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Title of Rule: Revision to the Medical Assistance Act Rule concerning Care and Case Management System, Sections 8.390, 8.393, 8.400, 8.500 & 8.615 .
Rule Number: MSB 23-01-13-A
Division / Contact / Phone: Office of Community Living / Michelle Topkoff / 303-866-3659

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 23-01-13-A, Revision to the Medical Assistance Act Rule concerning Care and Case Management System, Sections 8.390, 8.393, 8.400, 8.500 & 8.615 .

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) 8.390, 8.393, 8.400, 8.500 and 8.614, 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 8.390.1 with the proposed text beginning at 8.390.1 through the end of 8.390.1. Replace the current text at 8.393.1.M with the proposed text beginning at 8.393.1.M through the end of 8.393.1.M. Replace the current text at 8.393.2 with the proposed text beginning at 8.393.2.B through the end of 8.393.2.H. Replace the current text at 8.393.5 with the proposed text beginning at 8.393.5 through the end of 8.393.6.B. Replace the current text at 8.400 beginning at 8.400.12 through the end of 8.400.17. Replace the current text at 8.401 with the proposed text beginning at 8.401 through the end of 8.401.16. Replace the current text at 8.402.10 with the proposed text beginning at 8.402.10 through the end of 8.402.54. Replace the current text at 8.405.2 with the proposed text beginning at 8.405.2 through the end of 8.405.4.

*to be completed by MSB Board Coordinator

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Replace the current text at 8.470.2 with the proposed text beginning at 8.470.2 through the end of 8.470.5.D. Replace the current text at 8.485.50 with the proposed text beginning at 8.485.50 through the end of 8.485.90. Replace the current text at 8.486 with the proposed text beginning at 8.486.20 through the end of 8.486.40. Replace the current text at 8.486.200 with the proposed text beginning at 8.486.200 through the end 8.486.500. Replace the current text at Section 8.400-499, Appendix A with the proposed text beginning at Section 8.400-499, Appendix A through the end of Section 8.400-499, Appendix A. Replace the current text at 8.500 with the proposed text beginning at 8.500.1 through the end of 8.500.4.A. Replace the current text at 8.500.90 with the proposed text beginning at 8.500.90 through the end of 8.500.91.F. Replace the current text at 8.500.93 with the proposed text beginning at 8.500.93.A through the end of 8.500.93.A. Replace the current text at 8.500.103 with the proposed text beginning at 8.500.103.A through the end of 8.500.103.A. Replace the current text at 8.501 with the preposed text beginning at 8.501.A through the end of 8.501.A. Replace the current text at 8.503 with the proposed text beginning at 8.503.QQ. Replace the current text at 8.503.30 with the proposed text beginning at 8.503.30 through the end of 8.503.30. Replace the current text at 8.503.60 with the proposed text beginning at 8.503.60 through the end of 8.503.80. Replace the current text at 8.504 with the proposed text beginning at 8.504.1 through the end of 8.504.1. Replace the current text at 8.504.5 with the proposed text beginning at 8.504.5 through the end of 8.504.5. Replace the current text 8.506 with the preposed text beginning at 8.506.2 through the end of 8.506.4. Replace the current text at 8.506.6 with the proposed text beginning at 8.506.6.A through the end of 8.506.6.A. Replace the current text at 8.506.7 with the proposed text beginning at 8.506.7.H through the end of 8.506.7.H. Replace the current text at 8.506.10 with the proposed text beginning at 8.506.10 through the end of 8.506.10.H. Replace the current text at 8.508 with the proposed text beginning at 8.508.20 through the end of 8.508.20. Replace the current text at 8.508 with the proposed text beginning at 8.508.40 through the end of 8.508.70. Replace the current text at 8.508.121 with the proposed text beginning at 8.508.121 through the end of 8.508.121.A. Replace the current text at 8.509 with the proposed text beginning at 8.509.14 through the end of 8.509.16. Replace the current text at 8.509.31 with the proposed text beginning at 8.509.31 through the end of 8.509.33.A.1. Replace the current text at 8.510 with the proposed text beginning at 8.510.1 through the end of 8.510.1. Replace the current text at 8.515 with the proposed text beginning at 8.515.3 through the end of 8.515.85.B. Replace the current text at 8.517 with the proposed text beginning at 8.517.6 through the end of 8.517.6. Replace the current text beginning at 8.519 with the proposed text beginning at 8.519.1 through the end of 8.519.1. Remove the current text at 8.519.6. Replace the text at 8.550.6.B with the proposed text beginning at 8.550.6.B through the end 8.500.6.B. Replace the current text at 8.600 with the proposed text beginning at 8.600.4 through the end of 8.600.4. Replace the current text at 8.615 with the proposed text beginning at 8.615.1 through the end of 8.615.1. This rule is effective July 30, 2023.

*to be completed by MSB Board Coordinator

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Rule Number: MSB 23-01-13-A
Division / Contact / Phone: Office of Community Living / Michelle Topkoff / 303-866-3659

STATEMENT OF BASIS AND PURPOSE

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

   This proposed rule amends Sections 8.390, 8.393, 8.400, 8.500 and 8.614 in anticipation of adoption of a new assessment instrument, the Colorado Single Assessment Level of Care Eligibility Determination Screen. The current rule identifies by name the ULTC 100.2 as the instrument used to determine eligibility for Long Term Services and Supports (LTSS) and incorporates the instrument in its entirety into the regulations. The amendments to rule update terminology and language to allow for use of a second instrument, which will be used concurrently with the ULTC 100.2 during the phase in of the use of the new Colorado Single Assessment Level of Care Eligibility Determination Screen. During the phase in period, only one of the two instruments will used on any one member for any single certification period. This is in preparation for the eventual complete phase out of the ULTC 100.2 and replacement with the Colorado Single Assessment Level of Care Eligibility Determination Screen.

   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:

2. Federal authority for the Rule, if any:

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, 25.5-6-104, C.R.S. (2023);

Initial Review **05/12/23** Final Adoption **06/09/23**
Proposed Effective Date **07/30/23** Emergency Adoption

DOCUMENT #08

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REGULATORY ANALYSIS

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

   This proposed rule will affect Case Management Agencies and Medicaid LTSS members. Case management agencies and members will benefit from the proposed rule changes because it will allow the Department to phase in the implementation of the new Colorado Single Assessment, which is a new comprehensive level of care and needs assessment housed in the new Care and Case Management system. The new assessment process is required by SB 16-192 (codified at Section 25.5-6-104, C.R.S.)

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 new assessment has automated features that will streamline the assessment process for members and reduce duplication in administrative work for case managers. It is also more objective and standardized.

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.

   Initial cost associated with the change have been addressed through the fiscal note for SB 16-192. Enforcement costs are not anticipated to change. No other agency will incur any costs and there will be no effect on state revenues as a result of this rule change.

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

   Funding for the initial costs for the development and implementation of the new assessment instrument was allocated in a fiscal note for SB 16-192. The benefits of the proposed rule are that clients and case managers will benefit from the streamlined assessment process and the more objective and standardized Colorado Single Assessment Level of Care Eligibility Determination Screen. The cost of

inaction is that the Department will fail comply with statute and clients and case managers will be deprived of the efficiency, objectivity and standardization of the Colorado Single Assessment Level of Care Eligibility Determination Screen. No benefits of inaction have been identified.

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

   Because the current rules identify and incorporate the ULTC 100.2 as the single instrument to be used for assessments, the rule must be changed to allow use of the Colorado Single Assessment Level of Care Eligibility Determination Screen.

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 for achieving the purpose of the proposed rule change were considered.

8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM

The long-term care Single Entry Point system consists of Single Entry Point Agencies, representing geographic districts throughout the state, for the purpose of enabling persons in need of long-term services and supports to access appropriate services and supports.

8.390.1 DEFINITIONS

~~A. Agency Applicant means a legal entity seeking designation as the provider of Single Entry Point Agency functions within a Single Entry Point district.~~

~~A~~B. Applicant means an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in a Level of Care Eligibility Determination Screen.

C. Assessment means a comprehensive evaluation ~~with the individual seeking services~~of an Applicant or Member, including but not limited to ~~and appropriate collaterals, as appropriate (such as family members, advocates, friends and/or caregivers) and, chosen by the individual, and conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine~~ the individual's level of ~~functioning~~care, service needs, available resources, and potential funding resources using Department prescribed instrument(s), as required by the program for which they are applying or in which they are enrolled.~~.~~

~~BD~~C. Case Management means the ~~assessment~~ Assessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Person-Centered Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic R~~r~~eassessment of such individual's needs.

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

F~~D~~E. Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to, injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

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

H~~G~~F. Failure to Satisfy the Scope of Work means acts or failures to act by the Single Entry Point Agency that constitute nonperformance or breach of the terms of its contract with the Department.

I~~G~~H. Financial Eligibility means an individual meets the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources.

~~I. Functional Eligibility means an individual meets the level of care criteria for a Long-Term Services and Supports (LTSS) Program as determined by the Department.~~

~~J. Functional Needs Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, friends and/or caregivers) chosen by the individual and a written evaluation by the case manager utilizing the ULTC 100.2, with supporting diagnostic information from the individual's medical provider, to determine the individuals level of care and medical necessity for admission or continued stay in certain Long-Term Services and Supports (LTSS) Programs.~~

~~JHK~~. Home and Community Based Services (HCBS) waivers means services and supports authorized through a waiver under Section 1915(c) of the Social Security Act and provided in home- and community-based settings to individuals who require a~~n institutional~~ level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

K~~IL~~. Information Management System (IMS) means an automated data management system ~~approved~~ prescribed by the Department to ~~enter~~ document case management activities and information for each individual seeking or receiving long-term and/or State General Fund services as well as to compile and generate standardized or custom summary reports.

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

M~~K~~N. Level of Care Eligibility means an individual requires the level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities, as determined by the Department prescribed Level of Care Eligibility Determination Screen.~~meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.~~

~~L. Institutional Level of Care means an individual requires the level of care that is provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities, as determined by the Department prescribed Level of Care Eligibility Determination Screen.~~

O~~M~~. Level of Care Eligibility Determination means the outcome ~~of a comprehensive evaluation of an individual seeking Long-Term Services and Supports to determine their need for Institutional Level of Care using a Department prescribed assessment instrument.~~ of the LOC Screen,

P~~N~~. ~~Long-Term Services and Supports~~ Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation ~~with~~of the Applicant or ~~individual seeking services~~ Member ~~and collaterals as appropriate (such as family members, advocates, friends and/or caregivers) and chosen by the individual, and conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of care, service needs, available resources, and potential funding resources using a Department prescribed instrument(s) to determine an applicant or member's eligibility for Long-Term Services and Supports based on their need for Institutional Level of Care as determined~~ using a Department prescribed assessment instrument as outlined in section 8.401.

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

P~~RO~~. LTSS Program means any of the following: publicly funded programs, Home and Community-Based Services ~~for the~~ Elderly, Blind and Disabled Waiver (HCBS-EBD), Home and Community-Based Services ~~for Persons with a Spinal Cord Injury~~Complementary and Integrative Health

Waiver (HCBS-~~SCI~~CIH) ~~(where applicable)~~, Home and Community-Based Services ~~for Persons with a~~ Brain Injury Waiver (HCBS-BI), Home and Community-Based Services Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community-Based Services ~~for~~ Children with a Life Limiting Illness Waiver (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).

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

T. Person-Centered Support Planning means the process of collaborating with the individual receiving services and other people of their choosing to identify goals, needed services, individual choices and preferences, and service providers. This is based on Assessment and knowledge of the individual and of community resources and includes informing the individual of their rights and responsibilities.

U.~~R~~ Person-Centered Support Plan (PCSP) means the documentation of the Person-Centered Planning Process in the Department prescribed IMS using the Department prescribed format, including but not limited to the individual's chosen goals, services and providers.

V~~S~~. Pre-Admission Screening and Resident Review (PASRR) means the pre-screening of individuals seeking nursing facility admission to identify individuals with mental illness (MI) and/or intellectual disability (ID), to ensure that individuals are placed appropriately, whether in the community or in a NF, and to ensure that individuals receive the services they require for their MI or ID.

~~Q~~W~~T~~. Professional Medical Information Page (PMIP) ~~means the medical information form signed by a licensed medical professional used to certify level of care~~means the medical information form signed by a licensed medical professional used to verify the individual's medical necessity for Long-Term Care Services.

~~R~~X~~U~~. Reassessment means a comprehensive reevaluation of an Applicant or Member, including but not limited to the individual's level of care, service needs, available resources, and potential funding resources using Department prescribed instrument(s), as required by the program for which they are applying or in which they are enrolled.~~with the individual seeking services and collaterals, as appropriate (such as family members, advocates, friends and/or caregivers) and chosen by the individual, and conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of care, service needs, available resources, and potential funding resources using a Department prescribed instrument.means a periodic comprehensive reevaluation with the individual receiving services, appropriate collaterals, chosen by the individual, and case manager, to re-determine the individual's level of functioning, service needs, available resources and potential funding resources.~~

~~S~~Y~~V~~. Resource Development means the study, establishment and implementation of additional resources or services which will extend the capabilities of community LTSS systems to better serve individuals receiving long-term services and individuals likely to need long-term services in the future.

Z~~W~~T. Single Entry Point (SEP) means the availability of a single access or entry point within a local area where an individual seeking or currently receiving LTSS can obtain LTSS information, screening, assessment of need and referral to appropriate LTSS programs and case management services.

AA~~X~~U. Single Entry Point Agency means the organization selected to provide intake, screening, referral, eligibility determination, and case management functions for persons in need of LTSS within a Single Entry Point District.

BB~~Y~~V. Single Entry Point District means one or more counties that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of LTSS.

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

CC~~Z~~X. Target Group Criteria means the factors that define a specific population to be served through an HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic conditions, age, or diagnosis, and May include other criteria such as demonstrating an exceptional need.

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.M. Functions of the Case Manager.

1. The SEP Agency's case manager(s) shall be responsible for: intake, screening and referral, A~~a~~ssessment/R~~r~~eassessment, development of Person-Centered Support Plans, ongoing case management, monitoring of individuals' health and welfare, documentation of contacts and case management activities in the Department-prescribed IMS, resource development, and case closure.

    a. The case manager shall contact the individual at least once within each quarterly period, or more frequently if warranted by the individual's condition or as determined by the rules of the LTSS Program in which the individual is enrolled.

    b. The case manager shall have in-person monitoring at least one (1) time during the ~~Support Plan~~Person-Centered Support PlanPCSP ~~-~~year. The case manager shall ensure one required monitoring is conducted in-person with the Member, in the Member's place of residence~~.~~. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which ~~face-to-face~~in-person meetings would pose a documented safety risk to the case manager or client (e.g.~~,~~, natural disaster, pandemic, etc.).

    c. The case manager shall complete a new ~~ULTC 100.2~~LOC Screen during a ~~face-to-face~~in-person R~~r~~eassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the LTSS Program in which the individual is enrolled. Upon Department approval, R~~r~~eassessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which ~~face-to-face~~in-person meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

d. The case manager shall monitor the delivery of services and supports identified within the ~~Support Plan~~PCSP and the Prior Authorization Request (PAR). This includes monitoring:

i. The quality of services and supports provided;

ii. The health and safety of the individual; and

iii. The utilization of services.

e. The following criteria may be used by the case manager to determine the individual's level of need for case management services:

i. Availability of family, volunteer, or other support;

ii. Overall level of functioning;

iii. Mental status or cognitive functioning;

iv. Duration of disabilities;

v. Whether the individual is in a crisis or acute situation;

vi. The individual's perception of need and dependency on services;

vii. The individual's move to a new housing alternative; and

viii. Whether the individual was discharged from a hospital or Nursing Facility.

8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.2.B. Intake, Screening and Referral

1. The intake, screening and referral function of a SEP Agency shall include, but not be limited to, the following activities:

a. The completion and documentation of the intake, screening and referral functions using the Department~~'s~~ prescribed intake, screening and referral instruments in the IMS;

SEPs may ask referring agencies to complete and submit an intake and screening form to initiate the process;

b. The provision of information and referral to other agencies, as needed, and the documentation of those referrals in the IMS;

c. A screening to determine whether a ~~functional eligibility assessment~~LOC Screen is indicated~~needed~~;

d. The identification of potential payment source(s), including the availability of private funding resources; and

e. The implementation of a SEP Agency procedure for prioritizing urgent inquiries.

2. When LTSS are to be reimbursed through one or more of the publicly funded LTSS Pprograms served by the SEP system:

a. The SEP Agency shall verify the individual's demographic information collected during the intake;

b. The SEP Agency shall coordinate the completion of the financial eligibility determination by:

i. Verifying the individual's current financial eligibility status; or

ii. Referring the individual to the county department of social services of the individual's county of residence for application; or

iii. Providing the individual with financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides; and

iv. Conducting and documenting follow-up activities to complete the ~~functional eligibility determination~~LOC Screen and ~~coordinate~~ facilitate the completion of the financial eligibility determination, as needed.

c. The determination of the individual's financial eligibility shall be completed by the county department of social services for the county in which the individual resides, pursuant to Section 8.100.7 A-U.

d. Individuals shall be notified by the SEP Agency at the time of their application for publicly funded ~~long term services and supports~~ LTSS that they have the right to appeal actions of the SEP Agency, the Department, and contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

e. The county department shall notify the SEP Agency of the Medicaid application date for the individual seeking services upon receipt of the Medicaid application.

f. The county shall not notify the SEP Agency for individuals being discharged from a hospital or nursing facility or Adult Long-Term Home Health.

8.393.2.C. Initial ~~Assessment~~Level of Care Eligibility Determination

1. ~~For additional guidance on the ULTC 100.2, as well as the actual tool itself, see Section 8.401.1. GUIDELINES FOR LONG TERM CARE SERVICES~~

~~a.~~ The SEP Agency shall complete the ~~ULTC 100.2~~ LOC Screen within the following time frames:

~~i.~~a. For an individual who is not being discharged from a hospital or a nursing facility, the ~~individual assessment~~LOC Screen shall be completed within ten (10) working days after receiving confirmation that the Medicaid application has been received

by the county department of social services, unless a different time frame specified below applies.

bii. For a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the SEP Agency shall complete the assessment LOC Screen within five (5) working days after notification by the nursing facility.

ciii. For a resident who is being admitted to the nursing facility from the hospital, the SEP Agency shall complete the assessmentLOC Screen, including a PASRR Level 1 Screen within two (2) working days after notification, as required by Section 8.401.18 .

1) For PASRR Level 1 Screen regulations, refer to 8.401.18, PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

db. For an individual who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the SEP Agency shall complete the assessment LOC Screen within five (5) working days after notification by the nursing facility.

ec. For an individual who is being transferred from a hospital to an HCBS program, the SEP Agency shall complete the assessment LOC Screen within two (2) working days after notification from the hospital.

2. The start date of the Level of Care Eligibility Determination shall not be back dated by the SEP. Neither the state nor its agent(s) will approve late PAR revisions. Under no circumstances shall the start date for functional eligibilityLevel of Care Eligibility Determination be backdated by the SEP. based on the See Section 8.486.30 , LONG-TERM SERVICES AND SUPPORTS LEVEL OF CARE ELIGIBILITY DETERMINATION SCREEN (LOC SCREEN). Under no circumstances shall late PAR revisions be approved by the state or its agent. Seeand Section 8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES. ASSESSMENT.

3. The A trained SEP Agency Case Manager shall complete the ULTC 100.2LOC Screen for LTSS pPrograms, in accordance with Section 8.401.1.

a. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may complete the ULTC 100.2LOC Screen for CHCBS.

4. The SEP Agency shall assess the individual's functional statuslevel of care face-to-facein-person, in the location where the person currently resides.. Upon Department approval, assessment the LOC Screen may be completed conducted by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-facein-person meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.). .

5. The Applicant may choose to have family members, advocates, friends and/or caregivers, as appropriate, participate as respondents in the assessment process either by attending with the Applicant or separate interviews with the case manager.

5. The SEP Agency ~~shall~~ conduct the following activities for a ~~comprehensive assessment~~Level of Care Eligibility Determination of an ~~individual seeking services~~Applicant:

   a. Obtain supporting diagnostic information, including but not limited to, ~~through the Professional~~the Professional Medical Information Page (PMIP) form from the individual's medical provider for individuals in nursing facilities, HCBS ~~Programs for~~ Community Mental Health Supports Waiver (HCBS-CMHS), ~~Persons with a~~ Brain Injury Waiver (HCBS-BI), Elderly, Blind and Disabled Wavier (HCBS-EBD), ~~Persons with a Spinal Cord Injury~~Complementary and Integrated Health Waiver (HCBS-CHI~~SCI~~) and Children with a Life Limiting Illness Waiver (HCBS-CLLI).

      i. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may obtain diagnosis(es) information from the individual's medical provider.

   b. Determine the individual's ~~functional capacity~~level of care during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting ~~and determine the functional capacity score in each of the areas identified in Section 8.401.1.~~using a Department prescribed instrument as outlined in Section 8.401.1.

   c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.10.15.

   d. ~~Determine~~ Assess the need for ~~long-term services and supports~~ LTSS services ~~on the ULTC 100.2 during the evaluation~~using a Department prescribed instrument.

   e. For HCBS Programs and admissions to nursing facilities from the community, ~~the original ULTC 100.2 copy~~a copy of the LOC Eligibility Determination shall be sent to the prospective provider ~~agencies~~agency~~,~~ and a copy shall be ~~placed~~ retained in the ~~individual's~~ agency's case record for the individual. If there are changes in the individual's condition which significantly change the payment or services amount, a copy of the ~~ULTC-100.2~~LOC Eligibility Determination documenting the change must be sent to the provider agency~~,~~ and a copy is to be maintained in the agency's case record for the individual.

   f. When the SEP Agency assesses the individual's ~~functional capacity on the ULTC-100.2~~level of care using the Department's prescribed instrument, the A~~a~~ssessment is not an adverse action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into an LTSS Program by the SEP based on the ~~ULTC-100.2~~ thresholds for ~~functional~~ Level of Care ~~e~~Eligibility Determination as outlined in Section 8.401.1. The appeal process is governed by the provisions of Section 8.057.

6. The case manager and the nursing facility shall complete the following activities for discharges from nursing facilities:

   a. The nursing facility shall contact the SEP Agency in the district where the nursing facility is located to inform the SEP Agency of the discharge if placement into home- or community-based services is being considered.

b. The nursing facility and the SEP case manager shall coordinate the discharge date.

c. When placement into HCBS Programs is being considered, the SEP Agency shall determine the remaining length of stay.

i. If the end date for the nursing facility is indefinite, the SEP Agency shall assign an end date not past one (1) year from the date of the most recent ~~assessment~~Level of Care Eligibility Determination.

ii. If the ~~ULTC 100.2~~Level of Care Eligibility Determination is less than six (6) months, the SEP Agency shall generate a new ~~certification~~ Level of Care Determination~~page~~ that reflects the end date that was assigned to the nursing facility.

iii. The SEP Agency shall complete a new ~~ULTC 100.2~~LOC Screen if the current completion date is six (6) months old or older. The assessment results shall be used to determine level of care and the new length of stay.

iv. The SEP Agency shall ~~send a~~provide ~~copy of~~ the ~~ULTC 100.2~~Level of Care Determination ~~certification page~~ to the eligibility enrollment specialist at the county department of social services.

v. The SEP Agency shall submit the HCBS prior authorization request to the Department or its fiscal agent.

7. For individuals receiving services in HCBS Programs who are already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the SEP Agency shall:

a. Coordinate the admission date with the facility;

b. Complete the PASRR Level 1 Screen, and if there is an indication of a mental illness or developmental disability, submit to the Department or its agent to determine whether a PASRR Level 2 evaluation is required;

c. Maintain the Level 1 Screen in the individual's case file regardless of the outcome of the Level 1 Screen; and

d. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ~~ULTC 100.2~~Level of Care Eligibility Determination is not six (6) months old or older.

8.393.2.D. Ongoing Level of Care Eligibility Determination~~Reassessment~~

1. The case manager shall determine level of care eligibility on an ongoing basis~~commence a regularly scheduled reassessment~~ by completing the LOC Screen at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a ~~reassessment~~ LOC Screen of an individual receiving services within twelve (12) months of the initial or most recent LOC screen. ~~individual assessment or the most recent reassessment. A reassessment shall be completed sooner if the individual's condition changes or if required by program criteria.~~

2. A Level of Care Eligibility Determination shall be completed sooner if the individual's condition changes or if required by program criteria. The case manager shall ~~update~~ document changes ~~the information provided at the previous assessment or reassessment,~~ utilizing the ~~ULTC 100.2~~LOC Screen.

3. ~~Reassessment~~ Ongoing Level of Care Determination assessments shall be made according to 8.393.2.C.4 and shall include the following activities~~include, but not be limited to, the following activities:~~

~~a. Assess the individual's functional status face-to-face, in the location where the person currently resides.. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).~~

   a~~b~~. Review Person-Centered Support Plan, service agreements and provider contracts or agreements;

   b~~c~~. Evaluate effectiveness, appropriateness and quality of services and supports;

   c~~d~~. Verify continuing Medicaid eligibility, other financial and program eligibility;

   ~~e. Annually, or more often if indicated, complete a new Support Plan and service agreements;~~

   f. Inform the individual's medical provider of any changes in the individual's needs;

   g. Maintain appropriate documentation, including type and frequency of LTSS the individual is receiving for ~~certification~~ approval of continued program eligibility, if required by the program;

   h. Refer the individual to community resources as needed and develop resources for the individual if the resource is not available within the individual's community; and

   j. Submit appropriate documentation for authorization of services, in accordance with program requirements.

4. The SEP Agency shall be responsible for completing Level of Care Eligibility Determination R~~r~~eassessments of individuals receiving care in a nursing facility. A R~~r~~eassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a R~~r~~eassessment or if the case manager assigns a definite determination end date. The nursing facility shall be responsible to send the SEP Agency a referral for a ~~new assessment~~Reassessment, as needed.

5. In order to assure quality of services and supports and the health and welfare of the individual, the case manager shall ask for permission from the individual to observe the individual's residence as part of the reassessment process, but this shall not be compulsory of the individual. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.). ~~.~~

8.393.2.E. Person-Centered Support Plan

1. The nursing facility shall be responsible for developing a Support Plan for individuals residing in nursing facilities.

2. The SEP Agency shall develop the Person-Centered Support Plan (PCSP) for individuals not residing in nursing facilities within fifteen (15) working days after determination of program eligibility.

3. The SEP Agency shall:

   a. Address the functional needs identified through the individual assessment;

   b. Offer informed choices to the individual regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but that may not be available;

   c. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

   d. Reflect cultural considerations of the individual and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency;

   e. Formalize the Person-Centered Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;

   f. Contain prior authorization for services, in accordance with program directives, including cost containment requirements;

   g. Contain prior authorization of Adult Long-Term Home Health Services, pursuant to Sections 8.520-8.527;

   h. Include a method for the individual to request updates to the plan as needed;

   i. Include an explanation to the individual of complaint procedures;

   j. Include an explanation to the individual of critical incident procedures; and

   k. Explain the appeals process to the individual.

4. The case manager shall provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and shall ensure that the development of the Person-Centered Support Plan:

   a. Occurs at a time and location convenient to the individual receiving services;

   b. Is led by the individual, the individual's parent's (if the individual is a minor), and/or the individual's authorized representative;

   c. Includes people chosen by the individual;

d. Addresses the goals, needs and preferences identified by the individual throughout the planning process;

e. Includes the arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the individual regarding service provision and formalizing provider agreements in accordance with program rules; and

f. Includes referral to community resources as needed and development of resources for the individual if a resource is not available within the individual's community.

5. Prudent purchase of services:

a. The case manager shall arrange services and supports using the most cost-effective methods available in light of the individual's needs and preferences.

b. When family, friends, volunteers or others are available, willing and able to support the individual at no cost, these supports shall be utilized before the purchase of services, providing these services adequately meet the individual's needs.

c. When public dollars must be used to purchase services, the case manager shall encourage the individual to select the lowest-cost provider of service when quality of service is comparable.

d. The case manager shall assure there is no duplication in services provided by LTSS programs and any other publicly or privately funded services.

6. In order to assure quality of services and supports and health and welfare of the individual, the case manager shall observe the individual's residence prior to completing and submitting the individual's Person-Centered Support Plan. Upon Department approval, observation may be completed using virtual technology methods may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

8.393.2.F. Cost Containment

1. If the case manager expects that the cost of services required to support the individual will exceed the Department-determined Cost Containment Review Amount, the Department or its agent will review the Person-Centered Support Plan to determine whether the individual's request for services is appropriate and justifiable based on the individual's condition and quality of life and, if it is, will sign the Prior Authorization Request.

a. The individual may request of the case manager that existing services remain intact during this review process.

b. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:

i. The individual's appeal rights pursuant to Section 8.057; and

ii. Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

8.393.2.G. Ongoing Case Management

1. The functions of the ongoing case manager shall be:

   a. Assessment/Reassessment: The case manager shall continually identify individuals' strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of critical incidents;

   b. Person Centered Support Plan (PCSP) Development: The case manager shall work with individuals to design and update ~~Support Plans~~a PCSP that address individuals' goals and assessed needs and preferences;

   c. Referral: The case manager shall provide information to help individuals choose qualified providers and make arrangements to assure providers follow the ~~Support Plan,~~PCSP including any subsequent revisions based on the changing needs of individuals;

   d. Monitoring: The case manager shall ensure that individuals obtain authorized services in accordance with their PCSP~~Support Plan~~ and monitor the quality of the services and supports provided to individuals enrolled in LTSS Programs. Monitoring shall:

      1. Be performed when necessary to address health and safety and services in the ~~care plan; Person-Centered Support Plan~~PCSP.

      2. Include activities to ensure:

         A. Services are being furnished in accordance with the individual's ~~Support Plan;~~PCSP

         B. Services in the ~~Support Plan~~ PCSP are adequate; and

         C. Necessary adjustments in the ~~Support Plan~~ PCSP and service arrangements with providers are made if the needs of the individual have changed;

      3. Include an in-person contact and observation with the individual in their place of residence, at least once per certification period. Additional in person monitoring shall be performed when required by the individual's condition or circumstance. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)

   e. Remediation: The case manager shall identify, resolve, and to the extent possible, establish strategies to prevent Critical Incidents and problems with the delivery of services and supports.

