/exits at non-residential settings have the effect of restricting or controlling egress or monitoring the coming and going of individuals, they are subject to the Rights Modification requirements of Section 8.484.5.

   b. The right of privacy includes the right not to have one's name or other confidential items of information posted in common areas of the setting.

4. The setting fosters individual initiative and autonomy, and the individual is afforded the opportunity to make independent life choices. This includes, but is not limited to, daily activities, physical environment, and with whom to interact.

5. The setting facilitates individual choice regarding services and supports, and who provides them.

6. The Person-Centered Support Plan drives the services afforded to the individual, and the setting staff/contractors are trained on this concept and person-centered practices, as well as the concept of dignity of risk.

7. Each individual is afforded the opportunity to:

   a. Lead the development of, and grant Informed Consent to, any provider-specific treatment, care, or support plan;

   b. Have freedom of religion and the ability to participate in religious or spiritual activities, ceremonies, and communities;

   c. Live and receive services in a clean, safe environment;

   d. Be free to express their opinions and have those included when any decisions are being made affecting their life;

   e. Be free from physical abuse and inhumane treatment;

   f. Be protected from all forms of sexual exploitation;

   g. Access necessary medical care which is adequate and appropriate to their condition;

   h. Exercise personal choice in areas including personal style;

   i. Receive the same consideration and treatment as anyone else regardless of race, color, ethnic or national origin, ancestry, age, sex, gender, sexual orientation, gender identity and expression, religion, creed, political beliefs, or disability; and

   j. Accept or decline services and supports of their own free will and on the basis of informed choice.

8. Nothing in this rule shall be construed to prohibit necessary assistance as appropriate to those individuals who may require such assistance to exercise their rights.

9. Nothing in this rule shall be construed to interfere with the ability of a guardian or other legally authorized representative to make decisions within the scope of their guardianship order or other authorizing document.

10. Providers shall supply all individuals at the setting with a Plain Language explanation of their rights under this Section 8.484.

11. Providers shall supply all individuals at the setting with a Plain Language explanation of available dispute resolution and grievance/complaint procedures, along with outside agency contact information, including phone numbers, for assistance. Providers must allow grievances/complaints to be submitted anonymously and at any time (not subject to a deadline).

8.484.4 ADDITIONAL CRITERIA FOR HCBS SETTINGS

8.484.4.A Provider-Owned or -Controlled Residential Settings must have all of the following qualities and protect all of the following individual rights, based on the needs of the individual as indicated in their Person-Centered Support Plan, subject to the Rights Modification process in Section 8.484.5:

1. The unit or dwelling is a specific physical place that can be owned, rented, or occupied under a legally enforceable agreement by the individual, and the individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of the State, county, city, or other designated entity. For settings in which landlord/tenant laws do not apply, a lease, residency agreement, or other form of written agreement must be in place for each individual, and the document must provide protections that address eviction processes and appeals comparable to those provided under the jurisdiction's landlord/tenant law.

    a. The lease, residency agreement, or other written agreement must:

        i. Provide substantially the same terms for all individuals;

        ii. Be in Plain Language, or if the provider/its independent contractor cannot adjust the language, at least be explained to the individual in Plain Language;

        iii. Provide the same responsibilities and protections from eviction that tenants have under the landlord/tenant law of their State, county, city, or other designated entity (or comparable responsibilities and protections, as the case may be), and indicate the authorities that govern these responsibilities, protections, and related disputes;

        iv. Specify that the individual will occupy a particular room or unit;

        v. Explain the conditions under which people may be asked to move or leave;

        vi. Provide a process for individuals to dispute/appeal and seek review by a neutral decisionmaker of any notice that they must move or leave, or tell individuals where they can easily find an explanation of such a process, and state this information in any notice to move or leave;

        vii. Specify the duration of the agreement;

        viii. Specify rent or room-and-board charges;

        ix. Specify expectations for maintenance;

        x. Specify that staff/contractors will not enter a unit without providing advance notice and agreeing upon a time with the individual(s) in the unit;

        xi. Specify refund policies in the event of a resident's absence, hospitalization, voluntary or involuntary move to another setting, or death; and

xii. Be signed by all parties, including the individual or, if within the scope of their authority, their guardian or other legally authorized representative.

b. The lease, residency agreement, or other written agreement may:

i. Include generally applicable limits on furnishing/decorating of the kind that typical landlords might impose; and

ii. Provide for a security deposit or other provisions outlining how property damage will be addressed.

c. The lease, residency agreement, or other written agreement may not modify the individual rights protected under Sections 8.484.3 and 8.484.4, such as (a) by imposing individualized terms that modify these conditions or (b) by requiring individuals to comply with house rules or resident handbooks that modify everyone's rights.

d. Providers and their independent contractors must engage in documented efforts to resolve problems and meet residents' care needs before seeking to move individuals or asking them to leave. Providers and their independent contractors must have a substantial reason for seeking any move/eviction (e.g., protection of someone's health/safety), and minor personal conflicts do not meet this threshold.

e. A violation of a lease or residency agreement, a change in the resident's medical condition, or any other development that leads to a notice to leave must include at least 30 days' notice to the individual (or, if authorized, their guardian or other legally authorized representative).

f. If an individual has not moved out after the end of a 30-day (or longer) notice period, the provider/its independent contractor may not act on its own to evict the individual until the individual has had the opportunity to pursue and complete any applicable grievance, complaint, dispute resolution, and/or court processes, including obtaining a final decision on any appeal, request for reconsideration, or further review that may be available.

g. A provider/its independent contractor may not require an individual who has nowhere else to live to leave the setting.

h. This Section 1 does not apply to children under age 18.