2. The case manager shall assure quality of services and supports, the health and welfare of the individual, and individual safety, satisfaction and quality of life, by monitoring

service providers to ensure the appropriateness, timeliness and amount of services provided. The case manager shall take corrective actions as needed.

3. The case manager may require the Contractor to revise the ~~Support Plan~~PCSP and Prior Authorization if the results of the monitoring indicate that the plan is inappropriate, the services as described in the plan are untimely, or the amount of services need to be changed to meet the Client's needs.

4. Ongoing case management shall include, but not be limited to, the following tasks:

    a. Review of the individual's ~~Support Plan~~PCSP and service agreements;

    b. Contact with the individual concerning their safety, quality of life and satisfaction with services provided;

    c. Contact with service providers to coordinate, arrange or adjust services, to address quality issues or concerns and to resolve any complaints raised by individuals or others;

    d. Conflict resolution and/or crisis intervention, as needed;

    e. Informal assessment of changes in individual functioning, service effectiveness, service appropriateness and service cost-effectiveness;

    f. Notification of appropriate enforcement agencies, as needed; and

    g. Referral to community resources as needed.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or mis-utilization of any public assistance benefit and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services Income Maintenance Rules at 9 C.C.R. 2503-8, Section 3.810 and Section 8.076.

6. The case manager shall contact the individual at least quarterly, or more frequently as determined by the individual's needs or as required by the program.

7. The case manager shall review the Department prescribed assessment and the ~~Support Pla~~PCSP~~n~~ with the individual every six (6) months. The review shall be conducted by telephone or at the individual's place of residence, place of service or other appropriate setting as determined by the individual's needs or preferences.

8. The case manager shall complete a new ULTC 100.2 when there is a significant change in the individual's condition and when the individual changes LTSS programs.

9. The case manager shall contact the service providers, as well as the individual, to monitor service delivery as determined by the individual's needs and as required by the authorities applicable to the service.

10. Case Managers shall report critical incidents within 24 hours of notification within the State Approved IMS.

    a. Critical Incident reporting is required when the following occurs

        i. Injury/Illness;

ii. Missing Person;

iii. Criminal Activity;

iv. Unsafe Housing/Displacement;

v. Death;

vi. Medication Management Issues;

vii. Other High-Risk Issues;

viii. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;

ix. Damage to the Consumer's Property/Theft.

b. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the Agency administrator or designee.

c. Case Managers shall comply with mandatory reporting requirements set forth at Section 18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102, C.R.S.

d. Each Critical Incident Report must include:

i. incident type

a. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, 26-3.1-101, 16-22-102 (9), and 25.5-10-202 C.R.S.

b. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, other high-risk issues.

ii. Date and time of incident;

iii. Location of incident, including name of facility, if applicable;

iv. Individuals involved;

v. Description of incident, and

vi. Resolution of incident, if applicable.

e. The Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.

8.393.2.H. Case Recording/Documentation

1. The SEP Agency shall complete and maintain all required records included in the State approved IMS and shall maintain individual case records at the Agency level for any

additional documents associated with the individual applying for or enrolled in a LTSS Program.

2. The case record and/or IMS shall include:

   a. Identifying information, including the individual's state identification (Medicaid) number and Social Security number (SSN);

   b. All State-required forms; and

   c. Documentation of all case management activity required by these regulations.

3. Case management documentation shall meet all the following standards:

   a. Documentation must be objective and understandable for review by case managers, supervisors, program monitors and auditors;

   b. Entries must be written at the time of the activity or no later than five (5) business days from the time of the activity;

   c. Entries must be dated according to the date of the activity, including the year;

   d. Entries must be entered into Department's IMS;

   e. The person making each entry must be identified;

   f. Entries must be concise, but must include all pertinent information;

   g. All information regarding an individual must be kept together, in a logical organized sequence, for easy access and review by case managers, supervisors, program monitors and auditors;

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

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

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

   k. Whenever the case manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the SEP Agency's control, the circumstances shall be documented in the case record. These circumstances shall be taken into consideration upon monitoring of SEP Agency performance.

4. Summary recording to update a case record shall be entered into the IMS at least every six (6) months, whenever a case is transferred from one SEP Agency to another, and when a case is closed.

8.393.4. COMMUNICATION

A. In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of an individual receiving services in SEP Agency-served programs, including changes in income, within one (1) working day after the case manager learns of the change. The case manager shall provide the eligibility enrollment specialist with copies of the certification page of the approved ULTC-100.2 form.

2. If the individual has an open adult protective services (APS) case at the county department of social services, the case manager shall keep the individual's APS worker informed of the individual's status and shall participate in mutual staffing of the individual's case.

3. The case manager shall inform the individual's physician of any significant changes in the individual's condition or needs.

4. The case manager shall report to the Colorado Department of Public Health and Environment (CDPHE) any congregate facility which is not licensed.

8.393.5 ~~FUNCTIONAL ELIGIBILITY~~ LEVEL OF CARE ELIGIBILITY DETERMINATION

A. The SEP Agency shall be responsible for the following:

1. Ensuring that the ~~ULTC 100.2 is~~ Level of Care Screen is completed in the IMS in accordance with Section 8.401.1 and justifies that the individual seeking or receiving services ~~should be approved~~ is eligible or ~~disapproved~~ineligible for admission to or continued stay in an applicable LTSS program.

2. Once the assessment is complete in the IMS, the case manager shall generate a Level of Care Eligibility ~~Determination~~certification page inDetermination in the IMS within three (3) business days for hospital discharge to a Nursing Facility, within six (6) business days for Nursing Facility discharge and within eleven (11) business days of receipt of referral.

3. If the assessment indicates approval, the SEP Agency shall notify the appropriate parties.

4. If the assessment indicates denial, the SEP Agency shall notify the appropriate parties in accordance with 8.393.3.A.2.

5. If the individual or individual's legally authorized representative appeals, the SEP Agency shall process the appeal request, according to Section 8.057.

8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

8.393.6.A. Intercounty Transfers

1. SEP agencies shall complete the following procedures to transfer individuals receiving case management services to another county within the same SEP district:

   a. Notify the current county department of social services eligibility enrollment specialist of the individual's plans to relocate to another county and the date of transfer, with financial transfer details at Section 8.100.3.C.

b. If the individual's current service providers do not provide services in the area where the individual is relocating, make arrangements, in consultation with the individual, for new service providers.

c. In order to assure quality of services and supports and health and welfare of the individual, the case manager must observe and evaluate the condition of the individual's residence. Upon Department approval, observation may be completed using virtual technology methods. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

d. If the individual is moving from one county to another to enter an Alternative Care Facility (ACF), forward copies of the following individual records to the ACF prior to the individual's admission to the facility:

i. ~~ULTC 100.2,~~Level of Care Eligibility Determination. ~~certified by the SEP;~~

ii. The individual's updated draft Prior Authorization Request (PAR) and/or Post Eligibility Treatment of Income (PETI) form; and

iii. Verification of Medicaid eligibility status.

8.393.6.B. Inter-district Transfers

1. SEP Agencies shall complete the following procedures in the event an individual receiving services transfers from one SEP district to another SEP district:

a. The transferring SEP Agency shall contact the receiving SEP Agency by telephone and give notification that the individual is planning to transfer, negotiate a transfer date and provide all necessary information.

b. The transferring SEP Agency shall notify the original county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and eligibility enrollment specialist shall follow rules described in Section 8.100.3.C. The receiving SEP Agency shall coordinate the transfer with the eligibility enrollment specialist of the new county.

c. The transferring SEP Agency shall make available in the IMS the individual's case records to the receiving SEP Agency prior to the relocation.

d. If the individual is moving from one SEP District to another SEP District to enter an ACF, the transferring SEP Agency shall forward copies of the individual's records to the ACF prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

e. To ensure continuity of services and supports, the transferring SEP Agency and the receiving SEP Agency shall coordinate the arrangement of services prior to the individual's relocation to the receiving SEP Agency's district and within ten (10) working days after notification of the individual's relocation.

f. The receiving SEP Agency shall complete a ~~face-to-face~~ n in person meeting with the individual in the individual's residence and a case summary update within ten (10) working days after the individual's relocation, in accordance with assessment procedures for individuals served by SEP Agencies. Upon Department approval, meeting may be completed using virtual technology

methods or may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.)

g. The receiving SEP Agency shall review the PCSP~~Support Plan~~ and the ~~ULTC 100.2~~LOC Screen ~~-~~and change or coordinate services and providers as necessary.

h. If indicated by changes in the PCSP~~Support Plan~~, the receiving SEP Agency shall revise the PCSP ~~Support Plan~~ and prior authorization forms as required by the publicly funded program.

i. Within thirty (30) calendar days of the individual's relocation, the receiving SEP Agency shall forward to the Department, or its fiscal agent, revised forms as required by the publicly funded program.

8.400 LONG-TERM CARE

.12 Home and Community Based Services under the Medicaid Waivers include distinct service programs designed as alternatives to standard Medicaid nursing facility or hospital services for discrete categories of clients. These waivers are Home and Community Based Services Waiver for Persons Who Are Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based Services Waiver for Complementary and Integrative Health~~Persons with Spinal Cord Injury~~ (HCBS-~~SCI~~CHI), Community Mental Health Supports Waiver (HCBS-CMHS), Home and Community Based Services Waiver for Persons With Brain Injury (HCBS-BI); Home and Community Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD), Supportive Living Services Waiver (HCBS-SLS); Home and Community Based Services Waiver for Children with Autism (HCBS-CWA), Children with Life-limiting Illness Waiver (HCBS-CLLI), Children's Habilitation Residential Program Waiver (HCBS-CHRP), Children Extensive Supports Waiver (HCBS-CES), Children's Home and Community Based Services Waiver (HCBS-CHCBS) and Home and Community Based Services for those inappropriately residing in nursing facilities (OBRA '87).

.13 Unless specified by reference to the specific programs described above, the term Home and Community Based Services where it appears in these rules and regulations shall refer to the programs described herein above, and the rules and regulations within this section shall be applicable to all Home and Community Based Services programs.

.14 Nursing facilities are prohibited from admitting any new client who has mental illness or intellectual or developmental disability, as defined in Section 8.401.18 Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability unless that client has been determined to require the level of services provided by a nursing facility as defined in Section 8.401.19.

.15 Clients eligible for Home and Community Based Services are eligible for all Medicaid services including home health services.

.16 Target Population Definitions. For purposes of determining appropriate type of long-term services, including home and community-based services, as well as providing for a means of properly referring clients to the appropriate community agency, the following target group designations are established:

A. Developmentally Disabled - includes all clients whose need for long-term care services is based on a diagnosis of Developmental Disability and Related Conditions, as defined in Section 8.401.18.

B. Mentally Ill - includes all clients whose need for long-term care is based on a diagnosis of mental disease as defined in Section 8.401.18.

C. Functionally Impaired Elderly - includes all clients who meet the level of care ~~screening guidelines~~ for SNF or ICF care, as determined by the LOC Screen and who are age 65 or over. ~~Clients who are mentally ill, as defined in Section 8.401.18, shall not be included in the target group of Functionally Impaired Elderly, unless the person's need for long-term care services is primarily due to physical impairments that are not caused by any diagnosis included in the definition of mental illness at Section 8.401.18, and determined by (URC) from the medical evidence.~~

D. Physically Disabled or Blind Adult - includes all clients who meet the level of care ~~screening guidelines~~ for SNF or ICF care, as determined by the LOC Screen and who are age 18 through 64. ~~Clients who are developmentally disabled or mentally ill, as defined in Section 8.401.18, shall not be included in the Physically Disabled or Blind target group, unless the person's need for long-term care services is primarily due to physical impairments not caused by any diagnosis included in the definition of intellectual or developmental disability or mental illness at Section 8.401.18, as determined by URC from the medical evidence.~~

E. Persons Living with AIDS - includes all clients of any age who meet either the nursing home level of care or acute level of care ~~screening guidelines~~ for nursing facilities or hospitals and have the ~~-~~diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may alternatively request to be designated as any other target group for which they meet the definitions above.

.17 Services in Home and Community Based Services programs established in accordance with federal waivers shall be provided to clients in accordance with the URC determined target populations as defined herein above.

8.401 LEVEL OF CARE SCREEN~~ING GUIDELINES~~

.01 The client must have been found by the ~~URC~~Case Management Agency to meet the applicable level of care ~~guidelines~~ for the type of services to be provided.

.02 The ~~URC~~Case Management Agency shall not make a L~~l~~evel of C~~c~~are Eligibility D~~d~~etermination unless the recipient has been determined to be Medicaid eligible or an application for Medicaid services has been filed with the County Department of Social/Human services.

.03 Payment for skilled (SNF) and intermediate nursing home care (ICF) Payment for skilled (SNF) and intermediate nursing home care (ICF) will only be made for clients whose ~~functional~~ Level of Care Eligibility Determination ~~assessment~~ and frequency of need for skilled and maintenance services meet the level of care ~~guidelines~~ for long-term care.

.04 Payment for care in an intermediate care facility for individuals with intellectual disabilities (ICF/IID) will only be made for developmentally disabled clients whose programmatic and/or health care needs meet the level of care ~~guidelines~~ for the appropriate class of ICF/IIDs.

.05 Services provided by nursing facilities are available to those ~~clients~~individuals who ~~that~~ meet the ~~guidelines~~ level of care below and are not identified as mentally ill or individuals with an

intellectual or developmental disability by the Determination Criteria for Mentally Ill or Individuals with an Intellectual or Developmental Disability in Section 8.401.18.

8.401.1 ~~GUIDELINES FOR LONG TERM CARE SERVICES~~LONG-TERM SERVICES AND SUPPORTS LEVEL OF CARE ~~-~~ELIGIBILITY DETERMINATION (CLASS I SNF AND ICF FACILITIES, *HCBS-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-SCI, HCBS-CLLI, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP*, PACE and Long-term Home Health)

.11 ~~The guidelines~~ Eligibility for long-term care ~~are~~ is based on a ~~level of care functional needs~~LOC Screen, as defined in Section 8.390.1, ~~assessment~~ in which an individual's needs~~s~~ are evaluated in at least the following areas of activities of daily living:

- Mobility
- Bathing
- Dressing
- Eating
- Toileting
- Transferring
- Need for supervision

~~A. The functional needs of an individual ages 18 and under shall be assessed in accordance with Appendix A, the Age Appropriate Guidelines for the Use of ULTC 100.2 on Children.~~

.12 Skilled services shall be defined as those services which can only be provided by a skilled person such as a nurse or licensed therapist or by a person who has been extensively trained to perform that service.

.13 Maintenance services shall be defined as those services which may be performed by a person who has been trained to perform that specific task, e.g., a family member, a nurses' aide, a therapy aide, visiting homemaker, etc.

.14 Skilled and maintenance services are performed in the following areas:

- Skin care
- Medication
- Nutrition
- Activities of daily living
- Therapies
- Elimination
- Observation and monitoring

.15

A. The ~~URC~~ case management agency shall certify as to the ~~functional~~ need for the nursing facility level of care~~. A URC reviews the information submitted on the~~, as demonstrated by ~~ULTC 100.2~~ the Level of Care Eligibility Determination Screen outcome ~~and assigns a score to each of the functional areas described~~ using criteria outlined in 10 CCR 2505-10 Section 8.401~~.11. The scores in each of the functional areas are based on a set of criteria and weights approved by the State which measures the degree of impairment in each of the functional areas. When the score in a minimum of two ADLs or the score for one category of supervision is at least a (2), the URC may certify that the person being reviewed is eligible for nursing facility level of care.~~

~~B.~~. ~~The URC's review shall include the information provided by the functional assessment screen~~LOC Screen~~.~~

B~~C~~. A person's need for ~~basic~~ Medicaid state plan benefits is not a proper consideration in determining whether a person needs long-term care services (including Home and Community Based Services).

~~D. The ULTC 100.2 shall be the comprehensive and uniform client assessment process for all individuals in need of long-term care, the purpose of which is to determine the appropriate services and levels of care necessary to meet clients' needs, to analyze alternative forms of care and the payment sources for such care, and to assist in the selection of long-term care programs and services that meet clients' needs most cost-efficiently.~~

.16 LONG-TERM CARE ELIGIBILITY ASSESSMENTS

The Department is implementing a new Level of Care Eligibility Determination Screen instrument- the Colorado Single Assessment Level of Care Screen, or CSA LOC Screen. The new LOC Screen will replace the current instrument, the Uniform Long-Term Care (ULTC) 100.2. The intent of the new instrument is to better understand individual needs, obtain objective and consistent assessment data, including standardized Functional Assessment Standardized Items (FASI), and is not intended to reduce eligibility or services. The Department will implement the new LOC Screen gradually, meaning the ULTC 100.2 and the new CSA LOC Screen instruments will both be in use concurrently for Level of Care Eligibility Determination Screens until the new CSA LOC Screen has been fully implemented across Colorado. During the transition, Case Management Agencies will use ~~only one of~~one of the two instruments, as determined by the Department, for initial and ongoing Level of Care Eligibility Determinations.

A. UNIFORM LONG-TERM CARE 100.2

~~General Instructions:~~ To qualify for Medicaid long-term care services using the ULTC 100.2, the ~~recipient/~~member/A~~a~~pplicant must have deficits in 2 of 6 Activities of Daily Living ~~,~~ (ADL)~~s~~, (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision as outlined below. The needs of an individual ages 18 and under shall be assessed in accordance with Appendix A, the ~~Age Appropriate~~Age-Appropriate Guidelines for the Use of ULTC 100.2 on Children. Specific ULTC scoring criteria is as follows:

~~**ACTIVITIES OF DAILY LIVING**~~

~~**I. BATHING**~~

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

ADL SCORING CRITERIA

☐0=The client is independent in completing the activity safely.

☐1=The client requires oversight help or reminding; can bathe safely without assistance or supervision, but may not be able to get into and out of the tub alone.

☐2=The client requires hands on help or line of sight standby assistance throughout bathing activities in order to maintain safety, adequate hygiene and skin integrity.

☐3=The client is dependent on others to provide a complete bath.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	☐Open Wound
☐Pain	☐Stoma Site
☐Sensory Impairment	Supervision:
☐Limited Range of Motion	☐Cognitive Impairment
☐Weakness	☐Memory Impairment
☐Balance Problems	☐Behavior Issues
☐Shortness of Breath	☐Lack of Awareness
☐Decreased Endurance	☐Difficulty Learning
☐Falls	☐Seizures
☐Paralysis	Mental Health:
☐Neurological Impairment	☐Lack of Motivation/Apathy
☐Oxygen Use	☐Delusional
☐Muscle Tone	☐Hallucinations
☐Amputation	☐Paranoia

Comments:

~~II.~~ DRESSING

Definition: The ability to dress and undress as necessary. This includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at the back of a dress or blouse do not constitute a functional deficit.

ADL SCORING CRITERIA

☐0=The client is independent in completing activity safely.

☐1= The client can dress and undress, with or without assistive devices, but may need to be reminded or supervised to do so on some days.

☐2= The client needs significant verbal or physical assistance to complete dressing or undressing, within a reasonable amount of time.

☐3= The client is totally dependent on others for dressing and undressing.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments: ☐Pain ☐Sensory Impairment ☐Limited Range of Motion ☐Weakness ☐Balance Problems ☐Shortness of Breath ☐Decreased Endurance ☐Fine Motor Impairment ☐Paralysis ☐Neurological Impairment ☐Bladder Incontinence ☐Bowel Incontinence ☐Amputation ☐Oxygen Use ☐Muscle Tone	☐Open Wound Supervision: ☐Cognitive Impairment ☐Memory Impairment ☐Behavior Issues ☐Lack of Awareness ☐Difficulty Learning ☐Seizures Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia

Comments:

~~III.~~ TOILETING

Definition: The ability to use the toilet, commode, bedpan or urinal. This includes transferring on/off the toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing.

ADL SCORING CRITERIA

☐0=The client is independent in completing activity safely.

☐1=The client may need minimal assistance, assistive device, or cueing with parts of the task for safety, such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.

☐2=The client needs physical assistance or standby with toileting, including bowel/bladder training, a bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environment clean.

☐3=The client is unable to use the toilet. The client is dependent on continual observation, total cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The client may or may not be aware of own needs.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments: ☐Pain ☐Sensory Impairment ☐Limited Range of Motion ☐Weakness ☐Shortness of Breath ☐Decreased Endurance ☐Fine Motor Impairment ☐Paralysis ☐Neurological Impairment ☐Bladder Incontinence ☐Bowel Incontinence ☐Amputation ☐Oxygen Use ☐Physiological defect ☐Balance ☐Muscle Tone ☐Impaction	☐Ostomy ☐Catheter Supervision Need: ☐Cognitive Impairment ☐Memory Impairment ☐Behavior Issues ☐Lack of Awareness ☐Difficulty Learning ☐Seizures Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia

Comments:

~~IV.~~ MOBILITY

Definition: The ability to move between locations in the individual's living environment inside and outside the home. Note: Score client's mobility without regard to use of equipment other than the use of prosthesis.

ADL SCORING CRITERIA

☐0=The client is independent in completing activity safely.

☐1=The client is mobile in their own home but may need assistance outside the home.

☐2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home.

☐3=The client is dependent on others for all mobility.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	Supervision Need:
☐Pain	☐Cognitive Impairment
☐Sensory Impairment	☐Memory Impairment
☐Limited Range of Motion	☐Behavior Issues
☐Weakness	☐Lack of Awareness
☐Shortness of Breath	☐Difficulty Learning
☐Decreased Endurance	☐Seizures
☐Fine or Gross Motor Impairment	☐History of Falls
☐Paralysis	Mental Health:
☐Neurological Impairment	☐Lack of Motivation/Apathy
☐Amputation	☐Delusional
☐Oxygen Use	☐Hallucinations
☐Balance	☐Paranoia
☐Muscle Tone	

Comments:

~~V.~~ TRANSFERRING

Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices, including properly functioning prosthetics, for transfers. Note: Score Client's ability to transfer without regard to use of equipment.

ADL SCORING CRITERIA

☐0=The client is independent in completing activity safely.

☐1=The client transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed.

☐2=The client transfer requires standby or hands on assistance for safety; client may bear some weight.

☐3=The client requires total assistance for transfers and/or positioning with or without equipment.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	Supervision Need:
☐Pain	☐Cognitive Impairment
☐Sensory Impairment	☐Memory Impairment
☐Limited Range of Motion	☐Behavior Issues
☐Weakness	☐Lack of Awareness
☐Balance Problems	☐Difficulty Learning
☐Shortness of Breath	☐Seizures
☐Falls	Mental Health:
☐Decreased Endurance	☐Lack of Motivation/Apathy
☐Paralysis	☐Delusional
☐Neurological Impairment	☐Hallucinations
☐Amputation	☐Paranoia
☐Oxygen Use	

Comments:

~~VI.~~ EATING

Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to cut, chew and swallow food. Note: If a person is fed via tube feedings or intravenously, check box 0 if they can do independently, or box 1, 2, or 3 if they require another person to assist.

ADL SCORING CRITERIA

☐0=The client is independent in completing activity safely.

☐1=The client can feed self, chew and swallow foods but may need reminding to maintain adequate intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding equipment.

☐2=The client can feed self but needs line of sight standby assistance for frequent gagging, choking, swallowing difficulty; or aspiration resulting in the need for medical intervention. The client needs reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by another person.

☐3=The client must be totally fed by another person; must be fed by another person by stomach tube or venous access.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments: ☐Pain ☐Sensory Impairment ☐Limited Range of Motion ☐Weakness ☐Shortness of Breath ☐Decreased Endurance ☐Paralysis ☐Neurological Impairment ☐Amputation ☐Oxygen Use ☐Fine Motor Impairment ☐Poor Dentition ☐Tremors ☐Swallowing Problems ☐Choking ☐Aspiration	☐Tube Feeding ☐IV Feeding Supervision Need: ☐Cognitive Impairment ☐Memory Impairment ☐Behavior Issues ☐Lack of Awareness ☐Difficulty Learning ☐Seizures Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia

Comments:

~~VII.~~ **SUPERVISION-**

~~A.~~ **Behaviors**

Definition: The ability to engage in safe actions and interactions and refrain from unsafe actions and interactions (Note, consider the client's inability versus unwillingness to refrain from unsafe actions and interactions).

SCORING CRITERIA

☐0=The client demonstrates appropriate behavior; there is no concern.

☐1=The client exhibits some inappropriate behaviors but not resulting in injury to self, others and/or property. The client may require redirection. Minimal intervention is needed.

☐2=The client exhibits inappropriate behaviors that put self, others or property at risk. The client frequently requires more than verbal redirection to interrupt inappropriate behaviors.

☐3=The client exhibits behaviors resulting in physical harm to self or others. The client requires extensive supervision to prevent physical harm to self or others.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments:	Supervision needs:
☐Chronic Medical Condition ☐Acute Illness ☐Pain ☐Neurological Impairment ☐Choking ☐Sensory Impairment ☐Communication Impairment (not inability to speak English) Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia ☐Mood Instability	☐Short Term Memory Loss ☐Long Term Memory Loss ☐Agitation ☐Aggressive Behavior ☐Cognitive Impairment ☐Difficulty Learning ☐Memory Impairment ☐Verbal Abusiveness ☐Constant Vocalization ☐Sleep Deprivation ☐Self-Injurious Behavior ☐Impaired Judgment ☐Disruptive to Others ☐Disassociation ☐Wandering ☐Seizures ☐Self Neglect ☐Medication Management

Comments:

SUPERVISION- ~~B.~~ Memory/Cognition Deficit

Definition: The age appropriate ability to acquire and use information, reason, problem solve, complete tasks or communicate needs in order to care for oneself safely.

SCORING CRITERIA

☐0= Independent no concern

☐1= The client can make safe decisions in familiar/routine situations, ~~-~~but needs some help with decision making support when faced with new tasks, consistent with individual's values and goals.

☐2= The client requires consistent and ongoing reminding and assistance with planning, ~~-~~or requires regular assistance with adjusting to both new and familiar routines, including regular monitoring and/or supervision, or is unable to make safe decisions, or cannot make his/her basic needs known.

☐3= The client needs help most or all of time.

Due To: (Score must be justified through one or more of the following conditions)

Physical Impairments: ☐ Metabolic Disorder ☐ Medication Reaction ☐ Acute Illness ☐ Pain ☐ Neurological Impairment ☐ Alzheimer's/Dementia ☐ Sensory Impairment ☐ Chronic Medical Condition ☐ Communication Impairment (does not include ability to speak English) ☐ Abnormal Oxygen Saturation ☐ Fine Motor Impairment Supervision Needs: ☐ Disorientation ☐ Cognitive Impairment ☐ Difficulty Learning ☐ Memory Impairment	☐ Self-Injurious Behavior ☐ Impaired Judgment ☐ Unable to Follow Directions ☐ Constant Vocalizations ☐ Perseveration ☐ Receptive Expressive Aphasia ☐ Agitation ☐ Disassociation ☐ Wandering ☐ Lack of Awareness ☐ Seizures ☐ Medication Management Mental Health: ☐ Lack of Motivation/Apathy ☐ Delusional ☐ Hallucinations ☐ Paranoia ☐ Mood Instability

Comments:

B. CSA LEVEL OF CARE SCREEN

~~To qualify for Medicaid long-term care services using the Level of Care Screen must meet the level of care for the program for which they are enrolling.~~ The Level of Care Eligibility Determination outcome is based on an individual's performance level as documented in the LOC Screen, in areas including, but not limited ~~to,completing~~to, completing Activities of Daily Living, memory and cognition, sensory and communication, and behavior, as well as other criteria specific to ~~the program for which they are enrolling or the age of the individual~~applicable program. The eligibility ~~C~~criteria and thresholds are ~~is~~ as follows:

~~1. 1.~~ Nursing Facility Level of Care Eligibility for ages four (4) and older

1.

a. Participants four (4) years of age or older must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.~~-~~B.~~-~~1 ~~-~~to be determined eligible for Long-Term Services and Supports.

i. Eligibility Criteria

1. Meets one or more ADL and Health Condition criteria thresholds in at least two areas to include Mobility, Transferring, Bathing, Dressing, Toileting, Eating (ADLs) or Health Condition; or
2. Meets one or more Behavior threshold(s); or
3. Meets one or more Memory and Cognition threshold(s); or
4. Meets the Sensory & Communication threshold.

ii. Criteria Thresholds

1. ADL and Health Condition criteria thresholds are as follows:
   a. Mobility threshold is met with either of the following:
      i. Participant does not walk but walking is indicated in the future or Participant does not walk and walking is not indicated in the future; or
      ii. Participant requires a cane or walker during all mobility activities; or
      iii. Participant uses a wheelchair or scooter as their primary mechanism for mobility; or
      iv. Participant requires, at minimum, partial moderate assistance to walk (once standing) 10 feet indoors; or
      v. Participant requires, at minimum, supervision or touching assistance to walk (once standing) 150 feet indoors; or
      vi. Participant requires, at minimum, supervision or touching assistance to walk 10 feet outside of the home; or
      vii. Participant requires, at minimum, supervision or touching assistance to walk 150 feet outside of the home.
   b. Transferring threshold is met with either of the following:
      i. Participant requires use of a cane or walker during all transfer activities; or
      ii. Participant requires, at minimum, partial/moderate assistance for the ability to roll left and right: from lying on back to left and right side, and return to lying on back on the bed; or
      iii. Participant requires, at minimum, partial/moderate assistance for the ability to complete a sit to stand transfer: safely come to a standing position from sitting in a chair or on the side of the bed.
   c. Bathing threshold is met with the following:
      i. Participant requires, at minimum, partial/moderate assistance for the ability to shower/bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower
   d. Dressing threshold is met with either of the following:
      i. Participant requires, at minimum, partial/moderate assistance with upper body dressing; or
      ii. Participant requires, at minimum, partial/moderate assistance with lower body dressing; or
      iii. Participant requires, at minimum, partial/moderate assistance with putting on/taking off footwear.
   e. Toileting threshold is met with either of the following:
      i. Participant requires, at minimum, partial/moderate assistance with toilet hygiene~~transfers~~; or

ii. Participant requires, at minimum, partial/moderate assistance with toilet transfers; or
iii. Participant requires, at minimum, partial/moderate assistance with menses care; or
iv. Participant requires assistance with managing *equipment* related to bladder incontinence; or
v. Participant is currently using a bladder program to manage participant's bladder continence; or
vi. Participant requires assistance with managing *equipment* related to bowel incontinence; or
vii. Participant is currently using a bowel program to manage the participant's bowel continence.

f. Eating threshold is met with either of the following:
i. Participant requires, at minimum, partial/moderate assistance for eating; or
ii. Participant requires, at minimum, partial/moderate assistance for tube feeding.

g. Health Condition threshold is met with the following:
i. Participant has a diagnosis of paralysis; or
ii. A missing limb.