2. Individuals have the right to dignity and privacy, including in their living/sleeping units. This right to privacy includes the following criteria:

a. Individuals must have a key or key code to their home, a bedroom door with a lock and key, lockable bathroom doors, privacy in changing areas, and a lockable place for belongings, with only appropriate staff/contractors having keys to such doors and storage areas. Staff/contractors must knock and obtain permission before entering individual units, bedrooms, bathrooms, and changing areas. Staff/contractors may use keys to enter these areas and to open private storage spaces only under limited circumstances agreed upon with the individual.

b. Individuals shall have choice in a roommate/housemate. Providers must have a process in place to document expectations and outline the process to accommodate choice.

c. Individuals 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 and, for individuals age 18 and older, complying with the applicable lease, residency agreement, or other written agreement.

3. The Residential Setting does not have institutional features not found in a typical home, such as staff uniforms; entryways containing numerous staff postings or messages; or labels on drawers, cupboards, or bedrooms for staff convenience.

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

5. Individuals have access to food at all times, choose when and what to eat, have input in menu planning (if the setting provides food), have access to food preparation and storage areas, can store and eat food in their room/unit, and have access to a dining area for meals/snacks with comfortable seating where they can choose their own seat, choose their company (or lack thereof), and choose to converse (or not);

6. Individuals are able to have visitors of their choosing at any time and are able to socialize with whomever they choose (including romantic relationships);

7. The setting is physically accessible to the individual, and the individual has unrestricted access to all common areas, including areas such as the bathroom, kitchen, dining area, and comfortable seating in shared areas. If the individual wishes to do laundry and their home has laundry machines, the individual has physical access to those machines; and

8. Individuals are able to smoke and vape nicotine products in a safe, designated outdoor area, unless prohibited by the restrictions on smoking near entryways set forth in the Colorado Clean Indoor Air Act, Section 25-14-204(1)(ff), C.R.S., or any law of the county, city, or other local government entity.

8.484.4.B Other Residential Settings in which one or more individuals receiving 24-hour residential services and supports reside must have all of the qualities of and protect all of the same individual rights as Provider-Owned or -Controlled Residential Settings, as listed above, other than Section 8.484.4.A relating to a lease or other written agreement providing protections against eviction, subject to the Rights Modification process in Section 8.484.5.

8.484.4.C Other Residential Settings in which no individuals receiving 24-hour residential services and supports reside are excluded from this Section 8.484.4.

1. This group of settings includes, but is not limited to, homes in which no individual receives IRSS and one or more individuals receive Consumer-Directed Attendant Support Services (CDASS), Health Maintenance Services, Homemaker Services, In-Home Support Services (IHSS), and/or Personal Care Services.

8.484.4.D Provider-Owned or -Controlled Non-residential Settings must have all of the qualities of and protect all of the same individual rights as Provider-Owned or -Controlled Residential Settings, as listed above, other than Section 8.484.4.A relating to a lease or other written agreement providing protections against eviction and Section 8.484.4.B relating to privacy in one's living/sleeping unit, subject to the Rights Modification process in Section 8.484.5.

1. Provider-Owned or -Controlled Non-residential Settings must afford individuals privacy in bathrooms and changing areas and a lockable place for belongings, with only the individuals and appropriate staff/contractors having keys to such doors and storage areas.

2. This Section 8.484.4 does not require Non-residential Settings to provide food if they are not already required to do so under other authorities. This Section 8.484.4 does require Non-residential Settings to ensure that individuals have access to their own food at any time.

8.484.4.E Other Non-residential Settings must have all of the qualities of and protect the same individual rights as Provider-Owned or -Controlled Non-residential Settings, as stated immediately above, to the same extent for HCBS participants as they do for other individuals, subject to the Rights Modification process in Section 8.484.5.

8.484.5 RIGHTS MODIFICATIONS

8.484.5.A Any modification of an individual's rights must be supported by a specific assessed need and justified in the Person-Centered Support Plan, pursuant to the process set out in Sections 8.484.5.C and 8.484.5.D below. Rights Modifications may not be imposed across-the-board and may not be based on the convenience of the provider. The provider must ensure that a Rights Modification does not infringe on the rights of individuals not subject to the modification. Wherever possible, Rights Modifications should be avoided or minimized, consistent with the concept of dignity of risk.