2. ~~**NF-LOC 4+ eligibility**~~**B ~~behavior~~** criteria thresholds are as follows:

a. Behavior threshold area one is as follows:
i. Participant's behavior status previously or currently requires interventions or presents symptoms for Injury to Self, Physical Aggression or Property Destruction; and
ii. One or more of the following are met:
1. Cueing frequency, at minimum, is required more than once per month and up to weekly; or
2. Physical intervention frequency, at minimum, is required more than once per month up to weekly; or
3. Planned intervention frequency, at minimum, is required less than monthly up to once per month.

b. Behavior criteria threshold area two is as follows:
i. Participant's behavior status for Verbal Aggression currently requires interventions or presents symptoms for this behavior; and
ii. Participant presents threat(s) to own or other's safety; and
iii. One or more of the following are met:
1. Cueing frequency, at minimum, is required more than once per month and up to weekly; or
2. Physical intervention frequency, at minimum, is required more than once per month up to weekly; or
3. Planned intervention frequency, at minimum, is required less than monthly up to once per month.

c. Behavior criteria threshold area three is as follows:
i. Injurious to Self, property destruction, physical aggression, or verbal aggression behavior status

currently requires intervention and/or displays symptoms and

ii. Likelihood behavior would occur and/or escalate if HCBS services were withdrawn is likely or highly likely.

3. ~~NF-LOC 4+ eligibility~~ Memory and Cognition criteria thresholds are as follows:
   a. Participant has a Level of Impairment of moderately or higher in at least one area (Memory, Attention, Problem Solving, Planning, or Judgment); or
   b. Participant has a level of impairment of mildly or higher in at least two areas (Problem Solving, Planning, Judgment).
4. ~~NF-LOC 4+ eligibility~~ Sensory and Communication criteria threshold is as follows:
   a. Participant frequently exhibits difficulty expressing needs and/or ideas with individuals they are familiar with; or
   ~~a.~~ Participant rarely or never expresses themself or is very difficult to understand.
   b.

2. Nursing Facility Level of Care Eligibility Criteria for individuals zero to three (0-3) years of age
   a. Participants zero to three (0-3) years of age must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.B.2, according to age, ~~Section XXXX~~ to be determined eligible for Long-Term Services and Supports.
      i. Eligibility Criteria
         1. The participant must meet the criteria threshold for two or more Activities of Daily Living, based on participant age.
         2. If the participant meets one or more of the two required ADL thresholds by selecting only "Other Concerns," a second level review is required to determine eligibility.
         3. Participants may also meet LOC using the behavior criteria for adults in Section 8.401~~.XXX.~~.16.B.1.ii.2.
      ii. Activities of Daily Living thresholds by age 0-5 months
         1. Bathing:
            a. Needs adaptive equipment, or
            b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., or
            c. Other concerns that may affect the amount of support the child needs and
            d. at least one of the bathing impairments above is expected to last for at least one year from the date of assessment.
         2. Dressing:
            a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., or
            b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., or
            c. Other concerns that may affect the amount of support the child needs and
            d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
         3. Eating:
            a. Requires more than one hour per feeding, or
            b. Receives tube feedings or TPN, or

c. Requires more than three hours per day for feeding or eating, or
d. Other concerns that may affect the amount of support the child needs and
e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

iii. Activities of Daily Living thresholds by age 6-11 months

1. Bathing:
   a. Needs adaptive equipment, or
   b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
   c. Other concerns that may affect the amount of support the child needs AND
   d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
2. Dressing:
   a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
   b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
   c. Other concerns that may affect the amount of support the child needs AND
   d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
3. Eating:
   a. Requires more than one hour per feeding, OR
   b. Receives tube feedings or TPN, OR
   c. Requires more than three hours per day for feeding or eating, OR
   d. Other concerns that may affect the amount of support the child needs AND
   e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
4. Mobility:
   a. Unable to maintain a sitting position when placed, OR
   b. Unable to move self by rolling, crawling, or creeping, OR
   c. Other concerns that may affect the amount of support the child needs AND
   d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

iv. Activities of Daily Living thresholds by age 12-17 months

1. Bathing:
   a. Needs adaptive equipment, OR
   b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
   c. becomes agitated requiring alternative bathing methods OR
   d. Other concerns that may affect the amount of support the child needs AND
   e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
2. Dressing:
   a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR

b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
c. Other concerns that may affect the amount of support the child needs AND
d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:
a. Requires more than one hour per feeding, OR
b. Receives tube feedings or TPN, OR
c. Requires more than three hours per day for feeding or eating, OR
d. Other concerns that may affect the amount of support the child needs AND
e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:
a. Unable to sit alone, OR
b. Requires a stander or someone to support the child's weight in a standing position, OR
c. Unable to crawl or creep, OR
d. Other concerns that may affect the amount of support the child needs AND
e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

v. Activities of Daily Living thresholds by age 18-23 months

1. Bathing:
a. Needs adaptive equipment, OR
b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND
d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:
a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR
c. Other concerns that may affect the amount of support the child needs AND
d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:
a. Receives tube feedings or TPN, OR
b. Requires more than three hours per day for feeding or eating, OR
c. Other concerns that may affect the amount of support the child needs AND
d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

a. Requires a stander or someone to support the child's weight in a standing position, OR
b. Uses a wheelchair or other mobility device not including a single cane, OR
c. Unable to take steps holding on to furniture, OR
d. other concerns that may affect the amount of support the child needs AND
e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

vi. Activities of Daily Living thresholds by age 24-35 months

1. Bathing:
   a. Needs adaptive equipment, OR
   b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
   c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND
   d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
2. Dressing:
   a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
   b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR
   c. Unable to pull hats, socks, and mittens, OR
   d. Other concerns that may affect the amount of support the child needs AND
   e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
3. Eating:
   a. Receives tube feedings or TPN, OR
   b. Requires more than three hours per day for feeding or eating, OR
   c. Cannot pick up appropriate foods with hands and bring them to his/her mouth, OR
   d. Other concerns that may affect the amount of support the child needs AND
   e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
4. Mobility:
   a. Requires a stander or someone to support the child's weight in a standing position, OR
   b. Does not walk or needs physical help to walk, OR
   c. Uses a wheelchair or other mobility device not including a single cane, OR
   d. Other concerns that may affect the amount of support the child needs AND
   e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
5. Transfers:
   a. Requires transfer assistance due to physical or cognitive deficits, OR

b. Other concerns that may affect the amount of support the child needs AND
c. at least one of the impairments above is expected to last for at least one year from the date of assessment.

vii. Activities of Daily Living thresholds by age 36-47 months

1. Bathing:
   a. Needs adaptive equipment, OR
   b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
   c. Is combative during bathing (e.g., flails, takes two caregivers to accomplish task), OR
   d. Other concerns that may affect the amount of support the child needs AND
   e. at least one of the impairments above is expected to last for at least one year from the date of assessment.
2. Grooming:
   a. Is combative during grooming (e.g., flails, clamps mouth shut, takes two caregivers to accomplish task), OR
   b. Has physical limitations that prevent completing the task (e.g. limited range of motion, unable to grasp brush), OR
   c. Other concerns that may affect the amount of support the child needs AND
   d. at least one of the impairments above is expected to last for at least one year from the date of assessment.
3. Dressing:
   a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
   b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
   c. Is combative during dressing (e.g., flails, resists efforts to put clothes on, takes two caregivers to accomplish task), OR
   d. Does not or cannot assist with dressing by helping to place arms in sleeves or legs into pants, OR
   e. Unable to undress self independently, OR
   f. Other concerns that may affect the amount of support the child needs AND
   g. at least one of the impairments above is expected to last for at least one year from the date of assessment.
4. Eating:
   a. Is combative while eating (e.g., flails, throws food so will not have to eat, takes two caregivers to accomplish task), OR
   b. Receives tube feedings or TPN, OR
   c. Requires more than three hours per day for feeding or eating, OR
   d. Needs to be fed by another individual, OR
   e. Needs one-on-one monitoring to prevent choking, aspiration, or other serious complications, OR
   f. Other concerns that may affect the amount of support the child needs AND
   g. at least one of the impairments above is expected to last for at least one year from the date of assessment.
5. Toileting:
   a. Is combative during toileting (e.g., flails, takes two caregivers to accomplish task), OR
   b. Has no awareness of being wet or soiled, OR

c. Requires caregiver assistance to be placed onto the toilet/potty chair, OR
d. Does not use toilet/potty chair when placed there by a caregiver, OR
e. Other concerns that may affect the amount of support the child needs AND
f. at least one of the impairments above is expected to last for at least one year from the date of assessment.

6. Mobility:
a. Does not walk or needs physical help to walk, OR
b. Uses a wheelchair or other mobility device not including a single cane, OR
c. Other concerns that may affect the amount of support the child needs AND
d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

7. Transfers:
a. Needs physical help with transfers, OR
b. Uses a mechanical lift, OR
c. Other concerns that may affect the amount of support the child needs AND
d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Nursing Facility Level of Care Eligibility Alternative Criteria
a. Alternative ADL criteria shall be applicable for participants four (4) and older whose level of support for Activities of Daily Living (Mobility, Transferring, Bathing, Dressing Toileting, Eating) has varied over the last 30 days; and
i. Meet the following alternate ADL thresholds in two or more ADL areas (Mobility, Transferring, Bathing, Dressing Toileting, Eating):
1. Participant's performance level is, at minimum, scored at partial/moderate assistance or higher AND
2. Frequency of enhanced support is scored, at minimum, 1-2 times per month in the past 30 days, or
ii. Meets at least one Nursing Facility Level of Care ADL (Mobility, Transferring, Bathing, Dressing Toileting, Eating) thresholds as required at 10 CCR 2505-10 Section 8.401.16.B.1.a.ii.1., ~~[insert citation NF-LOC 4+];~~ and
iii. Meets the alternate ADL thresholds in at least one ADL area.
b. If the alternative LOC criteria is used, a second level review is required to determine eligibility.

4. Hospital Level of Care Eligibility Criteria
a. Complementary and Integrative Health (CIH), Brain Injury (BI), Children's Home and Community Based Services (CHCBS), and Children with Life Limiting Illness (CLLI) have a Hospital Level of Care (H-LOC)).
i. CIH and BI may be met through NF-LOC and H-LOC Criteria.
ii. CHCBS and CLLI have distinct criteria.
b. H-LOC for SCI and BI participants must meet in at least one of the following areas:
i. Transfers:
1. Participant has met Nursing Facility Level of Care (NF-LOC) AND
2. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair Transfers-the ability to safely transfer to and from a bed to a chair.
ii. Bathing:
1. Participant has met NF-LOC AND
2. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self-the ability to bathe self in shower or

tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.

iii. Dressing:
1. Participant has met NF-LOC AND
2. Participant's performance level is, at minimum, substantial/maximum assistance for Upper Body Dressing-the ability to put on and remove shirt or pajama top. Includes buttoning, if applicable OR
3. Participant's performance level is, at minimum, substantial/maximum for Lower Body Dressing-the ability to dress and undress below the waist, including fasteners. Does not include footwear.

iv. Toileting:
1. Participant has met NF-LOC AND
2. Participant's performance level is, at minimum, substantial/maximum assist for Toilet hygiene-the ability to maintain perineal/feminine hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment. OR
3. Participant's performance level is, at minimum, substantial/maximum assistance for Toilet Transfers: the ability to safely get on and off a toilet or commode.

v. Eating:
1. Participant has met NF-LOC AND
2. Participant's performance level is, at minimum, substantial/maximum assistance for Eating - the ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. This includes modified food consistency OR
3. Participant's performance level is, at minimum, substantial/maximum assistance for Tube feeding - the ability to manage all equipment/supplies related to obtaining nutrition.

c. H-LOC for CLLI participants must meet in at least ONE of the following threshold areas:
i. Threshold Area 1:
1. Participant has met NF-LOC or Alt-LOC AND
2. Participant has been diagnosed with a life limiting illness by a medical professional.

ii. Threshold Area 2:
1. Participant has NOT met NF-LOC or Alt-LOC AND
2. Participant has been diagnosed with a life limiting illness by a medical professional AND
3. ONE of the following conditions apply to the participant:
a. Technologically dependent for life or health-sustaining functions OR
b. Complex medication regimen or medical interventions to maintain or improve health status, OR
c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk
4. A second-level review is required to verify whether the conditions documented justify a H-LOC.

d. H-LOC for CHCBS participants must meet in at least ONE of the following threshold areas:
i. Threshold Area 1:
1. Transferring:
a. Participant met NF-LOC or Alt-LOC AND
b. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair

Transfer -The ability to safely transfer to and from a bed to a chair.

2. Bathing:
    a. Participant has met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self- The ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
3. Dressing:
    a. Participant has met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for Upper Body Dressing - The ability to put on and remove shirt or pajama top. Includes buttoning, if applicable OR
    c. Participant's performance level is, at minimum, substantial/maximum assistance for Lower Body Dressing - The ability to dress and undress below the waist, including fasteners. Does not include footwear.
4. Toileting:
    a. Participant has met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for toilet hygiene-The ability to maintain perineal/feminine hygiene, adjust clothes before and after using toilet, commode, bedpan, urinal. If managing ostomy, include wiping opening but not managing equipment. OR
    c. Participant's performance level is, at minimum, substantial/maximum assistance for Toilet Transfer: The ability to safely get on and off a toilet or commode.
5. Eating:
    a. Participant has met NF-LOC or Alt-LOC AND
    b. Participant's performance level is, at minimum, substantial/maximum assistance for Eating - The ability to use suitable utensils to bring food to the mouth and swallow food once the meal is presented on a table/tray. This includes modified food consistency OR
    c. Participant's performance level is, at minimum, substantial/maximum assistance for Tube feeding - The ability to manage all equipment/supplies related to obtaining nutrition.

ii. Threshold Area 2:
1. Participant has not met NF-LOC or Alt-LOC AND
2. One of the following conditions apply to the participant:
    a. Technologically dependent for life or health-sustaining functions, OR
    b. Complex medication regimen or medical interventions to maintain or improve health status, OR
    c. Need of ongoing assessment or intervention to prevent serious deterioration of health status or medical complications that place life, health or development at risk.
3. A second-level review is required to verify whether the conditions documented justify a H-LOC.

8.402.10 ADMISSION PROCEDURES FOR CLASS I NURSING FACILITIES

.11 The URC/Single Entry Pointy (SEP) shall certify a client for nursing facility admission after a client is determined to meet the lfunctional level of care and passes the PASRR Level 1 screen requirements for long-term care. However, the URC/SEP shall not certify a client for nursing facility admission unless the client has been advised of long-term care options including Home and Community Based Services as an alternative to nursing facility care.

.12 The medically licensed provider must complete the necessary documentation prior to the client's admission.

.13 The ~~ULTC 100.2~~ Level of Care Eligibility Determination Screen and other transfer documents concerning medical information as applicable, must accompany the client to the facility.

.14 The nursing facility or hospital shall notify the URC/SEP agency of the pending admission by faxing or emailing the appropriate form. The date the form is received by the URC/SEP agency shall be the effective start date if the client meets all eligibility requirements for Medicaid long-term care services.

.15 The URC/SEP case manager shall determine the client's length of stay using the appropriate form developed by the Department. The length of stay shall be less than a year, one year or indefinite. All indefinite lengths of stay shall be approved by the case manager's supervisor.

.16 The URC/SEP agency shall notify in writing all appropriate parties of the initial length of stay assigned. Appropriate parties shall include, but are not limited to, the client or the client's designated representative, the attending physician, the nursing facility, the Fiscal Agent, the appropriate County Department of Social/Human Services, the appropriate community agency, and for clients within the developmentally disabled or mentally ill target groups, the Department of Human Services or its designee.

.17 The nursing facility shall be responsible for tracking the length of stay end date so that a timely R~~r~~eassessment is completed by the URC/SEP.

.18 The URC will determine the start date for nursing facility services. The start date of eligibility for nursing facility services shall not precede the date that all the requirements (functional level of care, financial eligibility, disability determination) have been met.

8.402.30 ADMISSION PROCEDURES FOR HOME AND COMMUNITY BASED SERVICES

.31 When the client meets the level of care requirements for long-term care, is currently living in the community, and could possibly be maintained in the community, the URC/SEP agency shall immediately communicate with the appropriate community agency, according to the URC/SEP agency-determined target group, for an evaluation for alternative services. The URC/SEP agency shall forward a copy of the worksheet plus a State prescribed disposition form to the agency either immediately after the telephone referral, or in place of the telephone referral.

.32 Based upon information obtained in the pre-admission review, the URC/SEP case manager shall make the referral to the appropriate community agency based on the client's target group designation, as defined below:

A. Individuals determined by the URC/SEP agency to be in the Mentally Ill target group, regardless of source, shall be referred to the appropriate community mental health center or clinic.

B. Individuals determined by the URC to be in the Functionally Impaired Elderly target group, or the Physically Disabled or Blind target group shall be referred to the appropriate Single Entry Point Agency for evaluation for Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD).

C. Individuals identified by the URC to be in the Developmentally Disabled target group shall be referred to the appropriate Community Centered Board.

D. Individuals determined by the URC to be in the Persons Living with AIDS target group shall be referred to the appropriate Single Entry Point Agency for evaluation for HCBS-EBD.

E. The URC shall notify any clients referred to case management agencies of the referral, the provisions of the program, and shall inform them of the complaint procedures.

.33 The case management agency or community mental health center or clinic shall complete an evaluation for alternative services within five (5) working days of the referral by the URC.

.34 Single Entry Point Agencies shall conduct the evaluation in accordance with the procedures at 10 CCR 2505-10 Sections 8.486 and 8.390.

.35 Community Centered Boards shall conduct the evaluation in accordance with procedures at 10 CCR 2505-10 Section 8.500.

.36 Community mental health centers and clinics shall conduct the evaluation in accordance with Standards/Rules and Regulations for Mental Health 2 CCR 502-1 Section 21.940 and Rules and Regulations Concerning Care and Treatment of the Mentally Ill, 2 CCR 502-1 Section 21.280.

.37 If the community agency develops an approved plan for long-term care services, the URC will approve one (1) certification for long-term care services and the client shall be placed in alternative services. Following receipt of the fully completed ~~ULTC~~ LOC Screen the URC will review the information submitted and make a certification decision. If certification is approved, the URC shall assign an initial length of stay for alternative services. If certification is denied, the decision of the URC may be appealed in accordance with 10 CCR 2505-10 Section 8.057 through 8.057.8.

.38 If the appropriate community agency cannot develop an approved plan for long-term care services, the URC will approve certification for long-term care services and utilize the procedure for nursing home admissions described previously in this section.

8.402.40 ADMISSION TO NURSING FACILITY WITH REFERRAL FOR COMMUNITY SERVICES

.41 When a client who meets the level of care requirements for long-term care is currently hospitalized but could possibly be maintained in the community, certification shall be issued. The client may be placed in the nursing facility, given a short length of stay and immediately referred to the appropriate community agency for evaluation for alternative services in accordance with the procedure described in the preceding section.

8.402.50 DENIALS (ALL TARGET GROUPS)

.51 When, based on the pre-admission review, the client does not meet the level of care requirements for skilled and maintenance services, certification shall not be issued. The client shall be notified in writing of the denial.

.52 If the URC denied long-term care certification based upon the information on the ~~ULTC 100.2,~~LOC Screen written notification of the denial shall be sent to the client, the attending physician, and the referral source (hospital, nursing facility, etc.).

If the information provided on the ~~ULTC 100.2~~LOC Screen indicates the client does meet the level of care requirements, the URC shall proceed with the admission and/or referral procedures described above.

.53 Denials of certification for long-term care may be appealed in accordance with the procedures described at 10 CCR 2505-10 Section 8.057 through 8.057.8.

.54 Denial of designation into a specifically requested target group may also be appealed in accordance with 10 CCR 2505-10 Section 8.057 through 8.057.8.

8.405.2 ADMISSION PROCEDURES FOR ICF/IID FACILITIES

.21 When the client, based on CCB review, cannot reasonably be expected to make use of ICF/IID or HCBS-DD~~-~~, the CCB shall notify the physician and the URC. The physician and the URC/Community Center Board (URC/CCB) agency then proceed with the SNF or ICF placement under the provisions set forth at 10 CCR 2505-10 Section 8.402.10.~~Section.~~

22 When the CCB determines that a client is not appropriately served through HCBS-DD services or, in accordance with provisions permitting the client or the client's designated representative to choose institutional services as an alternative to HCBS-DD services, the CCB shall recommend placement to an ICF/IID facility. The CCB shall seek the approval of the client's physician. The physician shall notify the URC/CCB agency of the proposed placement. Based on information provided by the CCB and the client's physician, the URC/SEP agency may certify the client for long-term care prior to ICF/IID admission.

.23 The URC/CCB agency shall advise the County Department of Social/Human Services of the certification to enable the County Department staff to assist with the placement arrangements.

24. The ~~ULTC 100.2~~LOC Screen and other transfer documents concerning medical information as applicable must accompany the client to the facility.

.25 Following receipt of the fully completed ~~ULTC 100.2~~LOC Screen, the URC/CCB shall review the information and make a final certification decision. If certification is approved, the URC/CCB shall assign an initial length of stay according to 10 CCR 2505-10 Section 8.404.1. If certification is denied, the decision of the URC/CCB may be appealed in accordance with the appeals process at 10 CCR 2505-10 Section 8.057.

8.405.30 ADMISSION PROCEDURES FOR HCBS-DD

.31 CCBs may evaluate clients for HCBS-DD services if, in the judgment of the CCB, such services represent a viable alternative to SNF, ICF, or ICF/IID services. The evaluation shall be carried out in accordance with the procedures set forth in 2 CCR Section 503-1.

.32 If the CCB recommends HCBS-DD placement, then the URC/CCB will approve certification for services for the developmentally disabled at the level of care recommended by the CCB. The client will be placed in alternative service.

Following receipt of the completed ~~ULTC 100.2~~ LOC Screen and any other supporting information, the URC/CCB will review the information and make a final certification determination.

If certification is approved, the URC/CCB shall assign an initial length of stay for HCBS-DD services.

If certification is denied, the decision of the URC/CCB may be appealed in accordance with Section 8.057.

8.405.4 CONTINUED STAY REVIEW PROCEDURES; SERVICES FOR INDIVIDUALS WITH INTELLECTUAL AND DEVELOPMENTAL DISABILITIES

.41 Continued Stay Reviews shall be conducted by the URC for all intellectually and clients in ICF/IID services, in accordance with 42 CFR Part 456 Subpart F.

.42 As a result of the Continued Stay Review, the URC shall renew or deny certification.

8.470 HOSPITAL BACK UP LEVEL OF CARE

8.470.1 DEFINITION

The Hospital Back Up (HBU) Program is a long-term care program that provides hospital level care in a skilled nursing facility (SNF) setting. Clients who no longer need acute care in a hospital but require 24-hour monitoring and life sustaining technology for complex medical conditions may apply to receive long-term care in an HBU certified facility.

8.470.2 PROGRAM ELIGIBILITY

In order to be eligible for the hospital back up program, a client shall:

1. Meet ~~ULTC 100.2~~ LOC Screen level of care eligibility for long term care as determined by the appropriate single-entry point agency (SEP); and

2. Meet the client clinical eligibility requirements as identified in 10 CCR 2505-10 Section 8.470.3 as determined by the State Utilization Review Contractor (SURC);

3. Be medically stable in a chronically acute state;

4. Be in a hospital or **long-term** acute care facility prior to approval; or

5. Be in An HBU skilled facility under a qualified Medicare stay

8.470.3 CLIENT CLINICAL ELIGIBILITY

All prospective clients must meet the requirements of at least one of the following three categories in the clinical eligibility criteria in to participate in the Hospital Back Up Program:

1. Complex Wound as outlined in 8.470.3.A;

2. Ventilator Dependent as outlined in 8.470.3.B; or

3. Medically Complex as outlined in 8.470.3.C

8.470.3.A. Complex Wound Care means the client must meet all the following criteria:

1. At least one stage 3-4 pressure ulcer or injury, second- or third-degree burns, or a Medicare “pressure relieving support surface” rating of 2-3 to heal or prevent skin breakdown;

2. Documentation of extensive skin loss, active infection, compromised blood flow, sloughing, tunneling, fistulae, or undermining of surrounding tissue or necrosis with potential extension to underlying fascia;

3. Documentation of nutritional deficiencies including:

a. Identification of diagnostic markers and specific nutritional deficiencies;

b. A plan of treatment to address underlying conditions such as malabsorption or excess loss of nutrients; and

c. The modality of supplementation: oral, intramuscular or intravenous, and

4. Documentation of at least one of the following:

a. Full thickness wound graft surgery;

b. Negative pressure wound therapy, electromagnetic therapy, compression therapy or hyperbaric oxygen therapy;

c. Debridement (surgical, mechanical, chemical, autolytic or larval biotherapy); or

d. Advanced dressings with growth factors, silver/alginates, hyaluronic acid or collagens.

8.470.3.B. Ventilator dependent clients must meet all requirements in at least one of the following three subsections:

1. If the client is actively weaning off the ventilator, the client must:

a. Require direct assessment and monitoring of weaning at least 2 hours each day by a respiratory therapist;

b. Require supportive care at least 12 hours a day by a respiratory therapist or pulmonary trained nurse (under the supervision of a respiratory therapist) for ventilator management;

c. Require physical therapy, occupational therapy, speech therapy, or a combination of such therapies at least 5 days per week;

d. Have documented rehabilitation potential and a plan of treatment by a respiratory therapist in place at the time of the HBU referral; and

e. Have clinical documentation including (but not limited to) arterial bloods gas labs, standard breathing and capping trial results, pulmonary function tests, capnography, respiratory and speech language pathology progress notes and any other documentation to support active weaning efforts.

2. If active weaning fails, the client must:

a. Have documentation of failed weaning efforts by a respiratory therapist and a plan of treatment with prognosis for liberation from a respiratory therapist or pulmonologist;

b. Require continuous ventilator support at least 8 hours per day and skilled respiratory care at least 3.5 hours per day to remain medically stable;

c. Have difficulty communicating needs to others and/or requires assistance from skilled staff to set up adaptive equipment, or is unable to speak due to physical or cognitive impairment; and

d. ~~Have one of the following scores on the ULTC 100.2 assessment form:~~

i. ~~A score of at least 2 in a minimum of two activities of daily living (ADL); or~~

ii. ~~A score of at least 2 in one category of supervision.~~Meet Nursing Facility Level of Care as determined by the LOC Screen.

3. If the client has been successfully weaned off the ventilator and is actively working to reduce oxygen levels and/or removal of the tracheostomy tube, the client must:

a. ~~Have one of the following scores on the ULTC 100.2 assessment form:~~

i. ~~A score of at least 2 in a minimum of two activities of daily living (ADL); or~~

ii. ~~A score of at least 2 in one category of supervision;~~Meet Nursing Facility Level of Care as determined by the LOC Screen ~~eligibility~~.

b. Have documentation from a respiratory therapist and pulmonologist verifying the client has been weaned off active ventilation and/or is working to have a further reduction to standard home oxygen levels (1-6 LPM);

c. Require the support of a respiratory therapist under the supervision of a pulmonologist at least 3.5 hours a day to remain medically stable and/or show progress toward decannulation; and

d. Be capable of:

i. Communicating needs and following simple commands; and/or

ii. Managing basic tracheostomy care or respiratory hygiene.

8.470.3.C. Medically complex clients include ventilator dependent individuals and individuals successfully weaned off the ventilator with co-morbidities. To be deemed medically complex under the HBU program, clients must meet all of the following requirements:

1. ~~Have a score of at least 2 in a minimum of 2 activities of daily living or a score of at least 2 in one category of supervision on the ULTC 100.2 assessment form;~~Meet Nursing Facility Level of care as determined by the LOC Screen ~~eligibility~~.

2. Have difficulty communicating needs to others and requires assistance from skilled staff to set up adaptive equipment or be unable to seek assistance due to cognitive or physical impairment;

3. Require on-site assessment by a rounding physician or subspecialist at least once a week to remain stable;

4. Require artificial nourishment to be administered by registered nurse, including but not limited to a gastro-intestinal tube (G tube or NG tube) and/or jejunostomy tube (J tube), total parenteral nutrition (TPN) with or without lipids, or central line in active use for fluids or medication (excluding TPN);

5. Require documentation of rehabilitative therapies including physical, occupational and speech language therapy, and/or skilled nursing notes documenting assessment,

monitoring and intervention at a greater frequency than is provided in a class 1 nursing facility;

6. Require suctioning and/or airway maintenance at least every four hours by a respiratory therapist or pulmonary trained nurse under the supervision of a respiratory therapist for ventilator dependent clients or clients with a tracheostomy;

7. Physician documentation of life limiting disease which will require ongoing care in the HBU skilled nursing facility; and

8. Documentation of quarterly updates to plan of treatment, prognosis, status evaluation, care conference and/or palliative consult.

8.470.4 INITIAL ELIGIBILITY DETERMINATION AND ADMISSION

8.470.4.A. SURC Review for Initial Hospital Eligibility Determination

Upon receipt of the completed Hospital Back Up Application, patient choice form and the ~~ULTC 100.2~~LOC Screen ~~assessment~~, the SURC nurse reviewer shall:

1. Conduct a program eligibility review to determine whether the client meets the hospital back up level of care criteria and may successfully be treated in the requested skilled nursing facility;

2. Review the ~~ULTC 100.2~~ LOC Screen ~~assessment~~ by the SEP;

3. Provide initial assessment for secondary review by SURC physician reviewer;

4. Request additional medical documentation deemed necessary to make such determination;

5. Notify the Department of final eligibility determination;

6. Document all final physician determinations and maintain these records for the Department;

7. Issue a denial letter to the Department and referring provider within 10 business days of determination if the prospective client does not meet HBU level of care;

8. Notify the Department in writing within 10 days of determination if the SURC determines the Client meets HBU level of care; and

9. Issue a 90-day initial length of stay letter to the client and skilled nursing facility within 24 hours of approval from the Department, in accordance with the criteria specified below in subsection 8.470.4.C.