8.484.5.B The process set out in Sections 8.484.5.C-D below applies to all Rights Modifications.

8.484.5.C For a Rights Modification to be implemented, the following information must be documented in the individual's Person-Centered Support Plan, and any provider implementing the Rights Modification must maintain a copy of the documentation:

1. The right to be modified.

2. The specific and individualized assessed need for the Rights Modification.

3. The positive interventions and supports used prior to any Rights Modification, as well as the plan going forward for the provider to support the individual in learning skills so that the modification becomes unnecessary.

4. The less intrusive methods of meeting the need that were tried but did not work.

5. A clear description of the Rights Modification that is directly proportionate to the specific assessed need.

6. A plan for regular collection of data to measure the ongoing effectiveness of and need for the Rights Modification, including specification of the positive behaviors and objective results that the individual can achieve to demonstrate that the Rights Modification is no longer needed.

7. An established timeline for periodic reviews of the data collected under the preceding paragraph. The Rights Modification must be reviewed and revised upon reassessment of functional need at least every 12 months, and sooner if the individual's circumstances or needs change significantly, the individual requests a review/revision, or another authority requires a review/revision.

8. The Informed Consent of the individual (or, if authorized, their guardian or other legally authorized representative) agreeing to the Rights Modification.

9. An assurance that interventions and supports will cause no harm to the individual, including documentation of the implications of the modification for the individual's everyday life and the ways the modification is paired with additional supports to prevent harm or discomfort and to mitigate any undesired effects of the modification.

10. Alternatives to consenting to the Rights Modification, along with their most significant likely consequences.

11. An assurance that the individual will not be subject to retaliation or prejudice in their receipt of appropriate services and supports for declining to consent or withdrawing their consent to the Rights Modification.

8.484.5.D Additional Rights Modification process requirements:

1. Prior to obtaining Informed Consent, the case manager must offer the individual the opportunity to have an advocate, who is identified and selected by the individual, present at the time that Informed Consent is obtained. The case manager must offer to assist the individual, if desired, in identifying an independent advocate who is not involved with providing services or supports to the individual. These offers and the individual's response must be documented by the case manager.

2. Any providers that desire or expect to be involved in implementing a Rights Modification may supply to the case manager information required to be documented under this Section 8.484.5, except for documentation of Informed Consent and the offers and response relating to an advocate, which may be obtained and documented only by the case manager. The individual determines whether any information supplied by the provider is satisfactory before the case manager enters it into their Person-Centered Support Plan.

8.484.5.E Use of Restraints

1. If Restraints are used with an individual at an HCBS Setting, their use must:

a. Be based on an assessed need after all less restrictive interventions have been exhausted;

b. Be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights protected under Section 8.484.3, consistent with the Rights Modification process in this Section 8.484.5; and

c. Be compliant with any applicable waiver.

2. Prone Restraints are prohibited in all circumstances. Nothing in this Section E permits the use of any Restraint that is precluded by other authorities.

8.484.5.F If Restrictive or Controlled Egress Measures are used at an HCBS Setting, they must:

1. Be implemented on an individualized (not setting-wide) basis;

2. Make accommodations for individuals in the same setting who are not at risk of unsafe wandering or exit-seeking behaviors;

3. Be documented in the individual's Person-Centered Support Plan as a modification of the generally applicable rights protected under Section 8.484.3, consistent with the Rights Modification process in this Section 8.484.5, with the documentation including:

   a. An assessment of the individual's unsafe wandering or exit-seeking behaviors (and the underlying conditions, diseases, or disorders relating to such behaviors) and the need for safety measures;

   b. Options that were explored before any modifications occurred to the Person-Centered Support Plan;

   c. The individual's understanding of the setting's safety features, including any Restrictive or Controlled Egress Measures;

   d. The individual's choices regarding measures to prevent unsafe wandering or exit-seeking;

   e. The individual's (or, if authorized, their guardian's or other legally authorized representative's) consent to restrictive- or controlled-egress goals for care;

   f. The individual's preferences for engagement within the setting's community and within the broader community; and

   g. The opportunities, services, supports, and environmental design that will enable the individual to participate in desired activities and support their mobility; and

4. Not be developed or used for non-person-centered purposes, such as punishment or staff/contractor convenience.

8.484.5.G If there is a serious risk to anyone's health or safety, a Rights Modification may be implemented or continued for a short time without meeting all the requirements of this Section 8.484.5, so long as the provider immediately (a) implements staffing and other measures to deescalate the situation and (b) reaches out to the case manager to set up a meeting as soon as possible, and in no event past the end of the third business day following the date on which the risk arises. At the meeting, the individual can grant or deny their Informed Consent to the Rights Modification. The Rights Modification may not be continued past the conclusion of this meeting or the end of the third business day, whichever comes first, unless all the requirements of this Section 8.484.5 have been met.