8.470.5.D. Annual Continued Stay Review

1. The SURC nurse shall conduct an on-site continued stay review for each hospital back up client 15 days prior to the end of the client's currently approved annual stay.

2. The SURC may conduct an unscheduled on-site review at any time during the length of stay for client clinical change of condition or at the request of the Department.

3. The SURC shall observe the same review criteria and determination requirements as outlined in 8.470.4.C of the 90-day initial eligibility criteria for determining ongoing annual eligibility.

4. A new LOC Screen ~~ULTC 100.2 assessment~~ must be completed annually by the SEP agency. The nursing facility shall provide a current ~~ULTC 100.2~~ LOC Screen to the SURC as part of the annual eligibility assessment.

5. If the SURC determines that the client no longer meets the hospital back up level of care criteria or the nursing facility fails to provide documentation to support level of care and services provided, the SURC shall notify the Department within 24 hours of completion of the eligibility review.

6. The SURC shall observe the same determination and notification requirements as outlined in 8.470.4.C.6-7 of the 90-day initial eligibility criteria for determining ongoing annual eligibility.

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

8.485.50 GENERAL DEFINITIONS

A. Agency shall be defined as any public or private entity operating in a for-profit or nonprofit capacity, with a defined administrative and organizational structure. Any sub-unit of the agency that is not geographically close enough to share administration and supervision on a frequent and adequate basis shall be considered a separate agency for purposes of certification and contracts.

B. Assessment shall be as defined at Section 8.390.1.~~DEFINITIONS.B~~.

C. Case Management shall be as defined at Section 8.390.1. ~~C,~~ including the calculation of client payment and the determination of individual cost-effectiveness.

D. Categorically eligible shall be defined in the HCBS-EBD program as any client eligible for medical assistance (Medicaid), or for a combination of financial and medical assistance; and who retains eligibility for medical assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, but not for medical assistance, or persons who are eligible for HCBS-EBD as three hundred percent eligible persons, as defined at Section 8.485.50.T.

E. Congregate facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

F. Uncertified Congregate Facility shall be a facility as defined at Section 8.485.50.E. that is not certified as an Alternative Care Facility. See Section 8.495.1.

G. Continued Stay Review shall be a Reassessment as defined at 10 CCR 2505-10 Sections 8.402.60 and 8.390.1. ~~DEFINITIONS.R.~~

H. Corrective Action Plan shall be as defined at Section 8.390.1. ~~DEFINITIONSD.~~

I. Cost containment shall be defined as the determination that, on an individual client basis, the cost of providing care in the community is less than the cost of providing care in an institutional setting.

The cost of providing care in the community shall include the cost of providing HCBS-EBD services and long-term home health services.

J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-EBD. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected HCBS-EBD.

K. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized.

L. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long-term care, who would require nursing facility or hospital care without the provision of HCBS-EBD, and for whom HCBS-EBD services can be provided at no more than the cost of nursing facility or hospital care.

M. Intake/Screening/Referral shall be as defined 10 CCR 2505-10 Section 8.390.1.K~~M~~.

N. Level of C~~c~~are S~~s~~creen shall be as defined as an assessment conducted in accordance with 10 CCR 2505-10 Section 8.401.

O. Provider agency shall be defined as an agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at Section 8.485.40. A Single Entry Point Agency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria in Sections 8.390-8.393 are met.

P. Reassessment shall be as defined at 10 CCR 2505-10 Section 8.390.1.~~R.DEFINITIONS.~~

Q. ~~Service Plan~~Person-Centered Support Plan means as defined in 10 CCR 2505-10 Section 8.390.1. ~~DEFINITIONS. means the written document that identifies approved services, including Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a client to remain safely in the community and developed in accordance with the Department rules, including the funding source, frequency, amount and provider of each service, and written on a State-prescribed Long-term Care Plan form.~~

R. Single Entry Point Agency shall be defined as an organization described at Section 8.390.1.U.

S. The Department shall be defined described in 8.390.1.F.

T. Three hundred percent (300%) eligible shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level; and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for thirty consecutive days.

8.485.60 ELIGIBLE PERSONS

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

A. Financial Eligibility

Clients shall meet the eligibility criteria as stated at 10 CCR 2505-10 Section 8.100. Clients must also meet criteria specified in the Colorado Department of Human Services Income Maintenance Staff Manual, 9 CCR 2503-1, (2018).

B. Level of Care and Target Group

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

1. Determined by the Single Entry Point Agency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult; and

2. Determined by a ~~formal level of care assessment~~LOC Screen to require the Nursing Facility Level of Care~~level of care available in a nursing facility~~, according to 10 CCR 2505-10 Section 8.401.11 through 8.401.15; or

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

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

C. Receiving HCBS-EBD Services

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

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

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

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

D. Institutional Status

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

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

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

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

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

E. Cost-effectiveness

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

F. Waiting List

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

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

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

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

a. Clients being deinstitutionalized from nursing facilities.

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

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

d. Clients ~~with high ULTC 100.2 sc~~requiring nursing facility level of care and ~~ores~~ who are at risk of imminent nursing facility placement.

8.485.70 START DATE

.71 The start date of eligibility for HCBS-EBD services shall not precede the date that all of the requirements at Section 8.485.60 have been met. The first date for which HCBS-EBD services can be reimbursed shall be the later of any of the following:

A. Financial: The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care: This date is determined by the official ~~URC's stamp and the URC~~ assigned start date on the ~~ULTC 100.2 form~~LOC Screen.

C. Receiving Services: This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept services.

D. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the hospital or nursing facility.

.72 The start date for CTS may precede HCBS-EBD enrollment when a client meets the conditions set forth at Section 8.486.33. The start date for CTS shall be no more than 180 calendar days before a client's discharge from a nursing facility.

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

.91 The Department or its agent shall develop the Prior Authorization Request (PAR) form in compliance with all applicable regulations, and determine whether services requested are (a) consistent with the client's documented medical condition~~, and functional capacity~~ and Level of Care, (b) reasonable in amount, frequency and duration, (c) not duplicative, (d) not services for which the client is receiving funds to purchase, and (e) do not total more than twenty four (24) hours per day of care.

A. The case manager shall submit prior authorization approvals for all HCBS-EBD services to the fiscal agent within one (1) calendar month after the URC's assigned start date and approval of financial eligibility.

B. The Department or its fiscal agent will approve, deny or return for additional information home modification PARs over $1,000 within ten (10) working days of receipt.

.92 When home modifications are denied, in whole or in part, the Single Entry Point Agency shall notify the client or the client's designated representative of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et. seq.

.93 Revisions requested by providers six months or more after the end date shall always be disapproved.

.94 Approval of the PAR by the Department or its agent shall authorize providers of services under the ~~Service Plan~~ PCSP to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon the client's financial eligibility for long-term care medical assistance (Medicaid) on the dates of service; and upon provider's use of correct billing procedures.

.95 Every PAR shall be supported by information on the ~~Service Plan~~PCSP, the ~~ULTC 100.2~~ LOC Screen and written documentation from the income maintenance technician of the client's current monthly income. All units of service requested on the PAR shall be listed on the ~~Service Plan~~ PCSP.

.96 If a PAR is for an Alternative Care Facility client who is 300% eligible, all medical and remedial care requested as deductions shall be listed on the Client Payment form.

.97 The start date on the Prior Authorization Request form shall not precede the start date of eligibility for HCBS-EBD services, according to Section 8.485.70, except for CTS. A TCA may provide CTS up to 180 days prior to nursing facility discharge when authorized by the Single Entry Point Agency. The TCA is eligible for reimbursement beginning on the first day of the client's HCBS-EBD enrollment.

.98 The PAR shall not cover a period longer than the length of stay assigned by the URC.

Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.

8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

8.486.10 HCBS-EBD PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

Single entry point agencies shall comply with single entry point rules at 10 CCR 2505-10 section 8.390, et. seq., governing case management functions, and shall comply with all HCBS-specific requirements in the rest of this section on HCBS-EBD case management functions.

8.486.20 INTAKE

.21 Refer to Section 8.393.2.B for single entry point intake procedures. The intake form shall be completed before a LOC Screen~~n assessment~~ is initiated. The intake form may also be used as a preliminary case plan form when signed by the A~~a~~pplicant, for purposes of establishing a start date.

.22 Based upon information gathered on the intake form, the case manager shall determine the appropriateness of a referral for a ~~comprehensive uniform long-term care client assessment (ULTC-100),~~LOC Screen and shall explain the reasons for the decision on the Intake form. The client shall be informed of the right to request a~~n assessment~~ LOC Screen if the client disagrees with the case manager's decision.

8.486.30 ~~ASSESSMENT~~LEVEL OF CARE ELIGIBILITY DETERMINATION

.31 If the client is being discharged from a hospital or other institutional setting, the discharge planner shall contact the URC/SEP agency for assessment by emailing or faxing the initial intake and screening form.

.32 The URC/SEP case manager shall view and document the current Personal Care Boarding Home license, if the client lives, or plans to live, in a congregate facility as defined at Section 8.485.50, in order to ensure compliance with Section 8.485.20.

.33 A SEP may determine that a client is eligible for HCBS-EBD while the client resides in a nursing facility when the client meets the eligibility criteria as established at Section 8.400, et seq., the .client requests CTS and the SEP includes CTS in the client's long-term care plan. If the client has been evaluated with the ~~ULTC 100.2~~ LOC Screen and has been assigned a length of stay that has not lapsed, the SEP shall not conduct another review when CTS is requested.

8.486.40 HCBS-EBD DENIALS

.41 If a client is determined, at any point in the Level of Care Eligibility Determination ~~assessment~~ process, to be ineligible for HCBS-EBD according to any of the requirements at Section 8.485.60, the client or the client's designated representative shall be notified of the denial and the client's appeal rights in accordance with Long-term Care Single Entry Point System regulations at Section 8.393.3.A.

8.486.200 REASSESSMENT

.201 The case manager shall complete a R~~r~~eassessment of each SEP-managed waiver client before the end of the length of stay assigned by the Utilization Review Contractor at the last level of care determination. The case manager shall initiate a R~~r~~eassessment more frequently if required by single entry point regulations at 10 CCR 2505-10 section 8.393.25, or when warranted by significant changes that may affect HCBS-EBD eligibility.

.202 The case manager shall submit a continued stay review PAR, in accordance with requirements at 10 CCR 2505-10 section 8.485.90. For clients who have been denied by the Utilization Review Contractor at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ~~ULTC 100.2~~LOC Screen. Acceptable documentation of an appeal includes: (a) a copy of the request for reconsideration or the request for appeal, signed by the client and sent to the Utilization Review Contractor or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the Utilization Review Contractor or the Office of Administrative Courts to the client; or (c) a copy of the notice of a scheduled court date. Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed~~,~~ and shall not be accepted as a substitute for the approved ~~ULTC 100.2.~~LOC Screen. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.486.300 TERMINATION

.301 In accordance with Long-term Care Single Entry Point System regulations at Section 8.393.28, clients shall be terminated from any SEP-managed waiver whenever they no longer meet one or more of the eligibility requirements at Section 8.485.60. Clients shall also be terminated from the waiver if they die, move out of state or voluntarily withdraw from the waiver.

8.486.400 COMMUNICATION

.401 In addition to any communication requirement specified elsewhere in these rules, the case manager shall be responsible for the following communications:

A. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

B. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent, the case manager shall provide copies to all the HCBS-EBD providers in the care plan.

C. Within five (5) working days of ~~receipt from the URC of the certified ULTC 100.2 form,~~Level of Care Eligibility Determination ~~LOC Screen certification~~ the case manager shall send a copy of the ~~ULTC 100.2 form~~ Level of Care Eligibility Determination the ~~LOC Screen certification~~ to all personal care, and adult day services provider agencies on the care plan and to alternative care facilities listed on the care plan.

D. The case manager shall notify the URC, on a form prescribed by the Department, within thirty (30) calendar days, of the outcome of all non-diversions, as defined at Section 8.485.50.

8.486.500 CASE RECORDING/DOCUMENTATION

.501 Case management documentation shall meet all of the standards found at Sections 8,393.2.H.

10 CCR 2505-10, Section 8.400-499, Appendix A: Age Appropriate Guidelines for the Use of ULTC 100.2 Assessment on Children

These guidelines provide instructions for using the Uniform Long Term Care (ULTC) – 100.2 assessment to assess the needs of children for the following Home and Community-Based Services (HCBS) Waivers: Children's Extensive Support (CES), Children's HCBS (CHCBS), Children's Habilitation Residential Program (CHRP), Children with Life Limiting Illness (CLLI) and Children with Autism (CWA). Each individual and their circumstances must be considered when completing the assessment. Case Managers must score each child according to his/her age and individual needs.

Please consult evidence based resources and references to further your understanding of child development.

A. What is child development?

1. Child development refers to the various stages of physical, biological, social, intellectual and psychological changes that occur from birth through the end of adolescence.

2. Growing process refers to the process of becoming physically larger in size and more mature through natural development.

3. The following are child development categories:

    a. Gross Motor Skill: The ability to coordinate and control large muscles of the body. Some examples of gross motor control are sitting upright, balancing, walking, lifting, kicking and throwing a ball.

    b. Fine Motor Skill: The ability to coordinate small muscles for precise small movements involving the hands, wrists, feet, toes, lips and tongue. Some examples of fine motor control are handwriting, drawing, grasping objects, dressing, cutting and controlling a computer mouse.

    c. Speech and Language: The ability to both understand and use language to communicate thoughts and feelings through speaking, body language and gestures.

    d. Cognitive: The ability to learn, understand, remember, reason, and solve problems.

    e. Social and Emotional: The ability to interact with others, have relationships with family, friends, and teachers, exercise self-control, cooperate and respond to the feelings of others.

B. What are developmental milestones?

1. Developmental milestones refer to abilities achieved by most children by a certain age.

    Milestones are used to gauge how a child is developing. Each milestone is associated with a specific age, however, the age when a developing child actually reaches each milestone may vary.

C. What is the Uniform Long Term Care (ULTC) 100.2 Assessment?

The ULTC 100.2 is an assessment to determine the ~~functional n~~Level of Care ~~eeds~~ of a client by evaluating the client's ability to independently complete Activities of Daily Living (ADLs). ADLs are activities performed in the course of a typical day in a person's life such as: bathing, dressing, toileting,

mobility, transferring, and eating. ADLs also include behavior and memory supervision activities needed for daily life. The ULTC 100.2 is a foundational component of the Person-Centered Support Planning~~service planning~~ process that helps:

1. Determine the appropriate services

2. Determine the care that is necessary to meet clients' needs, and

3. Assist in the selection of long-term care supports and services that meet clients' needs.

The assessment measures what the child is able to do, not what he/she prefers to do. In other words, assess the child's ability to do particular activities, even if he/she doesn't usually do the activity.

Consider age-appropriate behavior when assessing the child's ability to complete any ADL. If the child is not able to complete the ADL due to his or her age, then the child will not score in the ADL. However, if a child needs assistance in completing an ADL that is above and beyond the assistance a typically developing peer would require, then a score above 0 may be warranted.

D. Scoring

The ULTC 100.2 asks you to give the child a score between 0 and 3 based on the child's abilities in eight ADL areas. Scoring is completed as follows:

0 = Independent:

The child requires no greater assistance to successfully complete this task than would a child of similar age and stage that does not have a disability or impairment. The child has age-appropriate independence and reliability in the use of adaptive equipment necessary to complete this task, if needed.

1 = Minimal Assistance:

The child is able to perform all essential components of the activity with some impairment, with or without assistive device within a reasonable amount of time.

A score of 1 indicates the child is able to perform most of the essential components of the activity within a reasonable amount of time and may require:

a. Minimal assistance to successfully complete the task compared to a child of similar age and stage.

b. Minimal assistance with adaptation and assistive device(s)/medical equipment(s).

c. Minimal interventions such as occasional standby assistance, oversight and/or cueing.

2 = Moderate Assistance:

The child is unable to perform most of the essential components of the activity even with assistive device, requires a great deal of supervision or exceeds a reasonable amount of time to perform the activity with or without assistive device.

A score of 2 indicates that the child is unable to perform essential components of the activity due to requiring:

a. Hands-on assistance.

b. Hands-on assistance to use assistive device(s)/medical equipment(s).

c. Interventions such as regular line of sight.

d. Significant prompting or step by step cueing to begin a task and to complete it successfully.

3 = Total Assistance:

The child is totally unable to perform the essential components of the activity and needs extensive assistance.

A score of 3 indicates that the child is unable to perform the essential components of the activity due to requiring (but not limited to):

a. Assistance with complex assistive device(s)/medical equipment(s).

b. Extensive for hands-on assistance.

c. A trained attendant to perform ADLs or prevent complications.

E. Justification of Scoring (Due To's)

All scores must be justified through one or more of the following conditions. Select all applicable "due to's" to support the ADL score.

1. Physical Impairment

   a. Example: client requires assistance due to paralysis

2. Supervision

   a. Example: client requires assistance due to lack of awareness

3. Mental Health

   a. Example: client requires assistance due to hallucinations

FD. Comment Box (Narratives)

Narratives are required in the "Comment box" to support each score and to help others who read the assessment understand a client's over all need. Descriptions should be person-centered, meaningful and should justify level of assistance required based on "due to's." Comment descriptions should include:

a. How/Source: How the information obtained: Individual/caregiver, Case Manager Observation, or other?

b. What: What type of assistance is required to complete the task and how does the child manage to complete the task?

c. Who: Who is providing assistance?

d. When: How often is the child able or not able to complete the task each day?

e. Why: Why is the child able or not able to complete the activity (task)?

In May 2015, the Department published information on the best practices for what to include in narrative statements in the assessment in the Departments training website as well as in a Dear Administrator Letter. For additional information or examples of narrative statements, please find these resources on our website:

a. Writing Narrative Statements in the Assessment

b. Dear Administrator Letter – May 11, 2015

GE. Activities of Daily Living (ADL)

1. BATHING

Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate hygiene.

For older children, this includes the ability to get in and out of the tub and/or shower, the ability to turn the faucets on and off, regulate water temperature and to wash and dry.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 10 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a child from birth to 59 months:

a. A child younger than 12 months is dependent on a caregiver for bathing.

b. A child 12-24 months can typically sit-up in the bath and begin to participate, however, the child still requires assistance and supervision.

c. A child 24-59 months typically participates in bathing, however, still requires assistance and supervision.

Considerations for a child from 5 to 18 years:

a. A child 5-18 years old typically has the ability to bathe and does not require assistance, supervision, and/or help transferring in and out of the tub.

A child may score if the child has a unique medical reason or cognitive impairment that impacts bathing, needs adaptive equipment or skilled/medical care during bathing. Please remember that all children under 4 years of age need some assistance in bathing.

2. DRESSING

Definition: The ability to dress and undress as appropriate.

This includes the ability to put on and remove basic garments such as underwear, shirts, sweaters, pants, socks, hats, and jackets. It also includes fine motor coordination for buttons, snaps, zippers, and the ability to choose appropriate clothing for the weather.

For older children, this activity includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 5 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for dressing.

b. A child 12-24 months can typically pull off hat, socks, and mittens.

c. A child 24-35 months can typically begin to help dress self.

d. A child 36-47 months can typically put on shoes (but cannot tie laces) and dress self with some help (buttons, snaps, zippers).

A child 48-59 months can typically dress self without much help.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-18 years old typically participates in dressing and may require supervision or reminders with selecting appropriate clothing.

A child may score if the child has physical characteristics that makes dressing difficult such as contractures, hypotonia/hypertonia causing a lack of endurance or range of motion, or paralysis. Consider safety and the need to assist with dressing due to seizure activity, lack of balance or cognitive impairment when scoring a child. Difficulties with a zipper or buttons at the back of a garment is not unusual and does not mean there is a functional deficit.

3. TOILETING

Definition: The ability to use the toilet, commode, bedpan, or urinal.

This includes independent transferring on and off the toilet, cleansing appropriately, and adjusting clothes. In older children, this activity could include managing their ostomy or catheter.

A child should be able to physically and cognitively perform all essential components of the task safely and without assistance at 5 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for toileting.

b. A child 12-42 months typically requires the use of diapers, though begins to gain some control of bowels/bladder.

c. A child 43-59 months is typically toilet trained; however occasional night time bedwetting or accidents may occur.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old may need to have intermittent supervision, cueing, or minor physical assistance and/or; have occasional night time bedwetting or accidents during waking hours.

b. A child age 7-18 years old should have the ability to toilet without assistance.

A child may score if he/she has cognitive impairment or skilled/medical care needs that affect toileting, such as ostomy, suppositories, or frequent infections. Children younger than 4 years old may still require diapers or need to have intermittent supervision, cueing, or minor physical assistance, or they may have occasional night time bedwetting or accidents during waking hours. Children should have an awareness of being wet or soiled and show interest in toilet training and/or appliances such as ostomies or urinary catheters.

4. MOBILITY

Definition: The ability to move between locations in the child's environment inside and outside the home.

This includes the ability to safely maneuver (ambulate) without assistance, go up/down the stairs, kneel without support, and assume a standing position.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 3 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child the same age without a disability or impairment.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 6 months is dependent on a caregiver for mobility.

b. A child 6-12 months can typically maintain a sitting position, may begin to move by rolling or crawling, and may begin to pull self up using furniture.

c. A child 12-18 months can typically pull self to standing position, sit or stand alone, and move by crawling and/or walking with or without the use of furniture for balance.

d. A child 18-59 months can typically stand and walk without assistance.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-18 years old should be totally mobile and have the ability to move between locations without assistance.

A child may score if the child is unable to maintain seated balance, unable to bear weight on one or both legs, has a high risk of falling and/or uses mobility devices. Consideration is given to safety and the need to assist with mobility due to visual concerns, seizure activity, frequent falls, and/or lack of balance.

5. TRANSFERS

Definition: The physical ability to move between surfaces.

This includes the physical ability to get in/out of bed or usual sleeping place; to transfer from a bed/chair to a wheelchair, walker or standing position; to transfer on/off the toilet; and the ability to use assisted devices for transfers.

A child should be able to physically and/or cognitively perform all essential components of the task safely and without assistance at 3 years of age or older.

Consider what the parent or other caregiver is doing that is above and beyond the requirements of another child without a disability or impairment at the same age.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for transfers.

b. A child 12-36 months may require physical assistance with transfers.

c. A child 36-59 months should require minimal assistance with transfers.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old may still require minimal assistance with transfers.

b. A child age 7-18 years old should be independent and be able to transfer without physical assistance.

A child may score if the child has limited ability to independently move between two nearby surfaces and/or use assisted devices to transfer. Consideration is given to safety and the need to assist with transfer due to visual concerns, seizure activity, and awareness to surrounding and/or lack of balance.

6. EATING

Definition: The ability to eat and drink using routine or adaptive utensils.

This includes the ability to cut, regulate the amount of intake, chew, swallow foods, and use utensils. Note other forms of feeding such as a tube or intravenous on the assessment.

A child should typically be able to physically and cognitively perform all essential components of the task safely and without assistance if 5 years of age or older.

Consider what the parent or caregiver is doing that is above and beyond the requirements of another child without a disability or impairment at the same age.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for feeding.

b. A child 12-24 months can typically eat finger foods and begin to use a utensils and cup.

c. A child 24-47 months can typically feed self solid foods and begin to try new flavors of foods.

d. A child 48-59 months can typically use spoon, fork, and dinner knife independently.

Considerations for a Child from 5 to 18 Years:

a. A child age 5-6 years old should physically participate in eating, and may need some supervision and/or assistance.

b. A child age 7-18 years old should have the ability to eat without assistance.

A child may score if the child requires more than one hour per feeding, tube feedings (or TPN), or requires more than three hours per day for feeding or eating. Consideration is given to safety and the need to assist with eating due to choking, dietary restrictions, allergies and eating disorders. Children younger than 5 years of age may require verbal prompting and assistance with cutting food.

7. SUPERVISION: (Behavioral)

Definition: The ability to engage in safe actions and interactions and refrain from unsafe actions and interactions.

Considerations for a Child from Birth to 59 Months:

a. A child younger than 48 months requires supervision and surveillance.

b. A child 18-36 months often gets physically aggressive when frustrated.

c. A child 36-59 months should begin to understand and refrain from unsafe actions and interactions.

Considerations for a Child from 5 to 18 Years:

a. A child 5-18 years old should begin to understand and refrain from unsafe actions and interactions with occasional reminders.

A child may score if the ultimate responsibility for the safety, care, wellbeing, and behavior of dependent children remains with the parent or caregiver. Consideration should be given if the child is not able to manage appropriate behaviors and requires constant supervision/prompting.

Examples of behaviors that may justify scoring a functional deficiency for children over 36 months include:

a. Verbal or physical threats and/or actions against self and/or others.

b. Socially inappropriate or sexually aggressive behaviors.

c. Wandering with little safety awareness.

d. Removing or destroying property.

8. SUPERVISION: (Memory/Cognition)

Definition: The ability to acquire and use information, communicate, reason, complete tasks, and problem-solve needs in order to care for oneself safely.

Considerations for a Child from Birth to 59 Months:

a. A child 12-18 months typically says 8-20 words, identifies objects in a book, and follows simple one step directions.

b. A child 18-24 months typically uses two to three word phrases, refers to self by name, and points to parts of face when asked.

c. A child 25-36 months typically enjoys simple make-believe games and enjoys simple stories or songs.

d. A child 36-59 months typically begins counting; identifying colors and letters; and can follow simple rules of a game.

Considerations for a Child from 5 to 18 years:

a. A child 5-9 years old may require occasional supervision necessary to acquire and use information, reason, problem-solve, complete tasks, or communicate needs in order to care for oneself safely.

b. A child 5-18 years old has the ability to recognize and adjust to daily routines, interact with peers and others appropriately, understand directions, understand basic home safety and stranger awareness.

A child may score if the child requires consistent reminding, planning or adjusting for both new and familiar routines; if the child needs preparation and assistance when transitioning between activities; or if the child has impaired ability to assure his or her safety in a strange environment (for example, the child cannot give name or address or would not be aware of dangerous situations).

Examples of behaviors that may justify scoring a functional deficiency for children over 59 months include:

a. Failure to recognize and adjust to daily routines.

b. Inappropriate interactions with peers and other.

c. Lack of basic home safety understanding and stranger awareness.

HF. Activities of Daily Living Scores

To be eligible for waiver services a child must have deficits in a minimum of two out of six ADLs (2+ score) or a moderate score (2+ score) in Behaviors or Memory/Cognition under Supervision category.

GI. Assessment Demographic

Check the appropriate box that best identifies the client situation. If one of the categories does not apply, select 'Other' and enter a description for the different categories in Assessment Demographics.

JF. Summary

Summarize the assessment findings and enter any additional comments that provide more information about the client's situation such as background information, current status, hospital visits, surgeries, seizure activities/frequency or police interactions. Comments can address issues not already identified by the assessment or expand on information presented in the assessment document. Please do not copy and paste entire assessment in this space.

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

8.500.1 This Section hereby incorporates the terms and provisions of the federally approved Home and Community-based Services for Individuals with Intellectual or Developmental Disabilities (HCBS-DD) waiver. To the extent that the terms of that federally approved waiver are inconsistent with the provisions of this Section, the waiver will control.

8.500.1 DEFINITIONS

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

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

C. APPLICANT means ~~an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment~~as defined in Section 8.390.1.

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

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

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

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

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

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

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

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

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

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means as defined in 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and is defined as:

A mother, father, brother, sister; or,

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

An adoptive parent; or,

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

A spouse; or,

The Client's children.

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

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

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

~~T.~~R. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem S, as set forth in Section 15-14-102 (4), C.R.S.

~~U~~S. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

~~V~~T. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IDD)

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

V~~X~~. INSTITUTION means a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IDD) for which the Department makes Medicaid payment under the Medicaid State Plan.

~~Y~~W. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately-operated facility that provides health and habilitation services to a Client with an intellectual or developmental disability or related conditions.

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

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

~~BB~~Z. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

~~CC~~AA. MEDICAID ELIGIBILE means an A~~a~~pplicant or Client meets the criteria for Medicaid benefits based on the A~~a~~pplicant's financial determination and disability determination when applicable.

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

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

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

~~GG~~EE. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

~~HH~~FF. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

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

~~II~~HH. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means ~~the medical information form signed by a licensed medical professional used to certify the client's medical necessity for long-term care services.~~as defined in Section 8.390.1 DEFINITIONS.

~~JJ.~~II PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined Section 8.600.4 et seq., that has received program approval to provide HCBS-DD waiver services.

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

~~LL~~KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

~~MM~~LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the support plan and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

~~NSERVICE PLAN Person-Centered Support Plan (PCSP)means as defined in Section 8.390.1 DEFINITIONS. the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.~~

~~OO~~MM. STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER means the state owned and operated agency providing HCBS waiver services to Clients enrolled in the HCBS-DD waiver.

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

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

PP~~RR~~. TARGETED CASE MANAGEMENT (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS

waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities; ~~comprehensive~~ aa~~a~~ssessment and periodic Rr~~e~~assessment, development and periodic revision of a ~~Service Plan~~PCSP,, referral and related activities, and monitoring.

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

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

8.500.2 HCBS-DD WAIVER ADMINISTRATION

8.500.2.A HCBS-DD shall be provided in accordance with the federally approved waiver document and these rules and regulations.

8.500.2.B The HCBS-DD waiver provides the necessary support to meet the daily living needs of a Client who requires access to 24-hour support in a community-based residential setting.

8.500.2.C HCBS-DD Waiver services are available only to address those needs identified in the ~~functional needs assessment~~ LOC Screen and authorized in the ~~service plan~~ PCSP and when the service or support is not available through the Medicaid state plan, EPSDT, natural supports or third-party resources.

8.500.4 CLIENT ELIGIBILITY

8.500.4.A To be eligible for the HCBS-DD waiver, an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability,

2. Be eighteen (18) years of age or older,

3. Require access to services and supports twenty-four (24) hours a day,

4. Meet ICF-IID level of care as determined by the ~~functional needs assessment~~LOC Screen, and

5. Meet the Medicaid financial determination for LTC eligibility as specified in Section 8.100, *et seq.*

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

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

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

support or meet all identified Client needs and are subject to the availability of appropriate services and supports within existing resources.