8.484.5.H When a provider proposes a Rights Modification and supplies to the case manager all of the information required to be documented under this Section 8.484.5, except for documentation that may be obtained only by the case manager, the case manager shall arrange for a meeting with the individual to discuss the proposal and facilitate the individual's decision regarding whether to grant or deny their Informed Consent. Except when the timeline in Section 8.484.5.G applies, the case manager shall arrange for this meeting to occur by the end of the tenth business day following the date on which they received from the provider of all the required information. The individual may elect to make a final decision during or after this meeting. If the individual does not inform their case manager of their decision by the end of the fifth business day following the date of the meeting, they are deemed not to have consented.

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

8.485.10 LEGAL BASIS

The Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-EBD program is also authorized under state law at C.R.S. section 25.5-6-301 et seq. – as amended.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Non-Medical Transportation, Sections 8.494 and 8.611
Rule Number: MSB 21-08-10-C
Division / Contact / Phone: Benefits and Services Management/ Cassandra Keller/ 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 21-08-10-C, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Non-Medical Transportation, Sections 8.494 and 8.611

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): 8.494 and 8.611

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 8.494 with the proposed text beginning at 8.494 through the end of 8.494.50.56. Replace the current text at 8.611 with the proposed text beginning at 8.611 through the end of 8.611.C.6. This rule is effective January 10,2022.

*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 Non-Medical Transportation, Sections 8.494 and 8.611
Rule Number: MSB 21-08-10-C
Division / Contact / Phone: Benefits and Services Management/ Cassandra Keller/ 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 purpose of these revisions is to modify the requirements for our Home and Community Based Services (HCBS) transportation providers. Effective July 1, 2021, House Bill 21-1206 transferred the responsibility of safety and oversight for Non-Medical Transportation (NMT) and Non-Emergent Medical Transportation (NEMT) from the Public Utilities Commission (PUC) to the Department, with the exception of taxi providers. These regulations remove the requirement that providers obtain a Medicaid Client Transport (MCT) permit through the PUC and outline the new provider agency, vehicle and driver requirements developed with the assistance of stakeholders.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021); Sections 25.5-6 and Sections 25.5-10 C.R.S. and 25.5.-1-802 C.R.S.

Initial Review **10/08/21** Final Adoption **11/12/21**
Proposed Effective Date **01/10/22** Emergency Adoption

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Non-Medical Transportation, Sections 8.494 and 8.611
Rule Number: MSB 21-08-10-C
Division / Contact / Phone: Benefits and Services Management/ Cassandra Keller/ 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.

   The revisions to these regulations will positively impact both members and providers. Members impacted include those served under the Elderly Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Spinal Cord Injury (SCI), and Brain Injury (BI), Supported Living Services (SLS), and Developmental Disabilities (DD) waivers. Previously, when oversight was through the Public Utilities Commission (PUC), providers had to comply with very onerous regulations and purchase vehicle stamps for each vehicle used. This was very costly for providers who already operate on thin margins. With the proposed regulations, the provider requirements are far more reasonable while maintaining appropriate oversight for member safety; they are not so arduous that providers feel forced to no longer provide services. By maintaining a robust provider network, members will have the ability to access critical services and engage with their community.

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

   These revisions will have a positive impact on members served in all the adult Home and Community Based Services (HCBS) waivers where NMT is a benefit. Members rely on the Non-Medical Transportation (NMT) benefit to attend day program, travel to and from work, and visit their family and friends. Without this critical service and our providers, members access to the community would be cut-off. The new regulations will allow the Department to have the necessary oversight of drivers and vehicles, without creating burdensome requirements that deter providers from providing this service.

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 proposed rule will not have a budgetary impact on the Department. Funds appropriated through House Bill 21-1206 will be used to ensure provider compliance with these regulations.

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

   There would be noted costs by not revising these regulations. The Department is legislatively mandated to implement an oversight process for NMT providers. Without revising these regulations and implementing these oversight requirements, the Department would be out of compliance with the legislation. Moreover, it would pose an issue with the Centers for Medicare and Medicaid Services (CMS). The Department is required to have oversight of providers; if the Department fails to do so, we could be at risk for federal financial participation (FFP).

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 intrusive methods available. Revising these regulations to include the new requirements is the best course of action.

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

   No other alternative methods were considered. In order to ensure compliance with the provider requirements, they must be outlined in regulation to be enforceable.

8.494 NON-MEDICAL TRANSPORTATION

8.494.1 DEFINITIONS

Non-Medical Transportation (NMT) services means transportation which enables eligible ~~clients~~ participants to gain physical access to non-medical community services and supports, as required by the care plan to prevent institutionalization.

Non-Medical Transportation Provider (provider) means a provider agency that has met all ~~of the~~ standards and requirements as specified in ~~subsection~~ Section 8.494.40 of this regulation.

~~Medicaid Client Transport (MCT) Permit means a permit that is issued to a Non-Medical Transportation provider by the Public Utilities Commission (PUC).~~

8.494.20 INCLUSIONS

.21 Non-Medical Transportation services shall include, but not be limited to, transportation between the ~~client's~~ participant's home and non-medical services or supports such as Adult Day Centers, shopping, activities that encourage community integration, therapeutic swimming, counseling sessions not covered by State Plan, and other services as required by the care plan to prevent institutionalization.

8.494.30 EXCLUSIONS

.31 Non-Medical Transportation services shall not be used to substitute for medical transportation, as defined in~~which is subject to reimbursement under 10 CCR 2505-10 s~~Section~~s~~ 8.014.1.~~680 through 8.691~~.

.32 Non-Medical Transportation services shall only be used after the case manager has determined that free transportation is not available to the participant~~client~~.

8.494.40 PROVIDER STANDARDS FOR NON-MEDICAL TRANSPORTATION SERVICES

.41 ~~Transportation p~~Providers shall conform to all general standards and procedures set forth within Department regulations ~~10 CCR 2505-10 s~~Sections 8.494 and 8.487.

.42 Providers must maintain liability insurance with the following automobile liability minimum limits:

A. Bodily injury (BI) $300/$600K per person/per accident; and

B. Property damage $50,000.

C. Drivers that utilize their personal vehicle on behalf of a provider agency to provide NMT must maintain the following minimum automobile insurance limits, in addition to the insurance maintained by the provider agency:

1. Bodily injury (BI) $25/$50K per person/per accident; and

2. Property damage $15,000.

.43 Providers shall ensure that each driver rendering NMT meets the following requirements:

A. Drivers must be 18 years of age or older to render services;

B. Have at least one year of driving experience;

C. Possess a valid Colorado driver's license;

D. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history; and

E. Complete a Colorado or National-based criminal history record check.

.44 Drivers shall be disqualified from serving as drivers for any program participants for any of the following:

A. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;

B. A conviction in the State of Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;

C. A conviction in the State of Colorado, within the seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);

D. A conviction in the State of Colorado, within the four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15 of Title 18, C.R.S.;

E. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D) within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; -§ 6114;

F. A conviction in the State of Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;

G. A conviction in Colorado within the two (2) years preceding the date the criminal history record check is completed of driving under the influence, as defined in § 42-4-1301(1)(f), C.R.S.; driving with excessive alcoholic content, as described in §42-4-1301(1)(g), C.R.S;

H. A conviction within the two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B), 4 C.C.R. 723-6; § 6114 in any other state or in the United States; and

For purposes of 4 C.C.R. 723-6; § 6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sentence.

.454 Vehicles used during the provision of NMT must be safe and in good working order. To ensure the safety and proper functioning of the vehicles, vehicles must pass a vehicle safety inspection prior to it being used to render services.

A. Safety inspections shall include the inspection of items as described in Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; § 6104.

B. Vehicles must be inspected on a schedule commensurate with their age:

1. Vehicles manufactured within the last five (5) years: no inspection.

2. Vehicles manufactured within the last six (6) to ten (10) years: inspected every 24 months.

3. Vehicles manufactured eleven (11) years or longer: inspected annually.

4. Vehicles for wheelchair transportation: inspected annually, regardless of the manufacture date of vehicle.

C. The vehicle inspector must be trained to conduct the inspection and be employed by an automotive repair company authorized to do business in Colorado.

.46 Transportation providers who maintain a certificate or permit through the Public Utilities Commission (PUC) are not required to meet the above requirements. PUC certificate and permit holders shall submit a copy of the certification to the Department for verification of provider credentials.

~~with the following exceptions:~~

~~A. Existing Non-Medical Transportation providers have until January 1st, 2018 to fully comply with section 8.494 regarding the new Medicaid Provider and MCT Permit applications.~~

~~.42 Transportation providers shall ensure that all drivers possess a valid Colorado driver's license, are be free of physical or mental impairment that would adversely affect driving performance, and have not had two or more convictions or chargeable accidents within the past two years.~~

~~.43 Transportation providers shall ensure that all vehicles and related auxiliary equipment shall meet all applicable federal, state, and local safety inspection and maintenance requirements, and transportation providers shall be in compliance with commercial liabilityliability insurance requirements and PUC financial responsibility requirements, as set forth in section 40-10.1-107, C.R.S.~~

~~.44 Provider and Driver Qualifications:~~

~~A. Each Provider must have and maintain a valid MCT Permit from the PUC, as required by section 40-10.1-302, C.R.S.; and~~

~~B. Each Provider must maintain safe and functioning vehicles, free of deficiencies, and in compliance with PUC safety rules as required by 4 C.C.R. 723-6, § 6100-6199; and~~

~~C. Each Provider shall ensure that all drivers, prior to providing NMT services, have been qualified based upon the results of the statutorily required criminal history record check as conducted via the PUC, as outlined in Section 40-10.1-110, C.R.S.~~

8.494.50 LIMITATIONS AND REIMBURSEMENT

.51 Reimbursement for non-medical transportation shall be the lower of billed charges or the prior authorized unit cost at a rate not to exceed the cost of providing medical transportation services.

.52 A provider's submitted charges shall not exceed those normally charged to the general public, other public or private organizations, or non-subsidized rates negotiated with other governmental entities.