8.500.90 DEFINITIONS

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

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

C. APPLICANT means ~~an individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.~~as defined in Section 9.390.1.

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

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

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

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

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

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

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

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

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

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and includes the following:

A mother, father, brother, sister; or,

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

An adoptive parent; or,

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

A spouse; or

The Client's children.

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

~~R. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long-term Care instrument and medical verification on the professional medical information page to determine if the applicant or Client meets the institutional Level of Care (LOC).~~

Q. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

R. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

S HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

T. INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) for which the Department makes Medicaid payment under the Medicaid State Plan.

U. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a public or private facility that provides health and habilitation services to a Client with intellectual or developmental disabilities or related conditions.

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

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

X. LEVEL OF CARE SCREEN means as defined in Section 8.390.1.

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

~~Y~~Z. MEDICAID ELIGIBLE means an A~~a~~pplicant or Client meets the criteria for Medicaid benefits based on the A~~a~~pplicant's financial determination and disability determination when applicable.

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

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

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

~~CC~~DD. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-Based Services for Persons with Developmental Disabilities (HCBS-DD), Home and Community-Based Services Supported Living Services (HCBS-SLS) and Home and Community-Based Services Children's Extensive Support (HCBS-CES) waivers.

~~DD~~EE. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

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

~~FF~~GG. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means ~~the medical information form signed by a licensed medical professional used to certify the Applicant's or Client's need for long-term care services.~~ as defined in Section 8.390.1 DEFINITIONS.

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

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

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

~~JJ~~KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

~~KK~~LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the Client received services according to the ~~service plan~~PCSP and that the Case Management Agency complied with requirements set forth in statute, waiver and regulation.

~~LL~~MM. SERVICE DELIVERY OPTION means the method by which direct services are provided for a Client and include a) by an agency and b) Client directed. ~~SERVICE PLAN- the written document that specifies identified and needed services to include Medicaid eligible and non-Medicaid eligible services, regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.~~

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

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

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

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

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

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

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

8.500.91 HCBS-SLS WAIVER ADMINISTRATION

8.500.91.A HCBS-SLS shall be provided in accordance with the federally approved waiver document and these rules and regulations, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities, 2 CCR 503-1 and promulgated in accordance with the provision of Section 25.5-6-404 (4), C.R.S.

8.500.91.B In the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the provisions of Section 25.5-6-404(4), C.R.S. shall apply and the regulations of the Department shall control.

8.500.10.C The HCBS-SLS waiver is operated by the Department of Health Care Policy and Financing.

8.500.910.E HCBS-SLS services are available only to address those needs identified in the ~~functional needs assessment~~ LOC Screen and authorized in the ~~service plan~~PCSP when the service or support is not available through the Medicaid State plan, EPSDT, natural supports, or third party payment resources.

8.500.91.F The HCBS-SLS Waiver:

1. Shall not constitute an entitlement to services from either the Department or the Operating Agency,

2. Shall be subject to annual appropriations by the Colorado General Assembly,

3. Shall ensure enrollments into the HCBS-SLS waiver do not exceed the federally approved waiver capacity, and

4. May limit the enrollment when utilization of the HCBS-SLS waiver program is projected to exceed the spending authority.

8.500.93 CLIENT ELIGIBILITY

8.500.93. A To be eligible for the HCBS-SLS waiver an individual shall meet the target population criteria as follows:

1. Be determined to have an intellectual or developmental disability

2. Be eighteen (18) years of age or older,

3. Does not require twenty-four (24) hour supervision on a continuous basis which is reimbursed as a HCBS-SLS service,

4. Is served safely in the community with the type or amount of HCBS-SLS waiver services available and within the federally approved capacity and cost containment limits of the waiver,

5. Meet ICF-IID level of care as determined by the ~~Functional Needs Assessment~~LOC Screen.

6. Meet the Medicaid financial determination for LTC eligibility as specified at Section 8.100; and,

7. Reside in an eligible HCBS-SLS setting. SLS settings are the Client's residence, which is defined as the following:

   a. A living arrangement, which the Client owns, rents or leases in own name,

   b. The home where the Client lives with the Client's family or legal guardian, or

   c. A living arrangement of no more than three (3) persons receiving HCBS-SLS residing in one household, unless they are all members of the same family.

8. The Client shall maintain eligibility by continuing to meet the HCBS-SLS eligibility requirements and the following:

   a. Receives at least one (1) HCB-SLS waiver service each calendar month,

   b. Is not simultaneously enrolled in any other HCBS waiver, and

   c. Is not residing in a hospital, nursing facility, ICF-IID, correctional facility or other institution.

9. When the HCBS-SLS waiver reaches capacity for enrollment, a Client determined eligible for a waiver shall be placed on a wait list in accordance with these rules at Section 8.500.96.

8.500.103 RETROSPECTIVE REVIEW PROCESS

8.500.103.A Services provided to a Client are subject to a retrospective review by the Department and the Operating Agency. This retrospective review shall ensure that services:

1. Identified in the ~~service plan~~PCSP are based on the Client's identified needs as stated in the ~~functional needs assessment,~~LOC Screen.

2. Have been requested and approved prior to the delivery of services,

3. Provided to a Client are in accordance with the ~~service plan,~~PCSP and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

8.501 State Funded Supported Living Services Program

The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide supports to individuals with an intellectual or developmental disability to remain in their community. The State-SLS program shall not supplant Home and Community-Based services for those who are currently eligible.

8.501.A Definitions

1. APPLICANT means an individual who is seeking supports from State-SLS program.

2. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by

the Department to provide case management services for Home and Community-Based Services waivers pursuant to section 25.5-10-209.5, C.R.S., has a valid provider participation agreement with the Department, and has a valid contract with the Department to provide these services.

3. CCB CASE MANAGER means the staff member of the Community Centered Board that works with individuals seeking services to develop and authorize services under the State-SLS program.

4. CLIENT means an individual who meets the DD Determination criteria and other State-SLS eligibility requirements and has been approved for and agreed to receive services in the State-SLS program.

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

6. CORRECTIVE ACTION PLAN means a written plan, which includes the detailed description of actions to be taken to correct non-compliance with State-SLS requirements, regulations, and direction from the Department, and includes the date by which each action shall be completed and the individuals responsible for implementing the action.

7. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that meets the requirements set forth in Section 25.5.-10-209, C.R.S. and is responsible for conducting level of care evaluations and determinations for State-SLS services specific to individuals with intellectual and developmental disabilities.

8. COMMUNITY RESOURCE means services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to, services provided through private insurance, non-profit services and other government programs.

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

10. DEVELOPMENTAL DISABILITY (DD) DETERMINATION means the determination of a Developmental Disability as defined in section 8.607.2

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

12. DEVELOPMENTAL DISABILITY means a disability that is defined in section 8.600.4.

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

14. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

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

16. MEDICAID ELIGIBLE means an Applicant or Client meets the criteria for Medicaid benefits based on a financial determination and disability determination.

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

18. NATURAL SUPPORTS means an informal relationship that provides assistance and occurs in the Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

19. PERFORMANCE AND QUALITY REVIEW means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by the CCB to ensure quality and compliance with all statutory and regulatory requirements.

20. PLAN YEAR mean a twelve (12) month period starting from the date when State-SLS Supports and Services where authorized.

21. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent.

22. PROGRAM APPROVED SERVICE AGENCY (PASA) means a developmental disabilities service agency or a service agency as defined in 8.602, that has received program approval, by the Department, to provide Medicaid Wavier services.

23. RELATIVE means a person related to the Client by virtue of blood, marriage, or adoption.

24. RETROSPECTIVE REVIEW means the Department's review after services and supports are provided and the PASA is reimbursed for the service, to ensure the Client received services according to the ~~service plan~~PCSP and standards of economy, efficiency and quality of service.

25. STATE-SLS INDIVIDUAL SUPPORT PLAN means the written document that identifies an individual's need and specifies the State-SLS services being authorized, to assist a Client to remain safely in the community.

26. STATE FISCAL YEAR means a 12-month period beginning on July 1 of each year and ending June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in the calendar year.

27. Services and Supports or Supports and Services means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided to

    a. To enable persons with intellectual and developmental disabilities to make responsible choices, exert greater control over their lives, experience presence and inclusion in their communities, develop their competencies and talents,

maintain relationships, foster a sense of belonging, and experience person security and self-respect.

28. SUPPORT SERVICE means the service(s) established in the State SLS program that a CCB Case Manager may authorize to support an eligible Client to complete the identified tasks identified in the Client's Individualized Support Plan.

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

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

8.503 DEFINITIONS

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

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

C. APPLICANT means a~~n individual who is seeking a long-term services and supports eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.~~s defined in Section 8.390.1.

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

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

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

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

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

I. COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate

amount. The cost of providing care in the community shall include the cost of providing Home and Community-based Services, and Medicaid State Plan benefits including long-term home health services and targeted case management.

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

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

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

M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as defined in Section 8.280.1.

P. FAMILY means a relationship as it pertains to the Client and is defined as:

A mother, father, brother, sister,

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

An adoptive parent,

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

A spouse or,

The Client's child.

Q. FISCAL MANAGEMENT SERVICE (FMS) means the entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual Client allocations for CDASS.

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

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

R. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

S. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963," set forth in Article 33 of Title 22, C.R.S.

T. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID).

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

V. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately operated facility that provides health and habilitation services to a Client with developmental disabilities or related conditions.

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

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

Y. LEVEL OF CARE SCREEN means as defined in Section 8.391.1.

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

~~Z~~AA. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities.

~~AA~~BB. MEDICAID ELIGIBLE means the A~~a~~pplicant or Client meets the criteria for Medicaid benefits based on the A~~a~~pplicant's financial determination and disability determination when applicable.

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

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

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

~~EE~~FF. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in Home and Community Services for persons with Developmental Disabilities (HCBS-DD), HCBS- Supported Living Services (HCBS-SLS) and HCBS- Children's Extensive Supports (HBCS-CES) waivers.

~~FF~~GG. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

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

~~HH~~II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means as defined in Section 8.390.1 DEFINITIONS.

~~II~~JJ. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received program approval to provide HCBS-CES waiver services.

~~JJ~~KK. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or common law marriage.

~~KK~~LL. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after services and supports are provided to ensure the Client received services according to the ~~service plan~~PCSP and that the Case Management Agency complied with the requirements set forth in statue, waiver and regulation.

~~SERVICE PLAN the written document that specifies identified and needed services, regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules~~

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

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

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

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

~~PP~~QQ. WAIVER SERVICE means optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

8.503.30 CLIENT ELIGIBILITY

A. To be eligible for the HCBS-CES waiver, an individual shall meet the target population criteria as follows:

1. Is unmarried and less than eighteen years of age,

2. Be determined to have a Developmental Disability which includes Developmental Delay if under five (5) years of age,

3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and Cost Containment limits of the HCBS-CES waiver,

4. Meet ICF-IID Level oOf Care as determined by the ~~Functional Needs Assessment,~~LOC Screen.

5. Meet the Medicaid financial determination for Long-term Care (LTC) eligibility as specified at Section 8.100 *et seq.* and,

6. Reside in an eligible HCBS-CES waiver setting as defined as the following:

    a. With biological, adoptive parent(s), or legal Guardian,

    b. In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement:

        i. The case manager will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or Supports requested during the time the Client is not residing in the Family home. The case manager will submit the transition plan to the Department for approval prior to the start of services.

7. Be determined to meet the Federal Social Security Administration's definition of disability,

8. Be determined by the Department or its agent to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:

    a. The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or medical condition must be considered beyond what is typically Age Appropriate and due to one or more of the following conditions:

        i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life-threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six (6) months,

        ii. A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six (6) months, or

        iii. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

b. In the instance of an annual Rreassessment, the Rreassessment must demonstrate in the absence of the existing interventions or preventions provided through Medicaid that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criterion listed above.

B. The Client shall maintain eligibility by meeting the HCBS-CES waiver eligibility as set forth in Section 8.503 and the following:

1. Receives at least one (1) HCBS-CES waiver service each calendar month,

2. Is not simultaneously enrolled in any other HCBS waiver, and

3. Is not residing in a hospital, nursing facility, ICF-IID, other Institution or correctional facility.

8.503.60 WAITING LIST PROTOCOL

A. When the HCBS-CES waiver reaches capacity for enrollment, a Client determined eligible for HCBS-CES waiver benefits shall be placed on a statewide waiting list in accordance with these rules and the Department's procedures.

1. The Community Centered Board shall determine if an Applicant has Developmental Delay if under age five (5), or Developmental Disability if over age five (5) , prior to submitting the HCBS-CES waiver application to the Department or its agent. Only a Client who is determined to have a Developmental Delay or Developmental Disability may apply for HCBS-CES waiver.

2. In the event a Client who has been determined to have a Developmental Delay is placed on the wait list prior to age five (5), and that Client turns five (5) while on the HCBS-CES waiver wait list, a determination of Developmental Disability must be completed in order for the Client to remain on the wait list.

3. The Case Management Agency shall complete the ~~Functional Needs Assessment,~~LOC Screen as defined in Department rules, to determine the Client's Level of Care.

4. The Case Management Agency shall complete the HCBS-CES waiver application (for use with the ULTC 100.2 only) with the participation of the Family. The completed application and a copy of the ~~Functional Needs Assessment~~LOC Screen that determines the Client meets the ICF-IID Level o~~O~~f Care shall be submitted to the Department or its agent within fourteen (14) calendar days of parent signature.

5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the Department or its agent.

6. The Department or its agent shall review the HCBS-CES waiver application. In the event the Department or its agent needs additional information; the Case Management Agency shall respond within two (2) business days of request.

7. Any Client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide waiting list in the order in which the Department or its agent received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the Client's appeal rights in accordance with Section 8.057.

8. The Case Management Agency will create or update the consumer record to reflect the Client is waiting for the HCBS-CES waiver with the waiting list date as determined by the Department or its agent.

8.503.70 ENROLLMENT

A. When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.

1. The Case Management Agency shall complete the HCBS-CES waiver application (with ULTC 100.2 only) and the ~~Functional Needs Assessment~~ LOC Screen in the Family home with the participation of the Family. The completed application, as applicable, and a copy of the ~~Functional Needs Assessment~~ LOC Screen shall be submitted to the Department or its agent within thirty (30) days of the authorized initial enrollment date.

   a. If it has been less than six (6) months since the review to determine waiting list eligibility by the URC and there has been no change in the Client's condition, the Case Management Agency shall complete the ~~Functional Needs Assessment~~LOC Screen and the parent may submit a letter to the Case Management Agency in lieu of the HCBS-CES waiver application stating there has been no change.

   b. If there has been any change in the Client's condition the Case Management Agency shall complete a ~~Functional Needs Assessment a~~LOC Screen and the HCBS-CES waiver application, as applicable, which shall be submitted to the Department or its agent.

2. Services and Supports shall be implemented pursuant to the ~~Service Plan~~PCSP within 90 days of the parent or Guardian signature.

3. All continued stay review enrollments shall be completed and submitted to the Department or its agent at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

8.503.80 CLIENT RESPONSIBILITIES

A. The parent or legal Guardian of a Client is responsible to assist in the enrollment of the Client and cooperate in the provision of services. Failure to do so shall result in the Client's termination from the HCBS-CES waiver. The parent or legal Guardian shall:

1. Provide accurate information regarding the Client's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions;

2. Cooperate with providers and Case Management Agency requirements for the HCBS-CES waiver enrollment process, Reassessment ~~continued stay review~~ process and provision of services;

3. Cooperate with the local Department of Human Services in the determination of financial eligibility;

4. Complete the HCBS-CES waiver application with fifteen (15) calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a ~~continued stay review~~Reassessment, at least thirty (30) days prior to the end of the current certification period;

5. Complete the ~~Service Plan~~PCSP within thirty (30) calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the Department or its agent.

6. Notify the case manager within thirty (30) days after changes:

   a. In the Client's Support system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF-IID placements;

   b. That may affect Medicaid financial eligibility such as prompt report of changes in income or resources;

   c. When the Client has not received an HCBS-CES waiver service for one calendar month;

   d. In the Client's care needs; and,

   e. In the receipt of any HCBS-CES waiver services.

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

8.504.05 Legal Basis

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

8.504.1 DEFINITIONS

A. ~~Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved assessment tool to complete assessments.~~ Assessment shall be as defined at Section 8.390.1.DEFINITIONS.

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

C. Case Management means as defined in Section 8.390.1 DEFINITIONS. ~~the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs.~~

D. Continued Stay Review (CSR) means a R~~r~~eassessment ~~by the Single Entry Point case manager to determine the Client's continued eligibility and functional level of care.~~as defined in Section 8.390.1 DEFINITIONS.

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

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

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

H. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other

programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

I. Level of Care Screen means as defined in Section 8.391.1.

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

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

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

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

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

M~~L~~. Person-Centered Support Planning means ~~the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking or receiving services of his or her rights and responsibilities.~~as defined in Section 8.390.1 DEFINITIONS.

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

NM. Professional Medical Information Page (PMIP) ~~Client means the medical information form signed by a licensed medical professional used to verify the Client needs institutional Level of Care~~ means as defined in Section 8.390.1 DEFINITIONS.

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

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

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

8.504.5 WAIT LIST

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

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

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

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

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

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

1. Reassess the Aapplicant for ~~functional~~ level of care using the Department ~~approved~~prescribed ~~assessment tool~~ Level of Care Screen if the date of the last a~~A~~ssessment is more than six months old.

2. Update the current LOC Screen if the date is less than six months old.

3. Reassess for the target population criteria.

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

8.506 CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

8.506.1 Legal Basis:

The Children's Home and Community -based Services 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-CHCBS program is also authorized under state law at Section 25.5-6-901, et seq. C.R.S.

8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.390.1 DEFINITIONS~~506.3.B~~ and the additional operations specifically defined for this waiver in Section 8.506.4.B.

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552

8.506.3 General Definitions

A. ~~Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved instrument to complete assessments.~~ Assessment ~~shall be~~means as defined at Section 8.390.1.DEFINITIONS.

~~B. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs. Additional operations specifically defined for this waiver are described in Section 8.506.4.B.~~

B. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency.

C. Continued Stay Review means ~~a~~ R~~r~~eassessment ~~by the case manager to determine the Client's continued eligibility and functional level of care.~~as defined in Section 8.390.1 DEFINITIONS.

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

E. County Department means the Department of Human or Social Services in the county where the resident resides.

F. Department means the Department of Health Care Policy and Financing.

G. Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.

~~I. Functional Eligibility means that the Client meets the criteria for long-term care services as determined by the Department's prescribed instrument.~~

H. Institutional Placement means residing in an acute care hospital or nursing facility.

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

J. Level of Care Screen means as defined in Section 8.390.1.

K. Level of Care Eligibility Determination means as defined in Section 8.390.1.

LJ. Performance and Quality Review means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by a Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements.

MK. Person-Centered Support Planning means ~~the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking or receiving services of his or her rights and responsibilities.~~as defined in Section 8.390.1 DEFINITIONS.

NL. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery and utilization of services.

OM. Professional Medical Information Page (PMIP)~~Client means the medical information form signed by a licensed medical professional used to certify Level of Care.~~ means as defined in Section 8.390.1 DEFINITIONS.

PN. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1

QO. Utilization Review Contractor (URC) means the agency or agencies contracted with the Department to review the CHCBS waiver application for confirmation that ~~functional eligibility~~ Level of Care eligibility and targeting criteria are met.

8.506.4 Benefits

8.506.4.A Home and Community-based Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at Section 26-1-114, C.R.S.

2. Case Management Agencies will complete all administrative functions of a Client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

   a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of Client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document

reason(s) why such contact was not possible. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.

b. At the time of making the initial in person contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.

c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

d. Verify that the child meets the eligibility requirements outlined in Client Eligibility, Section 8.506.6.

e. Submit the ~~assessment~~ LOC Screen and documentation to the URC to ensure the targeting criteria and ~~functional eligibility~~level of care eligibility criteria are met. Minimum documents required:

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the Level of Care Determination to the County Department for activation of a Medicaid State Identification Number.

g. Develop the Person-Centered Support Plan~~ning document~~ in accordance with Section 8.506.4.B.7.

i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with Section 8.506.10.

4. Continued Stay Review

a. Complete a ~~new Assessment~~ LOC Screen Reassessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.).

b. Submit the ~~assessment~~ LOC Screen and documentation to the URC to ensure the targeting criteria and ~~functional~~ Level of Care eligibility criteria are met.

c. Review and revise the Person-Centered Support Plan~~ning~~ document in accordance with Section 8.506.4.B.7.

d. Notify the county technician of the renewed Long-term Care certification.

5. Discharge/Withdrawal

   a. At the time that the Client no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:

      i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.

      iii. Submit PAR termination to the Department's Fiscal Agent.

      iv. Notify County Department of termination.

      v. Notify agencies providing services to the Client that the child has been discharged from the waiver.

6. Transfers

   a. Sending agency responsibilities:

      i. Contact the receiving case management agency by telephone and provide notification that:

         1) The child is planning to transfer, per the parent(s) or guardian choice.

         2) Negotiate an appropriate transfer date.

         3) Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.

      ii. Using a State designated form, notify the URC of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.

      iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual 9 CCR 2503-5 Section 3.560 Case Transfers.

         This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, Section 3.560 is available at Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

   b. Receiving agency responsibilities

      i. Conduct an in person visit with the child within ten (10) working days of the child's transfer. Upon Department approval, contact may be

completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.)., and

ii. Review and revise the Person-Centered Support Plan ~~ning document~~ and change or coordinate services and providers as necessary.

8.506.6 Client Eligibility

8.506.6.A An eligible Client shall meet the following requirements:

1. Targeting Criteria:

   a. Not have reached his/her eighteenth (18th) birthday.

   b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

   c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

   d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. ~~Functional~~ Level of Care Eligibility:

   a. The URC certifies, through the Case Management Agency completed ~~assessment~~LOC Screen, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.

3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.

4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

8.506.7 Waiting List

8.506.7.A The number of Clients who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.

8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

8.506.7.C The waiting list shall be maintained by the URC.

8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the URC will use for the individual's placement on the waiting list.

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the URC will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the URC that an opening for the CHCBS waiver is available the Case Management Agency shall:

1. Reassess the individual using the Department's prescribed LOC Screen instrument if more than six months has elapsed since the previous assessment.

2. Update the existing ~~functional~~ Level of Care Screen in the official Client record.

3. Reassess for eligibility criteria as set forth at 8.506.6.

4. Notify the URC of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the Person-Centered Support Plan~~ning document~~.

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

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

2. The assigned start date on the ~~certification page of the Assessment.~~Level of Care Eligibility Determination.

3. The date, on which the Client's parent(s) and/or legal guardian signs the Person-Centered Support Plan~~ning document~~ or Intake form, as prescribed by the Department, agreeing to receive services.

8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the ~~certification page of the Assessment.~~Level of Care Eligibility Determination.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Person-Centered Support Plan~~ning r~~~~document r~~esults in a change in services.

8.506.10.F The revised Person-Centered Support Plan ~~ning document~~ shall list the service being changed and state the reason for the change. Services on the revised Person-Centered Support Plan~~ning document~~, plus all services on the original document, shall be entered on the revised PAR.

8.506.10.G Revisions to the Person-Centered Support Plan~~ning document~~ requested by providers after the end date on a PAR shall be disapproved.

8.506.10.H The Long-Term Care Notice of Action Form (LTC-803) shall be completed in the Information Management System (IMS), ~~(as defined at 8.519.1.Z)~~ as defined in Section 8.390.1 DEFINITIONS for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, or at the time of discontinuation.

8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

8.508.10 LEGAL BASIS

The Home and Community based Services- Children's Habilitation Residential Program (HCBS-CHRP) is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a. The waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n.

8.508.20 DEFINITIONS

A. Abuse: As defined at § 16-22-102 (9) C.R.S., § 19-1-103, C.R.S., § 25.5-10-202 (1) (a)-(c), C.R.S., and § 26.3.1-101 C.R.S.

B. Adverse Action: A denial, reduction, termination, or suspension from a Long-Term Services and Supports (LTSS) program or service.

C. Applicant: A child or youth who is seeking a Long-Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

D. Assessment: As defined in Section 8.390.1 DEFINITIONS.

~~E~~D. Caretaker: As defined at Section 25.5-10-202 (1.6)(a)-(c), C.R.S.

~~E~~F. Caretaker neglect: As defined at Section 25.5-10-202 (1.8)(a)-(c), C.R.S.

~~F~~G. Case Management Agency (CMA): A public or private not-for-profit for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to sections 25.5-10-209.5 C.R.S. and pursuant to a provider participation agreement with the state department.

~~G~~H. Child Placement Agency: As defined at 12 CCR 2509-8; Section 7.701.2 (F).

~~H~~I. Client: A child or youth who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-based Services (HCBS)

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

K~~J~~. Community Centered Board: A private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-based Service waivers specific to individuals with intellectual and developmental disabilities, and management of state funded programs for individuals with intellectual and developmental disabilities.

L. Complex Behavior: Behavior that occurs related to a diagnosis by a licensed physician, psychiatrist, or psychologist that includes one or more substantial disorders of the cognitive, volitional or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior.

ML. Complex Medical Needs: Needs that occur as a result of a chronic medical condition as diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12) months, requires skilled care, and that without intervention may result in a severely life altering condition.

~~M. Comprehensive Assessment: An initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support.~~

NN. Cost Containment: Limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community-based Services, and Medicaid State Plan benefits including long- term home health services and targeted case management.

OO. Criminal Activity: A criminal offense that is committed by a person; a violation of parole or probation; and any criminal offense that is committed by a person receiving services that results in immediate incarceration.

PP. Crisis: An event, series of events, and/or state of being greater than normal severity for the Client and/or family that becomes outside the manageable range for the Client and/or their family and poses a danger to self, family, and/or the community. Crisis may be self-identified, family identified, and/or identified by an outside party.

QQ. Critical Incident: Incidents of Mistreatment; Abuse; Neglect; Exploitation, Criminal Activity; Damage to Client's Property/Theft; Death unexpected or expected; Injury/Illness to Client; Medication Mismanagement; Missing Person; Unsafe Housing/Displacement; and/or Other Serious Issues.

RR. Department: The Colorado Department of Health Care Policy and Financing the single state Medicaid agency.

SS. Damage to Client's Property/Theft: Deliberate damage, destruction, theft or use a Client's belongings or money. If the incident involves Mistreatment by a Caretaker that results in damage tor Client's property or theft in the incident shall be listed as Mistreatment.

T. Developmental Delay: A child who is:

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

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

    ii. Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development;

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

2. Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a CCB.

~~U~~T. Early and Periodic Screening Diagnosis and Treatment (EPSDT): As defined in Section 8.280.1.

~~V~~U. Exploitation: As defined in Sections 25.5-10-202(15.5)(a)-(d) and 26.3.1-101 C.R.S.

~~W~~V. Extraordinary Needs: A level of care due to Complex Behavior and/or Medical Support Needs that is provided in a residential child care facility or that is provided through community-based programs, and without such care, would place a child at risk of unwarranted child welfare involvement or other system involvement.

~~X~~W. Family: As defined at Section 25.5-10-202 (16)(a)(I)-(IV)(b), C.R.S.

~~Y~~X. Foster Care Home: A family care home providing 24-hour care for a child or children and certified by either a County Department of Social/Human Services or a child placement agency. A Foster Care Home, for the purposes of this waiver, shall not include a family member as defined in Section 25.10-202 (16)(a)(I)-(IV)(b), C.R.S.

~~Z~~Y. Guardian: An individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not guardian ad litem.

Z.~~AA~~. Guardian ad litem or GAL: A person appointed by a court to act in the best interests of a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963", set forth in Article 33 of Title 22, C.R.S.

~~BB~~AA. Harmful Act: as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.

BB~~CC~~. Home and Community-based Services (HCBS) Waivers: Services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

CC~~DD~~. Increased Risk Factors: Situations or events that when occur at a certain frequency or pattern historically have led to Crisis.

DD~~EE~~. Informed Consent: An assent that is expressed in writing, freely given, and preceded by the following:

1. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

2. A description of the attendant discomforts and risks;

3. A description of the expected benefits;

4. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

5. An offer to answer any inquiries regarding the procedure(s);

6. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

7. A statement that withholding or withdrawal of consent shall not prejudice future availability of services and supports.

EEFF. Injury/Illness to Client: An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, and skin wounds; an injury or illness requiring immediate emergency medical treatment to preserve life or limb; an emergency medical treatment that results in admission to the hospital; and a psychiatric crisis resulting in unplanned hospitalization.

FFGG. Institution: A hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the State Plan.

GGHH. Intellectual and Developmental Disability: A disability that manifests before the person reaches twenty-two (22) years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of “developmental disability” found in 42 U.S.C. sec. 15001 et seq., does not apply.

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

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

“Substantial intellectual deficits” An intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.

HHII. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID): A publicly or privately-operated facility that provides health and habilitation services to a Client with intellectual or developmental disabilities or related conditions.

IIJJ. Kin: As defined in 12 CCR 2509-1, Section 7.000.2.A.

JJKK. Kinship Foster Care Home: As defined in 12 CCR 2509-1, Section 7.000.2.A.

KKLL. Level of Care (LOC): The specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

LL~~MM~~. Level of Care Eligibility Determination: ~~An eligibility determination by a CCB of an Individual for a Long-Term Services and Supports (LTSS) program.~~As defined in Section 8.390.1.

MM~~NN~~. Level of Care Eligibility Determination Screen: As defined in Section 8.390.1.

~~Level of Care Evaluation: A comprehensive evaluation with the Individual seeking services and others chosen by the Individual to participate, conducted by the case manager utilizing th eDepartment's prescribed took, with supporting diagnostic information from the Individual's medical providers, for the purpose of determining the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports (LTSS) programs.~~

NN~~OO~~. Licensed Child Care Center (less than 24 hours): As defined in Section 26-6-102 (5), C.R.S. and as described in 12 CCR 2509-8; Section 7.701.

OO~~PP~~. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Clients of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

PP~~QQ~~. Medicaid Eligible: The Applicant or Client meets the criteria for Medicaid benefits based on the financial determination and disability determination.

QQ~~RR~~. Medicaid State Plan: The federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

RR~~SS~~. Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

SS~~TT~~. Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or there is a risk to public safety.

TT~~UU~~. "Mistreated" or "Mistreatment": As defined at Section 25.5-10-202(29.5)(a)-(d) and 26.3.1-101.

UU~~VV~~. Natural Supports: Unpaid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

VV~~WW~~. Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.

WW~~XX~~. Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or lesser likelihood of success of Crisis interventions.

XX~~YY~~. Prior Authorization: Approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the CMA.

YY~~ZZ~~. Professional: Any person, not including family, performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

~~AA~~ZZ. Professional Medical Information Page (PMIP): ~~The medical information form signed by a Licensed Medical Professional used to certify Level of Care.~~as defined in Section 8.390.1 DEFINITIONS.

~~BBB~~AAA. Relative: A person related to the Client by blood, marriage, adoption or common law marriage.

BBB~~CCC~~. Residential Child Care Facility: As defined in 12 CCR 2509-8, Section 7.705.1.

~~DDD~~CCC. Retrospective Review: The Department's review after services and supports are provided to ensure the Client received services according to the ~~service plan~~PCSP and standards of economy, efficiency and quality of service.

DDD~~EEE~~. Separation: The restriction of a Client for a period of time to a designated area from which the is not physically prevented from leaving, for the purpose of providing the Client an opportunity to regain self-control.

EEE~~FFF~~. Service Provider: A Specialized Group Facility, Residential Child Care Facility, Foster Care Home, Kinship Foster Care Home, Child Placement Agency, Licensed Child Care Facility (non-24 hours), and/or Medicaid enrolled provider.

~~GGG~~FFF. Person-Centered Support Plan (PCSP)~~Service Plan~~: ~~The written document that specifies identified and needed services, to include Medicaid and non-Medicaid covered services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with Department regulations.~~Defined in Section 8.390.1 DEFINITIONS.

GGG~~HHH~~. Person-Centered S~~upport~~ervice~~ Planning (PCSP): ~~The process of working with the Client receiving services and people chosen by the Individual, to identify goals, needed services, and appropriate service providers based on the Comprehensive Assessment and knowledge of the available community resources. Service planning informs the Individual seeking or receiving services of his or her rights and responsibilities.~~Defined in Section 8.390.1 DEFINITIONS.

~~III~~HHH. Specialized Group Facility: As defined in 12 CCR 2509-8; Section 7.701.2(B).

~~JJJ~~III. Support: Any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

~~KKK~~JJJ. Support Level: A numeric value determined by the Support Need Level Assessment that places Clients into groups with other Clients who have similar overall support needs.

KKK~~LLL~~. Support Need Level Assessment: The standardized assessment tool used to identify and measure the support requirements for HCBS-CHRP waiver participants.

LLL~~MMM~~. Targeted Case Management (TCM): Has the same meaning as in Section 8.761.

~~NNN~~MMM. Third Party Resources: Services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to community resources, services provided through private insurance, non-profit services and other government programs.

NNN~~OOO~~. Unsafe Housing/Displacement: An individual residing in an unsafe living condition due to a natural event (such as fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.

OOO~~PPP~~. Waiver Service: Optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

PPP~~QQQ~~. Wraparound Facilitator: A person who has a bachelor's degree in a human behavioral science or related field of study and is certified in a wraparound training program. Experience

working with LTSS populations in a private or public social services agency may substitute for the bachelor's degree on a year for year basis. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field. The wraparound certification must include training in the following:

Trauma informed care.

Youth mental health first aid.

Crisis supports and planning.

Positive Behavior Supports, behavior intervention, and de-escalation techniques.

Cultural and linguistic competency.

Family and youth serving systems.

Family engagement.

Child and adolescent development.

Accessing community resources and services.

Conflict resolution.

Intellectual and developmental disabilities.

Mental health topics and services.

Substance abuse topics and services.

Psychotropic medications.

Motivational interviewing.

Prevention, detection, and reporting of Mistreatment, Abuse, Neglect, and Exploitation.

~~RRR~~QQQ. Wraparound Transition Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a transition to the family home after out of home placement.

~~SSS~~RRR. Wraparound Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a plan to maintain stabilization, prevent Crisis, and/or for de-escalation of Crisis situations.

~~TTT~~SSS. Wraparound Support Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

TTT~~UUU~~. Wraparound Transition Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

8.508.40 ELIGIBILITY

A. Services shall be provided to Clients with an Intellectual and Developmental Disability who meet all of the following eligibility requirements:

1. A determination of developmental disability by a CCB which includes developmental delay if under five (5) years of age.

2. The Client has Extraordinary Needs that put the Client at risk of, or in need of, out of home placement.

3. Meet ICF-IID Level of Care as determined by a LOC Screen~~evel of Care Evaluation~~.

4. The income of the Client does not exceed 300% of the current maximum SSI standard maintenance allowance.

5. Enrollment of the Client in the HCBS- CHRP waiver will result in an overall savings when compared to the ICF/IID cost as determined by the State.

6. The Client receives at least one waiver service each month.

B. A Support Need Level Assessment must be completed upon determination of eligibility. The Support Need Level Assessment is used to determine the level of reimbursement for Habilitation and per diem Respite services.

C. Clients must first access all benefits available under the Medicaid State Plan and/or EPSDT for which they are eligible, prior to accessing funding for those same services under the HCBS-CHRP waiver.

D. Pursuant to the terms of the HCBS-CHRP waiver, the number of individuals who may be served each year is based on:

1. The federally approved capacity of the waiver;

2. Cost Containment requirements under section 8.508.80;

3. The total appropriation limitations when enrollment is projected to exceed spending authority.

8.508.50 WAITING LIST PROTOCOL

A. Clients determined eligible for HCBS-CHRP services who cannot be served within the appropriation capacity limits of the HCBS-CHRP waiver shall be eligible for placement on a waiting list.

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

2. The date used to establish the Client's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.508.40 were determined to have been met and the Department was notified.

3. As openings become available within the appropriation capacity limits of the federal waiver, Clients shall be considered for services based on the date of their waiting list placement.

8.508.60 RESPONSIBILITIES OF THE CCB

A. The CCB shall make eligibility determinations for developmental disabilities services to include the Level of Care ~~Evaluation Determination~~Eligibility Determination for any Applicant or Client being considered for enrollment in the HCBS-CHRP waiver.

B. Additional administrative responsibilities of CCBs as required in 8.601.

8.508.70 CASE MANAGEMENT FUNCTIONS

A. Case management services will be provided by a CMA as a Targeted Case Management service pursuant to sections 8.761.14 and 8.519 and will include:

1. Completion of a ~~Comprehensive Assessment;~~LOC Screen

2. Completion of a Person-Centered Support~~Service~~ Plan (PCSP);

3. Referral for services and related activities;

4. Monitoring and follow-up by the CMA including ensuring that the SP is implemented and adequately addresses the Client's needs.

5. Monitoring and follow-up actions, which shall

   a. Be performed when necessary to address health and safety and services in the PCSP;

   b. Services in the PCSP are adequate; and

   c. Necessary adjustments in the PCSP and service arrangements with providers are made if the needs of the Client have changed.

6. Face to face monitoring to be completed at least once per quarter and to include direct contact with the Client in a place where services are delivered. Upon Department approval, monitoring may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.).

8.508.121 REASSESSMENT AND REDETERMINATION OF ELIGIBILITY

A. The CMA shall conduct a Level of Care ~~Evaluation~~ Eligibility Determination and redetermine or confirm a Client's eligibility for the HCBS-CHRP waiver, at a minimum, every twelve (12) months.

B. The CMA shall conduct a ~~Comprehensive Assessment~~LOC Screen to redetermine or confirm a Client's individual needs, at a minimum, every twelve (12) months.

C. The CMA shall verify that the child or youth remains Medicaid Eligible at a minimum, every twelve (12) months.

8.509 HOME AND COMMUNITY-BASED SERVICES FOR COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS)

8.509.10 GENERAL PROVISIONS

8.509.11 LEGAL BASIS

A. The Home and Community-based Services for COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS) 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-CMHS program is also authorized under state law at Sections 25.5-6-601 through 25.5-6-607, C.R.S. The number of recipients served in the HCBS-CMHS program is limited to the number of recipients authorized in the waiver.

B. All congregate facilities where any HCBS Client resides must be in possession of a valid Assisted Living Residence license issued under Section 25-27-105, C.R.S., and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7.

8.509.14 GENERAL DEFINITIONS

A. Assessment shall be defined as a Client evaluation according to requirements at Section 8.~~509.31.B~~390.1 DEFINITIONS.

B. Case Management shall be defined as administrative functions performed by a case management agency according to requirements at Section 8.509.30.

C. Case Management Agency shall be defined as an agency that is certified and has a valid contract with the state to provide HCBS-CMHS case management.

D. Categorically Eligible, shall be defined in the HCBS-CMHS Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the Client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-CMHS as three hundred percent eligible persons, as defined at 8.509.14.S.

E. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

F. Uncertified Congregate Facility is a facility as defined in Section 8.509.14.G that is not certified as an Alternative Care Facility, which is defined at Section 8.495.1.

G. Continued Stay Review shall be defined as a Re~~re~~assessment as defined in Section 8.390.1 and conducted as described at Section 8.402.60.~~.~~

H. Cost Containment shall be defined at Section 8.485.50(I)

I. Department shall be defined as the State Agency designated as the Single State Medicaid Agency for Colorado, or another state agency operating under the authority of a memorandum of understanding with the Single State Medicaid Agency.

J. Deinstitutionalized shall be defined as waiver Clients who were receiving nursing facility services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-CMHS waiver. These include hospitalized Clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected the HCBS-CMHS waiver.

K. Diverted shall be define as HCBS-CMHS waiver recipients who were not deinstitutionalized, as defined at Section 8.485.50(K).

L. Home and Community-based Services for Community Mental Health Supports (HCBS-CMHS) shall be defined as services provided in a home or community-based setting to Clients who are eligible for Medicaid reimbursement for long-term care, who would require nursing facility care without the provision of HCBS-CMHS, and for whom HCBS-CMHS services can be provided at no more than the cost of nursing facility care.

M. Intake/Screening/Referral shall be as defined at Section 8.390.1(M) and as the initial contact with Clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term care services; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive long-term care Client assessment.

N. Level Ff Care Screen shall be defined as an assessment conducted in accordance with Section 8.401.16

O. Non-Diversion shall be defined as a Client who was certified by the URC as meeting the Ll~~l~~evel of C~~c~~are S~~s~~creen and target group for the HCBS-CMHS program, but who did not receive HCBS-CMHS services for some other reason.

P. Person-Centered Support Plan shall be as defined in Section 8.390.1 DEFINITIONS.

Q. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8.390-8.393 and 8.487 are met.

R. Reassessment shall be as defined ~~as a periodic revaluation according to the requirements at~~in Section 8.390.1 DEFINITIONS.~~509.32.C.~~

S. Three Hundred Percent (300%) Eligible persons shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level, and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for thirty (30) consecutive days.

8.509.15 ELIGIBLE PERSONS

A. HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements below:

1. Financial Eligibility

Clients shall meet the eligibility criteria as specified in 9 CCR 2503-5, and the Section 8.100.

2. Level of Care AND Target Group.

Clients who have been determined to meet the level of care AND target group criteria shall be determined by the Utilization Review Contractor (URC) as meeting the level of care eligibility for HCBS-CMHS. The URC shall only determine HCBS-CMHS eligibility for those Clients:

a. Determined to meet the target group definition, defined as a person experiencing a severe and persistent mental health need that requires assistance with one or more Activities of Daily Living (ADL);

i. A person experiencing a severe and persistent mental health need is defined as someone who:

1) Is 18 years of age or older with a severe and persistent mental health need; and

2) Currently has or at any time during the past year leading up to assessment has a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within the Diagnostic and Statistical Manual of Mental Disorders (DSM -5); and

a) Has a disorder that is episodic, recurrent, or has persistent features, but may vary in terms of severity and disabling effects; and

b) Has resulted in functional impairment which substantially interferes with or limits one or more major life activities.

ii. A severe and persistent mental health need does not include:

1) Intellectual or developmental disorders; or

2) Substance use disorder without a co-occurring diagnosis of a severe and persistent mental health need.

b. Determined by a formal ~~level of care assessment~~LOC Screen to require the level of care available in a nursing facility, according to Section 8.401.11-15; and

c. A length of stay shall be assigned by the URC for approved admissions, according to guidelines at Section 8.402.50.

3. Receiving Services

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

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

c. Desire or need for home health services or other Medicaid services that are not HCBS-CMHS services, as listed at Section 8.509.12, shall not satisfy this eligibility requirement.

d. HCBS-CMHS Clients who have not received HCBS-CMHS services for thirty (30) days shall be discontinued from the program.

4. Institutional Status

a. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-CMHS services while residing in such institutions.

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

c. A Client who is already an HCBS-CMHS recipient and who enters a nursing facility may not receive HCBS-CMHS services while in the nursing facility;

1) The case manager must terminate the Client from the HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a ~~URC-certified ULTC-100.2~~ LOC Eligibility Determination for the nursing facility placement, as verified by telephoning the URC.

2) A Client receiving HCBS-CMHS services who enters a nursing facility for Respite Care as a service under the HCBS-CMHS program shall not be required to obtain a nursing facility ~~ULTC-100.2,~~LOC Screen and shall be continued as an HCBS-CMHS Client in order to receive the HCBS-CMHS service of Respite Care in a nursing facility.

8.509.16 START DATE

The start date of eligibility for HCBS-CMHS services shall not precede the date that all of the requirements at Section 8.509.15, have been met. The first date for which HCBS-CMHS services can be reimbursed shall be the LATER of any of the following:

A. Financial The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.

B. Level of Care This date is determined by the official URC-assigned start date on the ~~ULTC 100.2 form.~~LOC Eligibility Determination.

C. Receiving Services This date shall be determined by the date on which the Client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept HCBS-CMHS services.

D. Institutional Status HCBS-CMHS eligibility cannot precede the date of discharge from the hospital or nursing facility.

8.509.30 CASE MANAGEMENT FUNCTIONS

8.509.31 NEW HCBS-CMHS CLIENTS

A. INTAKE/SCREENING/REFERRAL

1. Case management agency staff shall complete a State-prescribed Intake form in accordance with the Single Entry Point Intake Procedures at Section 8.393.2 for each potential HCBS-CMHS Aapplicant. The Intake form must be completed before an assessment is initiated. The Intake form may also be used as a preliminary case plan form when signed by the Aapplicant for purposes of establishing a start date. Additionally, at intake, Clients shall be offered an opportunity to identify a third party to receive Client notices. This information shall be included on the intake form. This designee shall be sent copies of all notices sent to Clients.

2. Case management agency staff shall verify the individual's current financial eligibility status or refer the Client to the county department of social services of the Client's county of residence for application. This verification shall include whether the Aapplicant is in a category of assistance that includes financial eligibility for long-term care.

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a comprehensive uniform long-term care Client assessment (ULTC-100.2),Level of Care Eligibility Determination Screen and shall explain the reasons for the decision on the Intake form. The Client shall be informed of the right to request an assessment LOC Screen if the Client disagrees with the case manager's decision.

4. If the case management agency staff has determined that a comprehensive uniform long-term care client assessment (ULTC-100.2) LOC Screen is needed, or if the Client requests an assessment,one a case manager shall be assigned to schedule the assessment.

B. ASSESSMENT

1. The URC/SEP case manager shall complete the Uniform Long-term Care Client Assessment Instrument (ULTC-100.2) LOC Screen in accordance with Section 8.393.2.C-D, ASSESSMENT.

2. The URC/SEP case manager shall begin and complete the LOC Screen within ten (10) days of notification of Client's need for assessment.

3. The URC/SEP case manager shall complete the following activities for a LOC Screen:

   a. Obtain all required information from the Client's medical provider including information required for target group determination;

   b. Determine the Client's level of care needs during a face-to-face interview, preferably with the observation of the Client in his or her residential setting. Upon Department approval, the assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).;

   c. Determine the ability and appropriateness of the Client's caregiver, family, or others and other collateral, to provide the Client assistance in activities of daily living;

d. Determine the Client's service needs, including the Client's need for services not provided under HCBS-CMHS

e. If the Client is a resident of a nursing facility, determine the feasibility of deinstitutionalization;

f. Review service options based on the Client's needs, the potential funding sources, and the availability of resources;

g. Explore the Client's eligibility for publicly funded programs, based on the eligibility criteria for each program, in accordance with state rules;

h. View and document the current Assisted Living Residence license, if the Client lives, or plans to live, in a congregate facility as defined at Section 8.509.14in order to assure compliance with the regulation at Section 5.509.11(B).

i. Determine and document Client preferences in program selection;

j. Complete documentation on the ~~ULTC 100.2 form.~~LOC Screen.

k. To de-institutionalize a Client who is in a nursing facility under payment by Medicaid, and with an existing ~~-~~nursing facility Level of Care Eligibility Determination with a completion date older than six (6) months, ~~current ULTC 100.2 already certified by the URC/SEP agency for the nursing facility level of ULTC 100.2 completion date is older than six (6) months~~, the URC/SEP case manager shall complete a new LOC Screen and determine whether~~if~~ the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-CMHS, the case manager must ~~obtain a new~~complete a new ~~ULTC 100.2~~ LOC Screen and the Client shall be treated as an A~~a~~pplicant from the community rather than as a de-institutionalized Client.

l. It is the URC/SEP case manager's responsibility to assess the behaviors of the Client and assure that community placement is appropriate.

C. HCBS-CMHS DENIALS AND/OR DISCONTINUATIONS

1. If a Client is determined, at any point in the level of care ~~assessment~~ eligibility determination process, to be ineligible for HCBS-CMHS according to any of the requirements at Section 8.509.15, the case manager shall refer the Client or the Client's designated representative to other appropriate services. Clients who are denied HCBS-CMHS services shall be notified of denials and appeal rights as follows:

a. Financial Eligibility

The income maintenance technician at the county department of social services shall notify the A~~a~~pplicant of denial for reasons of financial eligibility and shall inform the A~~a~~pplicant of appeal rights in accordance with Sections 3.840 and 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a denial based on financial eligibility, unless subpoenaed, or unless requested by the state.

b. Level of Care AND Target Group

The URC shall notify the ~~applicant~~Applicant of denial for reasons related to determination of level of care AND target group eligibility and shall inform the ~~applicant~~Applicant of appeal rights in accordance with Section 8.057. The case manager shall not make judgments as to eligibility regarding level of care or target group and shall refer all ~~applicant~~Applicants who request a URC review to the URC, independently of any action that may be taken by the case manager in regard to other eligibility requirements, in accordance with the rest of this section. The case manager shall not attend the appeal hearing for a denial based on level of care or target group determination, unless subpoenaed, or unless requested by the state.

c. Receiving Services

The case manager shall notify the ~~applicant~~Applicant of denial, on Department-prescribed form, when the case manager determines that the ~~applicant~~Applicant does not meet the HCBS-CMHS eligibility requirements at Section 8.509.15 and shall inform the ~~applicant~~Applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

d. Institutional Status

The case manager shall notify the ~~applicant~~Applicant of denial, on a Department-prescribed form, when the case manager determines that the ~~applicant~~Applicant does not meet the eligibility requirement at Section 8.509.15 and shall inform the ~~applicant~~Applicant of appeal rights in accordance with Section 8.057, et. seq. The case manager shall also attend the appeal hearing to defend this denial action. A denial and appeal for this reason is independent of any action that may be taken by the URC in regard to level of care and target group determination.

e. Cost-effectiveness

The case manager shall notify the ~~applicant~~Applicant of denial, on Department-prescribed form, when the case manager determines that the ~~applicant~~Applicant does not meet the eligibility requirement 8.509.15 and shall inform the ~~applicant~~Applicant of appeal rights in accordance with Section 8.057, et.seq. The case manager shall also attend the appeal hearing to defend this denial action. If the ~~applicant~~Applicant requests to receive less than the needed amount of services in order to become cost-effective, the case manager must assess the safety of the ~~applicant~~Applicant, and the competency of the ~~applicant~~Applicant to choose to live in an unsafe situation. If the case manager determines that the ~~applicant~~Applicant will be unsafe with the amount of services available and is not competent to choose to live in an unsafe situation, the case manager may deny HCBS-CMHS eligibility. To support a denial for safety reasons related to cost-effectiveness, the case manager must document the results of an Adult Protective Services assessment, a statement from the Client's physician attesting to the Client's mental competency status, and all other available information which will support the determination that the Client is unsafe and incompetent to make a decision to live in an unsafe situation; and, which will satisfy the burden of proof required of file case manager making the denial. Denials and appeals for reasons of cost-effectiveness, or safety related to cost-effectiveness, are

independent of any action that may be taken by the URC in regard to level of care and target group determination.

f. Waiver Cap

The case manager shall notify the ~~applicant~~Applicant of denial, on a Department-prescribed form, when the waiver cap limiting the number of Clients who may be served under the terms of the approved waiver has been reached.

8.509.32 ONGOING HCBS-CMHS CLIENTS

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS Clients shall be in accordance with Section 8.393.2. In addition, the case manager shall:

a. Contact each Client quarterly, or more frequently, as determined by the Client's assessed needs. Contact may be at the Client's place of residence, by telephone, or other appropriate setting as determined by the Client's needs.

b. Review the ~~ULTC.100.2~~ LOC Screen and the ~~Service Plan~~ PCSP with the client every six (6) months in person. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

2. The case manager shall refer the Client for mental health services taking into account Client choice. The case manager shall coordinate case management activities for those Clients who are receiving mental health services from the Behavioral Health Organizations (BHO).

3. On-going case management shall include, but not be limited to the following tasks:

a. Review of the Client's case plan and service agreements;

b. Contact with the Client concerning whether services are being delivered according to the plan; and the Client's satisfaction with services provided;

c. Contact with service providers concerning service delivery, coordination, effectiveness, and appropriateness;

d. Contact with appropriate parties in the event any issues or complaints have been presented by the Client or others;

e. Conflict resolution and/or crisis intervention, as needed;

f. Informal assessment of changes in Client functioning, service effectiveness, service appropriateness, and service cost-effectiveness;

g. Notification of appropriate enforcement agencies, as needed; and

h. Referral to community resources, and arrangement for non-HCBS-CMHS services, as needed.

4. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence or the local law enforcement agency.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment, or mis-utilization of any public assistance or Medicaid benefit. The case manager shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with the Colorado Department of Human Services' Staff Manual Volume 3, Section 3.810.

C. REASSESSMENT

1. The case manager shall complete a level of care R~~r~~eassessment of each HCBS-CMHS Client before the end of the length of stay assigned by the URC at the ~~st level of care determination.~~Level of Care Eligibility Determination. The case manager shall initiate a R~~r~~eassessment more frequently when warranted by significant changes that may affect HCBS-CMHS eligibility.

2. The case manager shall complete the R~~r~~eassessment, utilizing the ~~Uniform Long-term Care Client Assessment Instrument (ULTC 100.2).~~Department prescribed instrument.

3. Reassessment shall include, but not be limited to, the following activities:

   a. Verify continuing Medicaid eligibility, including verification of an aid category that includes eligibility for long-term care benefits;

   b. Evaluate service effectiveness, quality of care, appropriateness of services, and cost effectiveness;

   c. Evaluate continuing need for the HCBS-CMHS program, and clearly document reasons for continuing HCBS; or terminate the Client's eligibility according to Section 8.509.32(E);

   d. Ensure that all information needed from the medical provider for the~~URC level of care review is included on the ULTC 100.2 form;~~LOC Screen is included.

   e. Reassess the Client's ~~functional~~ level of care status, according to the procedures in Section 8.509.31(B);

   f. Review the PCSP, including verification of whether services have been delivered according to the PCSP, and write a new PCSP, according to procedures at Section 8.509.31(D);

   g. Refer the Client to community resources, as needed;

   h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31(G). For Clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the ~~approved ULTC 100.2~~Level of Care Eligibility Determination. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the Client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by

the URC or the Office of Administrative Courts to the Client; or (c) a copy of the notice of a scheduled court date.

Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed and shall not be accepted as a substitute for ~~the approved ULTC 100.2~~the Level of Care Eligibility Determination. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the income maintenance technician of any and all changes in the Client's participation in HCBS-CMHS and shall provide the technician with copies ~~of the first page of all URC-approved ULTC-100.2 forms.~~the Level of Care Eligibility Determination.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

A. Adaptive Equipment means one or more devices used to assist with completing activities of daily living.

B. Allocation means the funds determined by the Case Manager in collaboration with the Client and made available by the Department through the Financial Management Service (FMS) vendor for Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option.

C. ~~Assessment means a comprehensive evaluation with the Client seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the Client's medical provider to determine the Client's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department's prescribed tool to complete assessments.~~ Assessment shall be as defined at Section 8.390.1.DEFINITIONS.

D. Attendant means the individual who meets qualifications in 8.510.8 who provides CDASS as described in 8.510.3 and is hired by the Client or Authorized Representative through the contracted FMS vendor.

E. Attendant Support Management Plan (ASMP) means the documented plan described in 8.510.5, detailing management of Attendant support needs through CDASS.

F. Authorized Representative (AR) means an individual designated by the Client or the Client's legal guardian, if applicable, who has the judgment and ability to direct CDASS on a Client's behalf and meets the qualifications contained in 8.510.6 and 8.510.7.

G. Case Management Agency (CMA) means a public or private entity that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community-based Services waivers pursuant to §§ 25.5-10-209.5 and 25.5-6-106, C.R.S., and has a current provider participation agreement with the Department.

H. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual Client's functional eligibility for one or more Home and Community-based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the Client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and periodic Rr~~r~~eassessment of Client needs.

I. Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that empowers Clients to direct their care and services to assist them in accomplishing activities of daily living when included as a waiver benefit. CDASS benefits may include assistance with health maintenance, personal care, and homemaker activities.

J. CDASS Certification Period Allocation means the funds determined by the Case Manager and made available by the Department for Attendant services for the date span the Client is approved to receive CDASS within the annual certification period.

K. CDASS Task Worksheet: A tool used by a Case Manager to indicate the number of hours of assistance a Client needs for each covered CDASS personal care services, homemaker services, and health maintenance activities.

L. CDASS Training means the required CDASS training and comprehensive assessment provided by the Training and Operations Vendor to a Client or Authorized Representative.

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

N. Electronic Visit Verification (EVV) means the use of technology, including mobile device technology, telephony, or Manual Visit Entry, to verify the required data elements related to the delivery of a service mandated to be provided using EVV by the "21st Century Cures Act," P.L. No. 114-255, or this rule.

O. Family Member means any person related to the Client by blood, marriage, adoption, or common law as determined by a court of law.

P. Financial Eligibility means the Health First Colorado financial eligibility criteria based on Client income and resources.

Q. Financial Management Services (FMS) vendor means an entity contracted with the Department and chosen by the Client or Authorized Representative to complete employment-related functions for CDASS Attendants and to track and report on individual Client CDASS Allocations.

R. Fiscal/Employer Agent (F/EA) provides FMS by performing payroll and administrative functions for Clients receiving CDASS benefits. The F/EA pays Attendants for CDASS services and maintains workers' compensation policies on the Client-employer's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both Client-employer and Attendant-employee Social Security and Medicare taxes. ~~Functional Eligibility means the physical and cognitive functioning criteria a Client must meet to qualify for a Medicaid waiver program, as determined by the Department's functional eligibility assessment tool.~~

S. Home and Community-based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to Clients in community settings. These services are designed to help older persons and persons with disabilities to live in the community.

T. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and Operations Vendor or the FMS, and which includes documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language.

U. Licensed Medical Professional means the primary care provider of the Client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN), as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

V. Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the Client.

W. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web site, Client account statements, Case Manager contact, or FMS vendor contact.

X. Stable Health means a medically predictable progression or variation of disability or illness.

Y. Training and Operations Vendor means the organization contracted by the Department to provide training and customer service for self-directed service delivery options to Clients, Authorized Representatives, and Case Managers.

8.515 HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH BRAIN INJURY (HCBS-BI)

8.515.1 LEGAL BASIS

The Home and Community-based Services for Persons with Brain Injury (HCBS-BI) program is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. Section 1396a(a)(10)(B) (2018). This waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. Section 1396n (2018). This regulation is adopted pursuant to the authority in Section 25.5-1-303, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Sections 24-4-101 et seq., C.R.S. and the Home and Community-based Services for Persons with Brain Injury Act, Sections 25.5-6-701 et seq., C.R.S.

8.515.3 GENERAL DEFINITIONS

Brain Injury means an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Nonpsychotic mental disorders due to brain damage; or
2. Anoxic brain damage; or
3. Compression of the brain; or
4. Toxic encephalopathy; or
5. Subarachnoid and/or intracerebral hemorrhage; or
6. Occlusion and stenosis of precerebral arteries; or
7. Acute, but ill-defined cerebrovascular disease; or
8. Other and ill-defined cerebrovascular disease; or
9. Late effects of cerebrovascular disease; or
10. Fracture of the skull or face; or
11. Concussion resulting in an ongoing need for assistance with activities of daily living; or
12. Cerebral laceration and contusion; or
13. Subarachnoid, subdural, and extradural hemorrhage, following injury; or
14. Other unspecified intracranial hemorrhage following injury; or
15. Intracranial injury; or
16. Late effects of musculoskeletal and connective tissue injuries; or
17. Late effects of injuries to the nervous system; or

18. Unspecified injuries to the head resulting in ongoing need for assistance with activities of daily living.

Case Management Agency means the agency designated by the Department to provide the Single Entry Point Functions detailed at Section 8.393.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

~~Service Plan means the plan developed by the case manager in coordination with the HCBS-BI Client and/or the legal guardian to identify and document the HCBS-BI services, other Medicaid services, and any other non-Medicaid services or supports that the HCBS-BI Client requires in order to live successfully in the community.~~Person-Centered Support Plan means as defined in Section 8.390.1 DEFINITIONS.

8.515.4 SCOPE AND PURPOSE

The HCBS-BI program provides those services listed at Section 8.515.2.A to eligible individuals with brain injury that require long-term supports and services in order to remain in a community-based setting.

8.515.5 ELIGIBLE PERSONS

HCBS-BI program enrollment and services shall be offered only to individuals determined by the Department or its agent to have met all eligibility requirements in this Section 8.515.5..