.53 Provider charges shall not accrue when the recipient is not physically present in the vehicle.

.54 Providers shall not bill for services before they are an approved Medicaid provider and may bill only for those NMT services performed by a qualified driver utilizing a qualified vehicle~~that has been qualified based upon the results of the statutorily required criminal history record check~~.

.55 Excluding transportation to HCBS Adult Day facilities, a participant~~client~~ may not receive more than the equivalent of two (2) round trip services per week, or 104 round trip services per annual certification period utilizing NMT, unless otherwise authorized by the Department.

.56 A bus pass or other public conveyance may be used only when it is more cost effective than, or comparable to, the applicable service type and duration. Costs cannot exceed the total Wheelchair Van, Mileage Band 1 allowable per service plan. The most current HCBS Rate Schedule can be found on the Department website.

8.611 TRANSPORTATION

~~A~~ A. Definitions

1. Non-Medical Transportation (NMT) services means transportation which enables eligible participants to gain physical access to non-medical community services and supports, as required by the care plan to prevent institutionalization.

2. Non-Medical Transportation Provider (provider) means a provider agency that has met all standards and requirements as specified in Section 8.611.

3. Transportation acquisition services refers to the purchase or provision of transportation for participants receiving day program services under comprehensive services which enables them to gain access to programs and other community services and resources required by their Individualized Plan/Plan of Care. Funding for transportation activities incidental to the Residential Program are included in the Residential rate.

~~Community centered boards and program approved service agencies providing transportation to persons receiving services in vehicles owned and operated by the community centered board or program approved service agency shall develop and implement written policies and procedures which shall be in accordance with Department policies and procedures and which shall include, but not be limited to:~~

~~1. Insurance coverage;~~

~~2. Safety equipment;~~

~~3. Vehicle condition and maintenance;~~

~~4. Emergency procedures;~~

~~5. Personnel qualifications;~~

~~6. Use of aides;~~

~~7. Volunteers; and,~~

~~8. Recordkeeping.~~

~~B. Community centered boards and program approved service agencies policies and procedures shall also address the provision of transportation to individuals in vehicles not owned or operated by the community centered board or program approved service agency. These policies and procedures shall include, at a minimum section 8.611.A.1 through 8 and other procedures which may be needed for safety. Agencies shall ensure that all drivers are appropriately qualified and that drivers and vehicles meet all legal requirements.~~

~~C. Transportation services must be provided under contract/written agreement with the Department, the community centered board or program approved service agency. Each agency shall maintain a transportation reporting system in a manner and form specified by the Department.~~

~~D. Transportation acquisition services refers to the purchase or provision of transportation for individuals receiving day program under comprehensive services which enables them to gain access to programs and other community services and resources required by their Individualized Plan/Plan of Care. Funding for transportation activities incidental to the Residential Program are included in the Residential rate.~~

~~E.~~ B. Exclusions

1. Non-Medical Transportation services shall not be used to substitute for medical transportation, as defined in Section 8.014.

2. Non-Medical Transportation services shall only be used after the case manager has determined that free or no-cost transportation is not available to the participant. Prior to the use of funds for transportation acquisition services, the Community Centered Board, case management agency or program approved service agency shall investigate the feasibility of the use of public transportation options. If public transportation options are found to be inadequate or inappropriate, this shall be documented.

C. Provider Standards for Non-Medical Transportation Services

1. Providers shall conform to all general standards and procedures set forth in Department regulations at Section 8.611.

2. Providers must maintain liability insurance with the following automobile liability limits:

   a. Bodily injury (BI) $300/$600K per person/per accident; and

   b. Property damage $50,000.

   c. Drivers that utilize their personal vehicle on behalf of a provider agency to provide NMT must maintain insurance that meets the following minimum automobile insurance requirements in addition to the insurance maintained by the provider agency :

i. Bodily injury (BI) $25/$50K per person/per accident; and

ii. Property damage $15,000.

3. Providers shall ensure that each driver rendering NMT meets the following requirements:

a. Drivers must be 18 years of age or older to render services;

b. Have at least one year of driving experience;

c. Possess a valid Colorado driver's license;

d. Provide a copy of their current Colorado motor driving vehicle record, with the previous seven years of driving history; and

e. Complete a Colorado or National-based criminal history record check.