8.515.5.A LEVEL OF CARE

Eligible individuals shall be determined by the Department or its agent to require one of the following levels of care:

1. Hospital Level of Care as evidenced by:

   a. The individual shall have been:

      i. Referred to the Case Management Agency while receiving inpatient care in an acute care or rehabilitation hospital for the treatment of the individual's brain injury; or

      ii. Determined by the Department or its agent to have ~~a significant functional impairment a~~require a hospital level of care as determined using the Department prescribed LOC Screen.~~s evidenced by a comprehensive functional assessment using the Uniform Long-term Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15; and~~

   c. The individual shall require goal-oriented therapy with medical management by a physician; and

   d. The individual cannot be therapeutically managed in a community-based setting without significant supervision and structure, specialized therapy, and support services.

2. Nursing Facility Level of Care as evidenced by all the following:

   a. The individual shall have been determined by the Department or its agent to ~~have a significant functional impairment as evidenced by a comprehensive~~

~~functional assessment using the Uniform Long-term Care 100.2 (ULTC 100.2) assessment tool that results in at least the minimum scores required by Section 8.401.1.15;~~require nursing facility level of care as determined using the Department prescribed LOC Screen.

b. The individual shall require long-term support services at a level comparable to those services typically provided in a nursing facility.

8.515.5.B TARGET GROUP

Eligible individuals shall be determined by the Department or its agent to meet all the following target group criteria:

1. The individual shall have a diagnosis of Brain Injury. This diagnosis must be documented on the individual's Professional Medical Information Page (PMIP) and the ~~ULTC 100.2 assessment too~~LOC Screen~~l~~.

2. Age Limit

a. Individuals enrolled in the Brain Injury waiver shall be aged 16 years and older and shall have sustained the brain injury prior to the age of 65.

8.515.5.C FINANCIAL ELIGIBILITY

Individuals must meet the financial requirements for long-term care medical assistance eligibility specified at Section 8.100.7.

8.515.5.D NEED FOR HCBS-BI SERVICES

1. Only Clients that currently receive HCBS-BI services, or that have agreed to accept HCBS-BI services as soon as all other eligibility criteria have been met, are eligible for the HCBS-BI program.

a. Case management is provided as an administrative function, not an HCBS-BI service, and shall not be used to satisfy this requirement.

b. The desire or need for any Medicaid services other than HCBS-BI services, as listed at Section 8.515.1, shall not satisfy this eligibility requirement.

2. Clients that have not received an HCBS-BI service for a period greater than 30 consecutive days shall be discontinued from the program.

8.515.5.E EXCLUSIONS FROM ELIGIBILITY

1. Individuals who are residents of nursing facilities, hospitals, or other institutional settings are not eligible to receive HCBS-BI services.

2. HCBS-BI Clients that enter a nursing facility or hospital may not receive HCBS-BI services while admitted to the nursing facility or hospital.

a. HCBS-BI Clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the HCBS-BI program.

b. HCBS-BI Clients entering a nursing facility for Respite Care as an HCBS-BI service shall not be discontinued from the HCBS-BI program.

8.515.6 START DATE FOR SERVICES

8.515.6.A. The start date of eligibility for HCBS-BI services shall not precede the date that all of the requirements in Section 8.515.5~~,~~ have been met. The first date for which HCBS-BI services may be reimbursed shall be the later the following:

1. The date at which financial eligibility is effective.

2. The date at which the Department or its agent has made a Level of Care Determination ~~determined~~ that the Client has met all level of care eligibility requirements at Section 8.515.5.

3. The date at which the Client agrees to accept services and signs all necessary intake and Person-Centered Support Planning ~~service planning~~ forms.

4. The date of discharge from an institutional setting.

8.515.7 PRIOR AUTHORIZATION OF SERVICES

8.515.7.A. All HCBS-BI services must be prior authorized by the Department or its agent.

8.515.7.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.

8.515.7.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the Client's documented medical condition and functional capacity;

2. Reasonable in amount, scope, frequency, and duration;

3. Not duplicative of the other services or supports included in the Client's ~~Service Plan;~~PCSP;

4. Not for services for which the Client is receiving funds to purchase; and

5. Do not total more than 24 hours per day of care.

8.515.7.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

8.515.7.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-BI services to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR.

1. Payment for HCBS-BI services is also conditional upon:

   a. The Client's eligibility for HCBS-BI services;

   b. The provider's certification status; and

   c. The submission of claims in accordance with proper billing procedures.

8.515.7.F. The prior authorization of services does not constitute an entitlement to those services. All services provided and reimbursed must be delivered in accordance with regulation and be necessary to meet the Client's needs.

8.515.7.G. Services requested on the PAR shall be supported by information on the ~~Service Plan~~PCSP and the ~~ULTC-100.2 assessment.~~LOC Screen.

8.515.7.H. The PAR start date shall not precede the start date of HCBS-BI eligibility in accordance with Section 8.515.6.

8.515.7.I. The PAR end date shall not exceed the end date of the HCBS-BI eligibility certification period.

8.515.8 WAITING LIST

8.515.7.A. Persons determined eligible for HCBS-BI services that cannot be served within the capacity limits of the HCBS-BI waiver shall be eligible for placement on a waiting list.

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

2. The date used to establish the person's placement on the waiting list shall be the date on which all other eligibility requirements at Section 8.515.5 were determined to have been met and the HCBS-BI Program Administrator was notified.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the date of their waiting list placement.

8.515.85 SUPPORTIVE LIVING PROGRAM

8.515.85.A DEFINITIONS

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

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

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

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

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

6. Case Management Agency (CMA) means an agency within a designated service area where an ~~applicant~~Applicant or Client can obtain Case Management services. CMAs include Single Entry Points (SEPs), Community Centered Boards (CCBs), and private case management agencies.

7. Case Manager means an individual employed by a CMA who is qualified to perform the following case management activities: determination of an individual Client's

f~~unctional~~Level of Care E~~e~~ligibility Determination for the Home and Community-based Services – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and P~~p~~erson-C~~c~~entered ~~Service~~ Support Plan for the Client, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic R~~r~~eassessment of such Client's needs.

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

9. Department means the Department of Health Care Policy and Financing.

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

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

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

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

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

15. Person-Centered ~~Care~~ Support Plan is ~~a service plan created by a process that is driven by the individual and can also include people chosen by the individual pursuant to 42 C.F.R. § 441.540. It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents Client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the Client needs to function safely in the community.~~as defined in Secgtion 8.390.1 DEFINITIONS.

16. Protective Oversight is defined as monitoring and guidance of a Client to assure his/her health, safety, and well-being. Protective oversight includes, but is not limited to: monitoring the Client while on the premises, monitoring ingestion and reactions to prescribed medications, if appropriate, reminding the Client to carry out activities of daily

living, and facilitating medical and other health appointments. Protective oversight includes the Client's choice and ability to travel and engage independently in the wider community and providing guidance on safe behavior while outside the Supportive Living Program.

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

18. Supportive Living Program (SLP) certification means documentation from the Colorado Department of Public Health and Environment (CDPHE) recommending certification to the Department after the SLP provider has met all licensing requirements found in 6 C.C.R. 1011-1; Chapter 2, and either Chapter 7 or 26, in addition to all requirements in § 8.515.85.

8.515.85.B CLIENT ELIGIBILITY

1. SLP services are available to individuals who meet all of the following requirements:

   a. Clients are determined ~~functionally eligible~~to meet level of care eligibility for HCBS-BI waiver by a certified case management agency as outlined in Section 8.515.5~~;~~.

   b. Clients are enrolled in the HCBS-BI waiver; and

   c. Clients require the specialized services provided under the SLP as determined by assessed need.

2. Person-Centered Care Planning

   SLP providers must comply with the Person-Centered Care Planning process. Providers must work with CMAs to ensure coordination of a Client's Person-Centered Care Plan. Additionally, SLP providers must provide the following actionable plans for all HCBS-BI waiver Clients, updated every six (6) months:

   a. Transition Planning; and

   b. Goal Planning.

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

3. Exclusions

   The following are not included as components of the SLP:

   a. Room and board; and

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

8.517 HOME AND COMMUNITY-BASED SERVICES FOR THE COMPLEMENTARY AND INTEGRATIVE HEALTH WAIVER

8.517.1 HCBS-CIH WAIVER SERVICES

8.517.2 GENERAL DEFINITIONS

A. Acupuncture (CIHS) means the insertion of needles and/or manual, mechanical, thermal, electrical, and electromagnetic treatment to stimulate specific anatomical tissues for the promotion, maintenance and restoration of health and prevention of disease both physiological and psychological. During an acupuncture treatment, dietary advice and therapeutic exercises may be recommended in support of the treatment.

B. Chiropractic (CIHS) means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting and/or improving alignment, neurological function, and other musculoskeletal problems. During a chiropractic treatment, nutrition, exercise, and rehabilitative therapies may be recommended in support of the adjustment.

C. Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.

D. Complementary and Integrative Health Provider means an individual or agency certified annually by the Department to have met the certification standards listed at Section 8.517.11.

E. Complementary and Integrative Health Services (CIHS) means Acupuncture, Chiropractic, and Massage Therapy.

F. Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

G. Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

H. Massage Therapy (CIHS) means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services shall be offered only to individuals who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a qualifying condition of a spinal cord injury (traumatic or nontraumatic), multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability for independent ambulation directly resulting from one of

these conditions as defined by broad diagnoses related to each condition within the most current version of the International Classification of Diseases (ICD) at the time of assessment.

3. Individuals must have been determined to have an inability for independent ambulation resulting from the qualifying condition as identified by the case manager through the assessment process. The inability for independent ambulation means:

   a. The individual does not walk, and requires use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own, OR;

   b. The individual does walk, but requires use of a walker or cane in all settings, whether or not they can use the walker or cane safely, on their own, OR;

   c. The individual does walk ~~,~~ but requires "touch" or "stand-by" assistance to ambulate safely in all settings.

8.517.5.C LEVEL OF CARE CRITERIA

Individuals shall require long-term support services at a level of care comparable to services typically provided in a nursing facility or hospital.

8.517.6 WAITING LIST

9. Within ten business days of notification from the Department that an opening for the HCBS-CIH waiver is available the Case Management Agency shall:

   a. Reassess the individual for ~~functional~~ level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

   b. Update the existing ~~functional~~ level of care assessment in the official Client record if less than six months has elapsed since the date of the previous assessment.

   c. Reassess for eligibility criteria as set forth at 8.517.5.

   d. Notify the Department of the individual's eligibility status.

8.519 Case Management

8.519.1 Definitions

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

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

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

C~~D~~. Assessment means as defined in Section 8.390.1 DEFINITIONS.

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

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

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

G. Case Management means ~~the assessment of an individual's needs receiving long-term services and supports, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of services effectiveness, and the periodic reassessment of such individual's needs.~~as defined in Section 8.390.1 DEFINITIONS.

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

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

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

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

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

M. ~~Comprehensive Assessment means as defined in Section 8.390.1 DEFINITIONS. an initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support.~~

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

NO. Corrective Action Plan ~~means a written plan by the CMA, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.~~ shall be as defined at Section 8.390.1.DEFINITIONS.

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

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

QR. Developmental Delay means as defined in Section 8.600.4.

RS. Developmental Disability means as defined in Section 8.600.4.

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

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

UV. Guardian means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

VW. Guardian ad litem or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in article 33 of title 22, C.R.S.

WX. Home and Community-based Services (HCBS) waivers means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client

who requires a ~~n institutional~~ Level of Care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

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

YZ. Information Management System (IMS) ~~means an automated data management system approved by the Department to enter case management information for each individual seeking or receiving long-term services as well as to compile and generate standardized or custom summary reports.~~means as defined in Section 8.390.1 DEFINITIONS.

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

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

BBCC. Level of Care Eligibility Determination means ~~determining eligibility of an individual for a Long-Term Services and Supports (LTSS) program and determined by a Community Centered Board or Single Entry Point Agency~~as defined in Section 8.390.1 DEFINITIONS.

CCDD. Level of Care ~~Evaluation~~ Eligibility Determination Screen means as defined in Section 8.390.1 DEFINITIONS. ~~a comprehensive evaluation with the individual seeking services and others chosen by the individual to participate and an evaluation by the Case Manager utilizing the Department prescribed tool, with supporting diagnostic information from the Client's medical provider, and to determine the Client's level of functioning for admission or continued stay in certain Long-Term Services and Supports (LTSS) programs.~~

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

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

FFGG. Organized Health Care Delivery System (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.

GGHH. Parent means the biological or adoptive parent.

HH.II. Performance and Quality Review means a review conducted by the Department or its contractor at any time but no less than the frequency as specified in the approved waiver application. To

include a review of required case management services performed by the agency to ensure quality and compliance with all requirements. The agency shall provide all requested information and documents as requested by the Department or by its contractor.

II.~~JJ~~. Person-Centered Support Plan (PCSP) means as defined in Section 8.390.1 DEFINITIONS.

JJ. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.

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

LL~~KK~~. Professional Medical Information Page (PMIP) ~~means the medical information form signed by a licensed medical professional used to certify Level of Care.~~ means as defined in Section 8.390.1 DEFINITIONS.

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

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

OO~~NN~~. Retrospective Review means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the ~~Service Plan~~ PCSP and that the Case Management Agency complied with the requirements set forth in statute, waiver, and regulations.

~~OO. Person-Centered SupportService Plan (PCSP) means as defined in Section 8.390.1 DEFINITIONS. the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with the Department's rules.~~

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

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

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

~~SS. Person-Centered Support Planning means the process of working with an individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate services providers based on the individual's assessment and knowledge of the individual and available community resources. Support planning includes informing the individual seeking or receiving services of his or her rights and responsibilities.as defined in Section 8.390.1 DEFINITIONS.~~

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

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

~~**8.519.6 Case Management Agency selection- To be implemented no later than January 1, 2021**~~

~~8.519.6.A. Clients have the ability to change their Case Management Agency at any time, with the exception of initial enrollment into a waiver.~~

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

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

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

~~a. The Client, or the Client's guardian, shall inform the Department's contractor of their choice of Case Management Agency.~~

~~b. The Department's contractor shall assist the Client in selecting a CMA when necessary, which may include, but is not limited to:~~

~~i. Providing a list of qualified CMAs.~~

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

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

~~iv. In addition to other assistance as requested or needed by the Client.~~

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

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

~~i. The selected CMA, address and contact information;~~

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

iii. Contact information for the Department's contactor.

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

8.519.6.C Case Management Agency transfer

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

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

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

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

ii. When the Client seeking case management services and/or their guardian, as appropriate, does not know which approved CMA the Client wishes to select, the Department's contractor shall assist the Client in the selection of a CMA which may include, but is not limited to:

1. Providing a list of qualified CMAs.

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

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

4. Other assistance as requested or needed by the Client

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

1. The selected CMA;

2. Contact information for the CMA;

3. Information about the right to choose a CMA; and

4. Contact information for the Department's contractor.

iv. The selected CMA shall contact the Client within two (2) business days from notification of selection to confirm the choice and review service plan and any changes necessitated by the transfer.

v. The transferring CMA shall continue to provide case management services until the new CMA has been assigned in the Department's

~~prescribed system and contacted the Client in accordance with 8.519.6.B(3).~~

8.550.6.B. Special Requirements

1. Eligibility for, and access to, Hospice Services does not fall within the purview of the long-term care Single Entry Point system for prior authorization.

2. Nursing facility placement for a Client who has Medicaid and has Elected Hospice Services in a nursing facility does not require a ~~ULTC 100.2 assessment.~~LOC Screen. The nursing facility must complete a Pre Admission Screening and Resident Review (PASRR).

8.600 Services for Individuals with Intellectual and Developmental Disabilities

8.600.4 Definitions

As used in these rules, unless the context requires otherwise:

"Abuse" is as defined at Sections 16-22-102 (9), 19-1-103, 25.5-10-202 (1) (a)-(c), and 26.3.1-101 C.R.S..

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

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

"Assistive Technology Services" includes, but is not limited to, the evaluation of a person's need for assistive technology; helping to select and obtain appropriate devices; designing, fitting and customizing those devices; purchasing, repairing or replacing the devices; and, training the individual, or if appropriate a family member, to use the devices effectively.

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

"Authorized Services" means those services and supports authorized pursuant to Section 25.5-10-206, C.R.S., which the Department shall provide directly or purchase subject to available appropriations for persons who have been determined to be eligible for such services and supports and as specified in the eligible person's individualized plan.

"Caretaker" is as defined at Section 25.5-10-202(1.6)(a)-(c), C.R.S.

"Caretaker Neglect" is as defined at Section 25.5-10-202(1.8)(a)-(c), C.R.S.

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

"Challenging Behavior" means behavior that puts the person at risk of exclusion from typical community settings, community services and supports, or presents a risk to the health and safety of the person or others or a significant risk to property.

“Client” means an individual who has met Long-Term Services and Supports (LTSS) eligibility requirements and has been offered and agreed to receive Home and Community Based Services (HCBS) in the Children's Extensive Supports (HCBS-CES) waiver, the HCBS waiver for Children’s Habilitation Residential Program (CHRP), the HCBS waiver for Persons with Developmental Disabilities (HCBS-DD), Family Support Services Program (FSSP),or the Supported Living Services (HCBS-SLS) waiver.

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

“Comprehensive Review of the Person's Life Situation” means a thorough review of all aspects of the person's current life situation by the program approved service agency in conjunction with other members of the interdisciplinary team.

“Comprehensive Services” means habilitation services and supports that provide a full day (24 hours) of services and supports to ensure the health, safety and welfare of the individual, and to provide training and habilitation services or a combination of training and supports in the areas of personal, physical, mental and social development and to promote interdependence, self-sufficiency and community inclusion. Services include residential habilitation services and supports, day habilitation services and supports and transportation.

“Consent” means an informed assent, which is expressed in writing and is freely given. Consent shall always be preceded by the following:

A. A fair explanation of the procedures to be followed, including an identification of those which are experimental;

B. A description of the attendant discomforts and risks;

C. A description of the benefits to be expected;

D. A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

E. An offer to answer any inquiries regarding the procedure;

F. An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

G. A statement that withholding or withdrawal of consent shall not prejudice future provision of appropriate services and supports to individuals.

“Developmental Delay” means that a child meets one or more of the following:

A. A child who is less than five (5) years of age at risk of having a developmental disability because of the presence of one or more of the following:

1. Chromosomal conditions associated with delays in development,

2. Congenital syndromes and conditions associated with delays in development,

3. Sensory impairments associated with delays in development,

4. Metabolic disorders associated with delays in development,

5. Prenatal and perinatal infections and significant medical problems associated with delays in development,

6. Low birth weight infants weighing less than 1200 grams, or

7. Postnatal acquired problems resulting in delays in development.

B. A child less than five (5) years of age who is significantly delayed in development in one or more of the following areas:

1. Communication,

2. Adaptive behavior,

3. Social-emotional,

4. Motor,

5. Sensory, or

6. Cognition.

C. A child less than three (3) years of age who lives with one or both parents who have a developmental disability.

“Critical Incident” means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to: Injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death

“Developmental Disabilities Professional” means a person who has at least a Bachelor’s Degree and a minimum of two (2) years’ experience in the field of developmental disabilities or a person with at least five (5) years of experience in the field of developmental disabilities with competency in the following areas:

A. Understanding of civil, legal and human rights;

B. Understanding of the theory and practice of positive and non-aversive behavioral intervention strategies;

C. Understanding of the theory and practice of non-violent crisis and behavioral intervention strategies.

“Developmental Disability” means a disability that:

A. Is manifested before the person reaches twenty-two (22) years of age;

B. Constitutes a substantial disability to the affected individual, as demonstrated by the criteria below at C, 1 and/or C, 2; and,

C. Is attributable to an intellectual and developmental disability or related conditions which include Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological conditions when such conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of "developmental disability" found 42 U.S.C. § 15002, et seq., shall not apply.

1. "Impairment of general intellectual functioning" means that the person has been determined to have a full scale intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15).

   a. A secondary score comparable to the General Abilities Index for a Wechsler Intelligence Scale that is two or more standard deviations below the mean may be used only if a full scale score cannot be appropriately derived.

   b. Score shall be determined using a norm-referenced, standardized test of general intellectual functioning comparable to a comprehensively administered Wechsler Intelligence Scale or Stanford-Binet Intelligence Scales, as revised or current to the date of administration. The test shall be administered by a licensed psychologist or a school psychologist.

   c. When determining the intellectual quotient equivalent score, a maximum confidence level of ninety percent (90%) shall be applied to the full scale score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the ~~applicant~~Applicant being determined to have a developmental disability.

2. "Adaptive behavior similar to that of a person with intellectual disability " means that the person has an overall adaptive behavior composite or equivalent score that is two or more standard deviations below the mean.

   a. Measurements shall be determined using a norm-referenced, standardized assessment of adaptive behaviors that is appropriate to the person's living environment and comparable to a comprehensively administered Vineland Scale of Adaptive Behavior, as revised or current to the date of administration. The assessment shall be administered and determined by a professional qualified to administer the assessment used.

   b. When determining the overall adaptive behavior score, a maximum confidence level of ninety percent (90%) shall be applied to the overall adaptive behavior score to determine if the interval includes a score of 70 or less and shall be interpreted to the benefit of the ~~applicant~~Applicant being determined to have a developmental disability.

D. A person shall not be determined to have a developmental disability if it can be demonstrated such conditions are attributable to only a physical or sensory impairment or a mental illness.

"Emergency", as used in Section 8.608.3 regarding restraint, means a serious, probable, imminent threat of bodily harm to self or others where there is the present ability to affect such bodily harm.

“Emergency Control Procedure” means an unanticipated use of a restrictive procedure or restraint in order to keep the person receiving services and others safe.

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

“Exploitation” is as defined in Section 25.5-10-202(15.5)(a)-(d) and 26-3.1-101 C.R.S.

“Extreme Safety Risk to Self” means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client:

A. Displays self-destructiveness related to self-injury, suicide attempts or other similar behaviors that seriously threaten the Client's safety; and,

B. Has a rights suspension in accordance with Section 8.604.3 or has a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits the ability of the Client to harm himself or herself.

“Family”, as used in rules pertaining to support services and the Family Support Services Program means a group of interdependent persons residing in the same household that consists of a family member with a developmental disability or a child under the age of five (5) years with a developmental delay, and one or more of the following:

A. A mother, father, brother(s), sister(s) or any combination; or,

B. Extended blood relatives such as grandparent(s), aunt(s) or uncle(s); or,

C. An adoptive parent(s); or,

D. One or more persons to whom legal custody of a person with a developmental disability has been given by a court; or,

E. A spouse and/or his/her children.

“Family Support Council” means the local group of persons within the Community Centered Board's designated service area who have the responsibility for providing guidance and direction to the Community Centered Board for the implementation of the Family Support Services Program.

“Family Support Plan (FSP)” means a plan which is written for the delivery of family support services as specified in Section 8.613.

“Functional Analysis” means a comprehensive analysis of the medical, social, environmental, and personal factors that may influence current behavior. This analysis shall also investigate the person's ability to communicate, analyze whether the current behavior is a means to communicate, and identify historical factors which may contribute to the understanding of the current behavior.

“Guardian” means a person who has qualified as a guardian of a minor or incapacitated person by testamentary or count appointment but excludes a Guardian Ad Litem.

“Harmful Act” is as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.

“Home and Community-Based Services Waivers (HCBS)” means HCBS waiver programs, including the Home and Community Based Waiver for the Developmentally Disabled (HCBS-DD), Supported Living Services (SLS) and Children's Extensive Support (CES). “Host Home Provider” is an individual(s)who

provides residential supports in his/her home to persons receiving comprehensive services who are not family members as defined in Section 25.5-10-202(16), C.R.S. A host home provider is not a developmental disabilities service agency pursuant to Section 8.602 of these rules.

“Human Rights Committee” means a third-party mechanism to adequately safeguard the legal rights of persons receiving services by participating in the granting of informed consent, monitoring the suspension of rights of persons receiving services, monitoring behavioral development programs in which persons with intellectual and developmental disabilities are involved, monitoring the use of psychotropic medication by persons with intellectual and developmental disabilities, and reviewing investigations of allegations of mistreatment of persons with intellectual and developmental disabilities who are receiving services or supports.

“Individual Service and Support Plan (ISSP)” means a plan of intervention or instruction which directly addresses the needs identified in the person's Individualized Plan and which provides specific direction and methodology to employees and contractors providing direct service to a person.

~~“Individualized Plan (IP)” means a written plan designed by an interdisciplinary team for the purpose of identifying:~~

~~A. The needs of the person receiving services or family;~~

~~B. The specific services and supports appropriate to meet those needs;~~

~~C. The projected date for initiation of service and supports; and,~~

~~D. The anticipated results to be achieved by receiving the services and supports.~~

“Interdisciplinary Team (IDT)” means a group of people convened by a Community Centered Board which shall include the person receiving services, the parent or guardian of a minor, a guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as determined by such person's needs and preferences, who are assembled in a cooperative manner to develop or review the individualized plan.

“Mechanical Restraint” means the use of devices intended to restrict the movement or normal functioning of a portion of an individual's body. Mechanical restraint does not include the use of protective devices used for the purpose of providing physical support or prevention of accidental injury.

“Minimum Effective Dose” means the smallest medication dosage necessary to produce the intended effect.

“Mistreated” or “Mistreatment” is as defined at Sections 25.5-10-202(29.5)(a)-(d) and 26-3.1-101 C.R.S.:

“Notice” means written notification hand delivered to or sent by first class mail that contains at least all of the following:

A. The proposed action;

B. The reason or reasons for that action;

C. The effective date of that action;

D. The specific law, regulation, or policy supporting the action;

E. The responsible agency with whom a protest of the action may be filed including the name and address of the director.

F. The dispute resolution procedure, including deadlines, in conformity with Section 8.605 and procedures on accessing agency records:

1. For disputes involving individuals as defined in Section 8.605.2, information on availability of advocacy assistance, including referral to publicly funded legal services, corporation, and other publicly or privately funded advocacy organizations, including the protection and advocacy system required under 42 U.S.C. 15001, the Developmental Disabilities Assistance and Bill of Rights Act; and,

2. For disputes involving individuals as defined in Section 8.605.2 an explanation of how the agency will provide services to a currently enrolled person during the dispute resolution period, including a statement that services will not be terminated during the appeal. Such explanation will include a description of services currently received.

"Parent" means the biological or adoptive parent.

"Person-Centered Support Plan" means as defined in Section 8.390.1 DEFINITIONS.

"Physical Restraint" -means the use of manual methods to restrict the movement or normal functioning of a portion of an individual's body through direct physical contact by others except for the purpose of providing assistance/prompts. Assistance/prompts is the use of manual methods to guide or assist with the initiation or completion of and/or support the voluntary movement or functioning of an individual's body through the use of physical contact by others except for the purpose of providing physical restraint.

"PRN" (Pro Re Nata) means giving drugs on an "as needed" basis through a standing prescription or standing order.

"Program Approved Service Agency" means a developmental disabilities service agency or typical community service agency as defined in Section 8.602, which has received program approval by the Department pursuant to Section 8.603 of these rules.

"Program Services" means an organized program of therapeutic, habilitative, specialized support or remedial services provided on a scheduled basis to individuals with developmental disabilities.

"Prospective New Service Agency" means an individual or any publicly or privately operated program, organization or business that has completed and submitted an application with a Community Centered Board for selection and approval as a service agency to provide comprehensive services.

"Public Safety Risk-Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

A. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,

B. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

"Public Safety Risk-Not Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

A. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,

B. A rights suspension in accordance with Section 8.604.3or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

“Rate” means the amount of money, determined by a standardized rate setting methodology, reimbursed for each unit of a defined waiver service provided to a Client by a qualified provider.

“Referral” means any notice or information (written, verbal, or otherwise) presented to a Community Centered Board which indicates that a person may be appropriate for services or supports provided through the developmental disabilities system and for which the Community Centered Board determines that some type of follow-up activity for eligibility is warranted.

“Request for Provider (RFP)” means a formal process for case managers to notify Program Approved Provider Agencies when a Client is seeking authorized services including, but not limited to, a non-identifying description of the client’s support and supervision needs.

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

“Respondent” means a person participating in the SIS assessment who has known the Client for at least three months and has knowledge of the Client's skills and abilities. The respondent must have recently observed the Client directly in one or more places such as home, work, or in the community.

“Restrictive Procedure” means any of the following when the intent or plan is to bring an individual’s behavior into compliance:

A. Limitations of an individual's movement or activity against his or her wishes; or,

B. Interference with an individual's ability to acquire and/or retain rewarding items or engage in valued experiences.

“Request for Developmental Disability Determination” means written formal documentation, either handwritten or a signed standardized form, which is submitted to a Community Centered Board requesting that a determination of developmental disability be completed.

“Safety Control Procedure” means a restrictive procedure or restraint that is used to control a previously exhibited behavior which is anticipated to occur again and for which the planned method of intervention is developed in order to keep the person and others safe.

“Screening for Early Intervention Services” means a preliminary review of how a child is developing and learning in comparison to other similarly situated children. “Seclusion” means the placement of a Client alone in a closed room for the purpose of punishment. Seclusion for any purpose is prohibited.

“Service Agency” means an individual or any publicly or privately operated program, organization or business providing services or supports for persons with developmental disabilities.

“SIS Interviewer” means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department approved trainer using the Department approved curriculum. SIS Interviewers must maintain a standard for conducting SIS assessments as measured through periodic interviewer reliability reviews.

“Statewide Database” means the state web-based system that contains consumer-related demographic and program data.

“Support Coordinating Agency” means a Community Centered Board which has been designated as the agency responsible for the coordination of support services (supported living services for adults and the children's extensive support program) within its service area.

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

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

“Undue Influence” means use of influence to take advantage of a person with an intellectual or developmental disability’s vulnerable state of mind, neediness, pain, or emotional distress.

“Waiver Services” means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid State Plan services.

8.615 TELEHEALTH DELIVERY OF HOME AND COMMUNITY-BASED SERVICES

8.615.1 DEFINITIONS

A. ~~Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends, and/or caregivers), chosen by the individual, conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources.~~ Assessment shall be as defined at Section 8.390.1.DEFINITIONS.

B. Case Management means ~~the assessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs.~~as defined in Section 8.390.1 DEFINITIONS.

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

D. Community Centered Board (CCB) means a private corporation, for profit or not for profit, which when designated pursuant to Section 25.5-10-209, C.R.S., provides case management services to Members with developmental disabilities, is authorized to determine eligibility of such Members within a specified geographical area, serves as the single point of entry for Members to receive services and supports under Section 25.5-10-201, C.R.S. et seq , and provides authorized services and supports to such Members either directly or by purchasing such services and supports from service agencies.