4. Drivers shall be disqualified from driving for any of the following:

a. A conviction of substance abuse occurring within the seven (7) years preceding the date the criminal history record check is completed;

b. A conviction in the State of Colorado, at any time, of any Class 1 or 2 felony under Title 18, C.R.S.;

c. A conviction in the State of Colorado, within the seven (7) years preceding the date the criminal history record check is completed, of a crime of violence, as defined in C.R.S. § 18-1.3-406(2);

d. A conviction in the State of Colorado, within the four (4) years preceding the date the criminal history record check is completed, of any Class 4 felony under Articles 2, 3, 3.5, 4, 5, 6, 6.5, 8, 9, 12, or 15 of Title 18, C.R.S.;

e. A conviction of an offense in any other state that is comparable to any offense listed in subparagraphs (f)(II)(A) through (D), when conviction for that offense occurs within the same time periods as listed in subparagraphs (f)(II)(A) through (D) of 4 C.C.R. 723-6, § -6114;

f. A ~~C~~conviction in the State of Colorado, at any time, of a felony or misdemeanor unlawful sexual offense against a child, as defined in § 18-3-411, C.R.S., or of a comparable offense in any other state or in the United States at any time;

g. A conviction in Colorado within the two (2) years preceding the date the criminal history record check is completed of driving under the influence, as defined in § 42-4-1301(1)(f), C.R.S.; driving with excessive alcoholic content, as described in §42-4-1301(1)(g), C.R.S;

h. A conviction within the two (2) years preceding the date the criminal history record check is completed of an offense comparable to those included in subparagraph (f)(III)(B) in any other state or in the United States; and

For purposes of 4 C.C.R. 723-6 § -6114(f)(IV), a deferred judgment and sentence pursuant to § 18-1.3-102, C.R.S., shall be deemed to be a conviction during the period of the deferred judgment and sentence.

5. Vehicles used during the provision of NMT must be safe and in good working order. To ensure the safety and proper functioning of the vehicles, vehicles must pass a vehicle safety inspection prior to it being used to render services.

a. Safety inspections shall include the inspection of items as outlined in Rules Regulating Transportation by Motor Vehicle, 4 C.C.R. 723-6; §6104.

b. Vehicles must be inspected on the following schedule:

i. Vehicles manufactured within the last five (5 years:): no inspection.

ii. Vehicles manufactured within the last six (6) to ten (10) years: every 24 months.

iii. Vehicles manufactured eleven (11) years or later: annually.

iv. Vehicles for wheelchair transportation: annually, regardless of the manufacture date of vehicle.

c. The vehicle inspector must be trained to conduct the inspection and be employed by an automotive repair company authorized to do business in Colorado.

6. Transportation providers who maintain a certificate or permit through the Public Utilities Commission (PUC) are not required to meet the above requirements. PUC certificate and permit holders shall submit a copy of the certification to the Department for verification of provider credentials.

DO NOT PUBLISH THIS PAGE

Title of Rule: MSB 21-08-05-B, A Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Service Plan Authorization Limits (SPAL) and the Exception Review Process, to revise Section 8.500.102
Rule Number: MSB 21-08-05-B
Division / Contact / Phone: BSMD/ Lindsay Westlund/ 5453

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 21-08-05-B, A Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Service Plan Authorization Limits (SPAL) and the Exception Review Process, to revise Section 8.500.102

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) 8.500.102

   Sections(s) MSB 21-08-05-B, 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 text at 8.500.102 with the proposed text beginning at 8.500.102.E through the end of 8.500.102.5.a. This rule is effective January 10, 2022.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: MSB 21-08-05-B, A Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Service Plan Authorization Limits (SPAL) and the Exception Review Process, to revise Section 8.500.102
Rule Number: MSB 21-08-05-B
Division / Contact / Phone: BSMD/ Lindsay Westlund/ 5453

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 Office of Community Living (OCL), Benefits and Services Management Division (BSMD) is requesting to revise regulations to include the addition of The SLS Waiver Exception Review Process as requested through R – 08 and approved through the Long Bill, SB 21 – 205. The addition of this review process is a policy change and this rule revision will allow specific members on the HCBS – SLS waiver to access additional supports and services beyond the current SPAL and/ or service unit limitation caps. This review process is anticipated to allow for members to continue to live in the community of their choice while postponing or eliminating the need for an emergency enrollment onto the HCBS – DD waiver.

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 441.300, 440.180

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);
   Sections 25.5-6-404, C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: MSB 21-08-05-B, A Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Service Plan Authorization Limits (SPAL) and the Exception Review Process, to revise Section 8.500.102
Rule Number: MSB 21-08-05-B
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REGULATORY ANALYSIS

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

   The persons affected by this rule will include those members who are enrolled on the HCBS – SLS waiver who demonstrate a need to exceed current SPAL and/or service limitations. This proposed rule will benefit these persons by allowing access to additional services and supports to maintain living in the community of their choice.

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 qualitative impact of the proposed rule is positively affecting the quality of life of our members by allowing additional control over and access to services and supports that better meet their needs without having to seek enrollment in a program that possibly would be more restrictive, when 24-hour supports are not required.

   The proposed rule has the potential to achieve cost savings for the Department when members remain on the less costly program, SLS, as compared to the more expensive DD waiver program.

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

   The costs associated with implementation of this rule revision have been factored into the appropriations given to the Department with the approval to implement this Exceptions Review Process. The costs associated with this rule make up less than 0.5% of the Department's long bill appropriations.

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

There are no benefits of inaction as this approval to implement the Exception Review Process is included in the Department's budget Request (R-08) and is approved by the Long Bill, SB 21 – 205.

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

   There are no alternative methods for achieving the purpose of the proposed rule as alternative methods were explored during the budget request development process.

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 alternative methods for achieving access to services and supports that will meet the needs of an individual with an Intellectual or Developmental Disability is to allow all waiver members access to the Developmental Disability (DD) waiver, when their needs are not fully met through other waivers. The ability to enroll members onto the DD waiver is restricted due to the cost and waiting list associated with this waiver, and therefor rejected as an alternative method.

8.500 HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABLITIES(HCBS-DD) WAIVER

8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

8.500.102.A The service plan authorization limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a Client's ongoing service needs within one (1) service plan year.

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations, vehicle modifications, health maintenance activities available under the Consumer Directed Attendant Support Services (CDASS), home delivered meals, life skills training, peer mentorship, and transition setup.

8.500.102.C The total of all HCBS-SLS services in one service plan shall not exceed the overall authorization limitation as set forth in the federally approved HCBS-SLS waiver.

8.500.102.D Each SPAL is assigned a specific dollar amount determined through an analysis of historical utilization of authorized waiver services, total reimbursement for services, and the spending authority for the HCBS-SLS waiver. Adjustments to the SPAL amount may be determined by the Department and Operating Agency as necessary to manage waiver costs.

8.500.102.E Each SPAL is associated with one of the six support levels determined by an algorithm which analyzes ~~a~~ the level of support needed by a Client~~'s level of service need~~ as determined by the SIS assessment, and additional factors, including ~~and additional factors including exceptional medical and behavioral support needs and~~ whether a Client meets the definition of Public Safety Risk-Convicted, Public Safety Risk-Non Convicted, and Extreme Safety Risk to Self.~~identification as a community safety risk~~.

8.500.102.F The SPAL determination shall be implemented in a uniform manner statewide and the SPAL amount is not subject to appeal.

1. If a Client's HCBS waiver eligibility and/or services are adversely affected at any time, the Client will be sent their appeal rights as required at 8.612.4.E. and 8.057.2.A (10 C.C.R. 2505-10).

8.500.102.G The Department and/or Utilization Review Contractor (URC) shall implement an ~~There shall be an~~ Exception Review Process ~~implemented by the Department and/or Utilization Review Contractor (URC)~~ to allow a Member's SPAL and/ or HCBS unit limitations to be exceeded in certain situations.

1. ~~In order for a Client~~ To be eligible for the Exception Review Process, the following shall be demonstrated:

a. The Client must be at risk for seeking an emergency Developmental Disability (DD) waiver enrollment because one or more ~~when one~~ of the following criteria such as listed below are not currently being met through other Long-Term Services and Supports (LTSS) and or State Plan services:

i. Medically fragile with skilled care needs;

ii. Behavioral and/or Mental Health needs;

iii. Criminal convictions and/or law enforcement involvement;

iv. Homelessness;

v. Mistreatment, Abuse, Neglect, Exploitation (MANE) reports with potential need to remove from home;

vi. Extreme danger to self/others;

vii. Caregiver capacity or;

viii. 1:1 supervision needed.

b. The Client must demonstrate that less than 10% of current SPAL remains; ~~current utilization of SPAL within 10% of current limitation;~~ or

c. The Client must demonstrate that the current rate of utilization of Home and Community-Based Services (HCBS) will exhaust the number of approved units prior to the Client's regularly scheduled monitoring. ~~up to current specific HCBS unit limitation(s).~~

~~i. The Client may demonstrate using up to the current specific HCBS unit limitation through a service plan that will exhaust units prior to their regularly scheduled monitoring.~~

2. When a client is eligible ~~eligibility~~ for the Exception Review Process ~~has been identified~~, the Case Manager (CM) shall send the following documentation to the URC for review:

a. "Request for Exception Review Process" form;

b. Service Plan;

c. PAR; and,

d. Any documentation from current providers that demonstrate need to exceed service limitation caps for additional planned services.

3. The URC shall review and approve or deny the Exception Review Process requests made.

a. Upon completion of the review, the URC shall notify the CM of the outcome. ~~The URC shall complete a review of the submitted documentation and send notice to the CM outlining the outcome.~~

i. The outcome letter shall include the reason for approval or denial, ~~denial reason, the approval reason,~~ and/ or any information on partial approvals or negotiated outcomes.

b. The URC shall compete the review in accordance with the timelines as identified in their contract.

4. The Exception Review Process shall not be used in place of a Support Level Review or request for a Support Intensity Scale (SIS) reassessment. Provider rates shall not be changed based on the outcome of the Exception Review Process.

5. The Exception Review Process shall be implemented in a uniform manner applied to Members statewide ~~applied to Members across the state in a uniform manner~~, but outcomes shall be based on individual needs and circumstances. The Exception Review Process outcome is not an adverse action subject to appeal.

a. If a Client's HCBS waiver eligibility and/or services are adversely affected at any time, the Client will be sent their appeal rights as required at 8.612.4.E. and 8.057.2.A (10 C.C.R. 2505-10).