E. Department means the Department of Health Care Policy and Financing.

F. Home and Community-Based Services (HCBS) means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Member who requires a level of institutional care that would otherwise be provided in an institutional setting.

G. Home and Community-Based Services Telehealth (HCBS Telehealth) is a method of service delivery of those HCBS services listed at Section 8.615.2.

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

I. Member means ~~an individual who meets long-term services and support eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).~~as defined in Section 8.390.1.

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

K. Person-Centered Support Plan means as defined in Section 8.390.1 DEFINITIONS. ~~the document used for Support Planning.~~

L. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS. ~~the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking services of his or her rights and responsibilities.~~

M. Telehealth means the broad use of technologies to provide services and supports through HCBS waivers, when the Member is in a different location from the provider.

N. Waiver Service means optional services defined in the current federally approved waiver documents and do not include Medicaid State Plan benefits.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adult Day Services Dementia Training, Section 8.491
Rule Number: MSB 23-03-14-B
Division / Contact / Phone: OCL / Kyra Acuna / 5666

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 23-03-14-B, Revision to the Medical Assistance Rule concerning Adult Day Services Dementia Training, Section 8.491

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

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.491.4 with the proposed text beginning at 8.491.4 through the end of 8.491.4.K. This rule is effective July 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adult Day Services Dementia Training, Section 8.491
Rule Number: MSB 23-03-14-B
Division / Contact / Phone: OCL / Kyra Acuna / 5666

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).

   Senate Bill 22-079 was signed into Colorado law in May 2022, and codified, in part, at Section 25.5-6-314. This bill requires that by July 1, 2024, the State Board of Health shall adopt rules requiring all direct-care staff members at Adult Day Care Facilities to obtain dementia training pursuant to curriculum prescribed or approved by the State Department in collaboration with stakeholders that is consistent with the rules adopted pursuant to Colorado Revised Statutes 25.5-6-314(2). The proposed rules are necessary comply with Senate Bill 22-079 prior to the July 1, 2024 deadline. The new regulations ensure that all direct-care staff members of Adult Day Services providers are required to receive dementia training as outlined in Senate Bill 22-079.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   N/A

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, 25.5-6-314, C.R.S. (2022);

Initial Review **05/12/23** Final Adoption **06/09/23**
Proposed Effective Date **07/30/23** Emergency Adoption

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Adult Day Services Dementia Training, Section 8.491
Rule Number: MSB 23-03-14-B
Division / Contact / Phone: OCL / Kyra Acuna / 5666

REGULATORY ANALYSIS

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

   The proposed rule will impact all Adult Day Services providers and those Home and Community-Based Services (HCBS) waiver members who receive Adult Day Services, which may include members on the Elderly, Blind, and Disabled (EBD), Brain Injury (BI), Complementary and Integrative Health (CIH), and Community Mental Health Supports (CMHS) waivers. The rule will benefit members served as it is estimated that about 31% of members receiving Adult Day Services have dementia diseases or related disabilities. There may be a budgetary or additional financial burden on Adult Day Services providers because of the new requirements, however this depends on the training entity selected by each provider agency. It is up to each provider agency to select the training entity that best meets the needs of the members they serve.

2. To the extent practicable, describe the probable quantitative and qualitative impact of the proposed rule, economic or otherwise, upon affected classes of persons. Approximately 2,500 members utilize Adult Day services across 50 service providers. This rule will impact all providers offering Adult Day services and all members served.

   The proposed rule will have a significant, positive impact on the quality of services for HCBS members by ensuring that all Adult Day Services direct-care staff members are specifically trained in working with individuals with dementia.

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 should be no additional cost to the Department or the Department of Public Health and Environment because of these rules. This training required by this rule will simply be added to the list of items surveyors review when at an Adult Day Services setting to monitor compliance.

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

Implementing these rules ensures that the Department is compliant with state law. No budgetary impact is anticipated as a result of the passage of the rule. The cost of inaction is a failure to comply with state law, which puts the Department at risk of losing funding for these invaluable HCBS services. No benefits to inaction are identified.

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 the purpose of this proposed rule. These regulations must be implemented to comply with Section 25.5-6-314, C.R.S.

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.

8.491 ADULT DAY SERVICES

8.491.1 Definitions

Adult Day Services (ADS) Center is a certified center that provides Basic Adult Day Services and Specialized Adult Day Services to participants.

Adult Day Services (ADS) are provided in an Adult Day Services Center or through Non-Center-Based means including Telehealth, on a regularly scheduled basis, as specified in the Person Centered Care Plan, promoting social, recreational, physical, and emotional well-being that encompasses the supportive services needed to ensure the optimal wellness of the participant.

A. Basic Adult Day Services (ADS) Center means a community-based entity that provides basic Adult Day Services in conformance with all state established requirements as described in 10 CCR 2505-10 section 8.130 and 10 CCR 2505-10 section 8.491.

B. Center-Based Adult Day Services are services provided in a certified ADS Center.

C. Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where participants can engage in activities and community life, either in-person or through virtual means.

D. Specialized Adult Day Services (SADS) Center means a community-based entity providing Adult Day Services for participants with a primary diagnosis of dementia related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington's Disease, Parkinson's, or post-stroke participants, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have a diagnosis which is one of any of the above diagnoses. Each diagnosis must be verified by a Licensed Medical Professional, either directly or through Case Management Agency documentation, in accordance with Section 8.491.14.A.

E. Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for participants to engage in activities, with their community, and connect to staff and other ADS participants virtually or over the phone, only if a participant does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services.

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

Designated Representative means a representative who is designated by the participant to act on the participant's behalf, as defined in 10 CCR 2505-10 Section 8.500.1.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 10 CCR 2505-10 8.491.4.I.

Director means any person who owns and operates an ADS Center or SADS Center or is a managing employee with delegated authority by ownership to manage, control, or perform the day-to-day tasks of operating the Center as described in 10 CCR 2505-10 Section 8.491.

Licensed Medical Professional (LMP) means a medical professional that possesses one or more of the following Colorado licenses, which must be active and in good standing: Physician, Physician Assistant, Registered Nurse (RN) or Licensed Practical Nurse (LPN) governed by the Colorado Medical License Act, and as defined in 10 CCR 2505-10 Section 8.503.

Participant means any individual found to be eligible for and enrolled in Center-Based or Non-Center-Based Adult Day Services regardless of payment source.

Provider means a service agency enrolled with the Department to provide Center-Based and/or Non-Center-Based Adult Day Services.

Qualified Medication Administration Personnel (QMAP) means an individual that has completed training, passed a competency evaluation, and is included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the requisite competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

Restraint means any physical or chemical device, application of force, or medication, which is designed or used for restricting freedom of movement, and/or modifying, altering, or controlling behavior, excluding medication prescribed by a physician as part of an ongoing treatment plan or pursuant to a diagnosis.

Staff means a paid or voluntary employee or contracted professional of the ADS Center or SADS Center.

Universal Precautions refers to a system of infection control that prevents the transmission of communicable diseases. Precautions include, but are not limited to, disinfecting of instruments, isolation and disinfection of environment, use of personal protective equipment, hand washing, and proper disposal of contaminated waste.

8.491.2 PARTICIPANT BENEFITS

8.491.2.A. Adult Day Services

1. Only participants whose needs can be met by the ADS provider within its certification category and populations served may be admitted by the ADS provider.

2. ADS shall include, but are not limited to, the following:

    a. Monitoring to ensure participants are maintaining activity levels and goals set forth in the Care Plan, pursuant to Section 8.491.4.E; and assistance with activities of daily living (ADL) as needed when ADS is provided in-person. (ADLs include but are not limited to eating, ambulation, positioning, transferring, toileting, and incontinence care).

    b. Services provided to monitor the participant's health status, monitor or administer medications (administration of medication only during the in-person delivery of services), and carry out physicians' orders as set forth in participant's individual Care Plan.

    c. Center-Based ADS must be provided in an integrated, community-based setting, which, supports participation and engagement in community life and gaining access to the greater community; participants may engage in meaningful activities in integrated and community settings.

    d. Emergency services including written procedures to meet medical crises.

e. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.

f. Nutrition services including therapeutic diets and snacks in accordance with the participant's individual Care Plan and hours of attendance. Nutrition services are not required during the delivery of Non-Center-Based ADS.

g. Social and recreational supportive services as appropriate for each participant and their needs, as documented in the participant's Care Plan. Activities shall take into consideration individual differences in age, health status, sensory deficits, religious affiliation, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.

h. Participants have the right to choose not to participate in social and recreational activities.

8.491.2.B. Adult Day Service Requirements

1. The participant's Care Plan must include documentation of their diagnosis(es) and service goals.

2. A Specialized Adult Day Services (SADS) provider must verify all Medicaid participant's diagnosis(es) using the Professional Medical Information Page (PMIP) which shall be supplied by the case manager or documentation from the participant's Licensed Medical Professional (LMP). Documentation must be verified at the time of admission and whenever there is a significant change in the participant's condition. Any significant change must be recorded in the participant's record or Care Plan.

   a. For participants from other payment sources, diagnosis(es) must be documented in a care plan, or other admission form, and verified by the participant's physician or LMP. This documentation must be verified at the time of admission, and whenever there is a significant change in the participant's condition.

8.491.3 PROVIDER REQUIREMENTS

A. General

1. ADS providers shall conform to all provider participation requirements, as defined in 10 CCR 2505-10 Section 8.130. ADS Centers shall have in effect all required licenses, certifications, and insurance, as applicable. ADS Center providers shall comply with ADS Center regulations and Life Safety Code (LCS) regulations, as determined by the Colorado Division of Fire Protection and Control.

2. ADS providers shall be Medicaid certified by the Department as an ADS provider, in accordance with 10 CCR, 2505-10 Section 8.487.20. Proof of Medicaid certification consists of a completed Provider Agreement approved by the Department and the Department's fiscal agent, and recommendation for certification by CDPHE.

   a. Certification shall be denied, revoked, suspended, or terminated when a Provider is unable to meet, or adequately correct deficiencies relating to, certification standards as defined at 10 CCR 2505-10 section 8.491.

3. The Department or its designee will review an ADS Center's designation as a Specialized Adult Day Services (SADS) Center at the time of initial approval and during the recertification survey.

4. Denial, termination, or non-renewal of the Provider Agreement shall be for "Good Cause" as defined in 10 CCR 2505-10 section 8.076.

5. All providers of ADS shall operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation and other standards prescribed in law or regulations. This includes certification of building use occupancy.

8.491.4 PROVIDER ROLES AND RESPONSIBILITIES

A. Environment

1. All ADS providers must comply with the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings Final Rule requirements, 42 C.F.R. § 441.301(c)(4). This includes:

   a. ADS Center must be integrated in and supports full access of individuals to the greater community;

   b. ADS provider is selected by the individual from among setting options including non-disability specific settings;

   c. ADS provider ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;

   d. ADS provider optimizes individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact; and

   e. ADS provider facilitates individual choice regarding services and supports, and who provides them.

2. ADS Centers presumed to have institutional qualities will be subject to heightened scrutiny and reviewed by the Department and CMS, per 42 C.F.R. § 441.301(a)(2)(v). Settings in which this may apply include but are not limited to those where:

   a. The provision of inpatient institutional treatment within a publicly or privately-operated facility happens within the same building.

   b. Located on the grounds of, or adjacent to, a public institution.

   c. The effect of isolating participants receiving Medicaid Home and Community Based Services (HCBS) from the broader community.

2. If an ADS Center is subject to heightened scrutiny, Medicaid reimbursement by the Department may not be issued if the center fails CMS's heightened scrutiny review or until CMS approves the center.

3. ADS Centers shall provide a clean and sanitary environment that is free of obstacles that could pose a hazard to participant health and safety, allowing individuals the freedom to safely move about inside and outside the ADS Center.

4. ADS Centers shall provide lockers or a safe and secure place for participants' personal items.

5. ADS Centers shall provide recreational areas and recreational activities appropriate to the number and needs of the participants, at the times desired by the participants.

6. ADS Centers shall ensure the following are physically accessible to the participants at all times during hours of operation:

    a. Access to drinking water and other beverages;

    b. Bathrooms, sinks, and paper towel dispensers or hand dryers;

    c. Appliances and equipment used by or in the delivery of activities offered by the ADS Center, such as, tables/desks and chairs at a convenient height and location; and

    d. Free from obstructions such as steps, lips in doorways, narrow hallways, limiting individuals' mobility in the ADS Center. If obstructions are present, environmental adaptations are to be made to allow for participant access.

7. ADS Centers must provide for a private shower and/or bathing area located on site to address the emergency hygiene needs of participants as needed.

8. To accommodate the activities and program needs of the ADS Center, the center must provide eating and activity areas that are consistent with the number and needs of the participants being served, which is at a minimum of 40 square feet per participant.

9. ADS Centers shall maintain a comfortable temperature throughout the center. At no time shall the temperature fall outside the range of 68 degrees to 76 degrees Fahrenheit.

10. ADS Centers must provide an environment free from restraints.

11. ADS Centers, in accordance with 10 CCR 2505-10 section 8.491.4.A above, must provide a safe environment for all participants, including participants exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

B. Food Safety Requirements

1. ADS providers shall comply with all applicable local food safety regulations. In addition, all ADS Centers must ensure:

    a. Access to a handwashing sink, soap and disposable paper towels;

    b. Food handlers, cooks and servers, including participants engaged in food preparation, properly wash their hands using proper hand-washing guidelines;

    c. The ADS Centers do not allow any staff or participants who are not in good health and free of communicable disease to handle, prepare or serve food or handle utensils;

    d. Refrigerated foods opened or prepared and not used within 24 hours are marked with a “use by” or “discard by” date. The “use by” or “discard by” date may not exceed 7 days following opening or preparation, or exceed or surpass the manufacturer’s expiration date for the product or its ingredients;

e. For food service, foods are maintained at the proper temperatures at all times. Foods that are stored cold must be held at or below 41 degrees Fahrenheit and foods that are stored hot must be held at or above 135 degrees Fahrenheit in order to control the growth of harmful bacteria;

f. Kitchen and food preparation equipment are maintained in working order and cleanable; and

g. Any equipment or surfaces used in the preparation and service of food are washed, rinsed and sanitized before use or at least every 4 hours of continual use. Dish detergent must be labeled for its intended purpose. Sanitizer must be approved for use as a no-rinse food contact sanitizer. Sanitizers must be registered with the Environmental Protection Agency (EPA) and used in accordance with labeled instructions.

C. Medication Administration and Monitoring

1. All medications shall be administered by Qualified Medication Administration Personnel (QMAP) staff, LMP staff or self-administered, regardless of the location where services are rendered.

2. Center-Based and Non-Center-Based ADS providers shall require each staff person who administers medication, that is not a LMP, to have completed training, passed a competency evaluation and be included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the QMAP competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

3. All medication, when stored and administered by the ADS provider, shall be stored in a locked cabinet when unattended by QMAP or LMP staff.

4. Non-prescription medications, when stored by the ADS provider, shall be labeled with the recipient's name, and shall not be taken by any other participants.

5. A QMAP shall not conduct feeding or administer medication through a gastrostomy tube or administer intravenous, intramuscular or subcutaneous injections.

D. Records and Information

1. All ADS providers shall keep records and information necessary to document the services provided to participants receiving Adult Day Services. Records shall include but not be limited to:

a. Name, address, gender, and date of birth of each participant;

b. Name, address and telephone number of designated representative and/or emergency contact;

c. Name, address and telephone number of primary physician;

d. Documentation of the supervision and monitoring of services provided;

e. Documentation that all participants and their designated representatives (if any) were oriented to the ADS Center, their policies and procedures, to the services provided by the ADS provider, and delivery methods offered.;

f. A service agreement signed by the participant and/or the designated representative and appropriate staff; and

g. For SADS providers only, a copy of the PMIP, or diagnosis documentation from the participant's LMP;

h. Documentation specifically stating the types of services and monitoring that are provided when rendered via Telehealth, ensuring the integrity of the service provided and the benefit the service provides the participant.

E. Care Plan

1. The following information must be documented in the Care Plan and used to direct the participant's care and must be reviewed annually.

a. Medical Information:

i. All medications the participant is taking, including those while receiving Center-Based or Non-Center-Based ADS, and whether they are being self-administered;

ii. Special dietary considerations, instructions, or restrictions;

iii. Services that are administered to the participant while receiving Center-Based and/or Non-Center-Based ADS (may include nursing or medical interventions, speech therapy, physical therapy, or occupational therapy);

iv. Any restrictions on social and/or recreational activities identified by participant's LMP; and

v. Any other special health or behavioral management services or supports recommended to assist the participant by the participant's LMP.

b. Care Planning Documentation:

i. Documentation that the provider was selected by the individual and/or designated representative or legal representative;

ii. Individual choices, including location and delivery method for ADS, preferences, and needs shall be incorporated into the goals and services outlined in the Care Plan;

iii. All participant information and the Care Plan are considered protected health information and shall be kept confidential; and

iv. Participant and/or designated representative or legal representative must review and sign the Care Plan.

c. Modifications to the Care Plan must be supported by a specific and assessed need. Informed consent and proper documentation in the Care Plan are required for any changes including but not limited to:

i. Identification of the specific and individualized assessed need; and

ii. Documentation of any intervention and/or additional supports offered to support the participant appropriately.

d. Documentation that the participant and/or designated representative was provided with written information about the participant's right to establish an advance directive.

e. Documentation as to whether the participant has executed an advance directive or other declaration regarding medical decisions. Such documentation shall be maintained in the participant's record.

f. All entries into the record shall be legible, written in ink, dated, and signed with name and title designation, or records shall be maintained electronically with electronic signatures in accordance with standards for electronic medical record keeping practices.

F. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:

a. Death;

b. Abuse/neglect/exploitation;

c. Serious injury to participant or illness of participant;

c. Damage or theft of participant's property;

d. Medication mismanagement;

e. Lost or missing person; and

f. Criminal activity.

2. A provider must submit a verbal or written report of a Critical Incident to the HCBS participant's Case Management Agency (CMA) case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

a. Participant name;

b. Participant Medicaid identification number;

c. Waiver;

d. Incident type;

e. Date and time of incident;

f. Location of incident;

g. Persons involved;

h. Description of incident; and

i. Resolution, if applicable.

3. If any of the above information is not available within 24 hours of incident and not reported to the CMA case manager, a follow-up to the initial report must be completed.

G. Staff Requirements

1. In determining appropriate staffing levels, the ADS provider shall adjust staffing ratios based on the individual acuity and needs of the participants being served. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition of Direct Care Staff defined at 10 CCR 2505-10, Sections 8.491.1. Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

   a. Staffing for Center-Based and in person Non-Center-Based ADS shall be no less than the following standard:

      i. A minimum of 1 staff to 8 participants with continuous supervision of participants during program operation.

   b. Staffing for Telehealth ADS shall be no less than the following standard:

      i. A minimum of 1 staff to 15 virtual participants with continuous virtual supervision of participants during Telehealth program operation.

   c. Staff shall provide the following:

      i. Immediate response to emergency situations to assure the safety, health and welfare of participants;

      ii. Activities that are planned to support the plans of care for the participants; and

      iii. Administrative, recreational, social, and supportive functions and duties.

   d. Nursing services for regular monitoring of the on-going medical needs of participants and the supervision of medications. These services must be available a minimum of two hours daily during Center-Based ADS, and as needed for Non-Center-Based ADS, and must be provided by a Registered Nurse (RN) or Licensed Practical Nurse (LPN). Certified Nursing Assistant's (CNA) may provide nursing services under the direction of a RN or an LPN, in conformance with nurse delegation provisions outlined in CRS 12-38-132. Supervision of CNAs must include documented consultation and oversight on a weekly basis or more according to the participant's needs. If the supervising RN or LPN is an ADS provider staff member, with consultation and oversight of CNAs included in the member's job description, the supervising nurse's documented attendance shall be sufficient to document consultation and oversight.

2. In addition to the above services, Specialized Adult Day Services (SADS) Centers shall have sufficient staff to provide nursing services during all hours of operation.

a. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 10 CCR 2505-10 section 8.491.4.G.1.e above and employed or contracted by the SADS Center.

3. The ADS provider shall require any individual seeking employment with that agency to submit to a criminal history record check to ascertain whether the individual seeking employment has been convicted of a felony or misdemeanor that involves conduct that the provider determines could pose a risk to the health, safety or welfare of participants.

4. The criminal history record check shall, at a minimum, include a search of criminal history in the State of Colorado and be conducted not more than 90 days prior to employment of the individual.

5. In assessing whether to employ an applicant with a felony or misdemeanor conviction, the ADS provider shall consider the following factors:

   a. The history of convictions, pleas of guilty or no contest,

   b. The nature and seriousness of the crimes;

   c. The time that has elapsed since the conviction(s);

   d. Whether there are any mitigating circumstances; and

   e. The nature of the position for which the applicant would be employed.

6. The ADS provider shall develop and implement policies and procedures regarding the employment of any individual who is convicted of a felony or misdemeanor to ensure that the individual does not pose a risk to the health, safety and welfare of the consumer.

H. Director Qualifications

1. All Directors hired or designated after January 1, 2019, shall meet one of the following qualifications:

   a. At least a bachelor’s degree from an accredited college or university and a minimum of two years of social services or health services experience and shall have demonstrated ability to perform all aspects of the position; or

   b. A licensure by the state of Colorado as a Licensed Practical Nurse or Registered Nurse and completion of two years of paid or volunteer experience in planning or delivering health or social services including experience in supervision and administration; or

   c. A high school diploma or GED equivalent, a minimum of four years of experience in a social services or health services setting, skills to work with aging adults or adults with functional impairment, and skills to supervise ADS Center staff persons.

I. Training Requirements

1. All ADS staff and volunteers must be trained in the ADS provider’s programmatic policies and procedures.

2. ADS providers providing medication administration as a service must have QMAP staff qualified in accordance with C.R.S. 6 CCR 1011-1 Chapter 24, unless medications are administered only by LMPs.

3. All staff and volunteers must be trained in the use of universal precautions and infection control, as defined at 10 CCR 2505-10 section 8.491.1.

4. The ADS Director and staff must receive training specific to the needs and diagnoses of the participants served. Training may include, but is not limited to: behavioral expression and management techniques, effective communication techniques, redirection, cardiopulmonary resuscitation, validation theory and communication, seizure response, and brain injuries.

   a. Documentation of staff member and Director trainings must include, but is not limited to: training provided, who completed trainings, who conducted trainings, and completion date.

5. All ADS staff must be trained in the handling of emergency services including written procedures to meet medical crises, and natural and manmade disasters.

6. All required training must be documented, and documentation must be maintained in individual staff's personnel files. Each staff person's training must be up-to-date.

J. Dementia Training Requirements

1. As of October 1, 2023, each Adult Day Services provider shall ensure that its Direct-Care Staff Members ~~meet the following~~complete dementia training as required by Section 25.5-6-314, C.R.S~~requirements~~.

2. Definitions~~:~~ ~~for the purposes of dementia training~~applicable to Dementia Training Requirements:~~ as required by Section 25.5-6-314, C.R.S.~~

   a. "Covered Facility" means a ~~nursing care facility or an assisted living residence licensed by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a).~~Assisted Living Residences, Nursing Care Facilities, and Adult Day Care Facilities as defined in Section 25.5-6-303(1), C.R.S.

   b. "Dementia diseases and related disabilities" is a condition where mental ability declines and is severe enough to interfere with an individual's ability to perform everyday tasks. Dementia diseases and related disabilities include Alzheimer's disease, mixed dementia, Lewy Body Dementia, vascular dementia, frontotemporal dementia, and other types of dementia.

   c. "Direct-Care Staff Member" means a staff member caring for the physical, emotional, or mental health needs of participants of an Adult Day Services provider and whose work involves regular contact with participants who are living with Dementia Diseases and related disabilities.

   d. "Staff member" means an individual, other than a volunteer, who is employed by an Adult Day Services provider.

   e. "Equivalent training" ~~within this subsection of 8.491.4.J. shall~~ means any initial training provided by a Covered Facility ~~meeting~~that meets the requirements in Section 8.491.4.J.3. ~~If the Equivalent Training was provided more than 24 months prior to the date of hire as allowed in the exception found in Section~~

~~8.491.4.J.4., the individual must document participation in both the Equivalent Training and all required continuing education subsequent to the initial training.~~

3. Initial training: E~~e~~ach Adult Day Services provider is responsible for ensuring that all Direct-Care Staff Members are trained in dementia diseases and related disabilities.

   a. Initial training shall be available to D~~d~~irect-C~~c~~are ~~s~~Staff Members at no cost to them.

   b. The training shall be competency-based and ~~culturally competent~~culturally competent and shall include a minimum of four hours of training in dementia topics including the following content:

      1) Dementia diseases and related disabilities;

      2) Person-centered care;

      3) Care planning;

      4) Activities of daily living; and

      5) Dementia-related behaviors and communication.

   c. For Direct-Care Staff Members already employed prior to October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after October 1, 2023, unless an exception, as described in Section 8.491.4.J.4.a~~.~~, applies.

   d. For Direct-Care Staff Members hired or providing care on or after October 1, 2023, the initial training must be completed as soon as practical, but no later than 120 days after the start of employment or the provision of direct-care services, unless an exception, as described in Section 8.491.4.J.4.b~~.~~, applies.

4. Exception to initial dementia training requirement

   a. Any Direct-Care Staff Member who is employed by or providing direct-care services prior to the October 1, 2023, may be exempted from the provider's initial training requirement if all of the following conditions are met:

      1) The Direct-Care Staff Member has completed ~~an e~~Equivalent ~~initial dementia t~~Training program, as defined in these rules, within the 24 months immediately preceding October 1, 2023; and

      2) The Direct-Care Staff Member can provide documentation of the satisfactory completion of the Equivalent ~~initial t~~Training program.

      3) If the Equivalent Training was provided more than 24 months prior to the date of hire, the individual must document participation in both the Equivalent Training and all required continuing education subsequent to the initial training.

   b. Any Direct-Care Staff Member who is hired ~~by~~ or begins providing direct-care services on or after October 1 ,2023, may be exempted from the provider's initial training requirement if ~~all of the following conditions are met. T~~the Direct-Care Staff Member:

1) Has completed an equivalent initial dementia training program, as defined in these rules, either:

a) Within the 24 months immediately preceding October 1, 2023; or

b) Within the 24 months immediately preceding the date of hire or the first date the Direct-Care Staff Member ~~of providing~~provides direct care services; and

2) ~~Can provide~~Provides documentation of the satisfactory completion of the initial training program; and

3) ~~Can provide~~Provides documentation of all required continuing education subsequent to the initial training.

c. Such exceptions shall not ~~negat~~exempt a Direct-Care Staff Member from~~e~~ the requirement for dementia training continuing education as described in Section 8.491.4.J.5.

5. Dementia Training: Continuing Education

a. After completing the required initial training, all Direct-Care Staff Members shall have completed and documented a minimum of two hours of continuing education on dementia topics every two years.

b. Continuing education on this topic must be available to Direct-Care Staff Members at no cost to them.

c. This continuing education shall be culturally competent, include current information provided by recognized experts, agencies, or academic institutions, and include best practices in the treatment and care of persons living with dementia diseases and related disabilities.

6. ~~Minimum requirement for i~~Individuals conducting dementia training must meet the following minimum requirements:

a. Specialized training from recognized experts, agencies, or academic institutions in dementia disease~~.~~, or

b. Successful completion of ~~the training being offered or other similar initial~~ training which meets the minimum standards described herein; and

c. Two or more years of experience ~~in~~ working with person~~s~~ living with dementia diseases and related disabilities.

7. Documentation of initial dementia training and continuing education for Direct-Care Staff Members:

a. The provider shall maintain documentation that each Direct-Care Staff Member has ~~of the completion~~completed ~~of~~ initial dementia training and continuing education. Such records shall be made available upon request.

b. Completion shall be demonstrated by a certificate, attendance roster, or other documentation.

c. Documentation shall include the number of hours of training, the date of~~f~~n which it was received, and the name of the instructor and/or training entity.

d. Documentation of the satisfactory completion of an equivalent initial training program as defined in Section 8.491.4.J.2.e. ~~and as required in the criteria for an exception discussed in Section 8.491.4.J.4.,~~ shall include the information required in this Section 8.491.4.J.7.b. & c.

e. After the completion of training and upon request, such documentation shall be provided to the staff member for the purpose of employment at another Covered Facility. ~~For the purposes of dementia training documentation, Covered Facilities shall include Assisted Living Residences, Nursing Care Facilities, and Adult Day Care Facilities as defined in Section 25.5-6-303(1), C.S.R.~~

K~~J~~. Written Policies

1. The ADS provider shall have written policies and procedures relevant to its operation. Such policies shall include, but not be limited to, statements describing:

   a. Admission criteria for participants who can be appropriately served by the ADS provider;

   b. Intake procedures conducted for participants and/or designated representatives prior to admission with the ADS provider;

   c. The meals and nourishments including special diets that are provided;

   d. The hours and days that Center-Based ADS are open and available, and the days and times that Non-Center-Based ADS are available to participants, including the availability of nursing services;

   e. Medication administration and storage;

   f. The personal items that the participants may bring with them to the ADS Center;

   g. Emergency services including written procedures to meet medical crises, and natural and manmade disasters; and

   h. The administration of Telehealth Adult Day Services, if provided. This includes telehealth options, provision of services, and examples of virtually offered services.

2. There shall be a written, signed agreement between the participant and/or designated representative and the ADS provider outlining the rules and responsibilities of the ADS provider and the participant. Each party in the agreement shall be provided a copy.

~~K~~L. Exclusions

1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS and therefore are not reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.

8.491.5 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

A. Reimbursement for ADS for participants in the HCBS Elderly, Blind and Disabled (EBD) waiver, Community Mental Health Supports waiver (CMHS), and the Spinal Cord Injury (SCI) waiver is to be billed in accordance with the current rate schedule:

1. Providers may bill in 15-minute units or for 1-2 units of 3-5-hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 12 units or three (3) hours per day of Basic Adult Day Services. A provider may bill the maximum of 15-minute units for ADS in combination with no more than 1 unit of 3-5 hour ADS on the same day, as long as services were rendered at separate times.

B. For persons in the HCBS waiver for Persons with a Brain Injury (BI), reimbursement for BI-ADS is to be billed in accordance with the current rate schedule.

1. A unit is defined as the following:

a. Providers may bill in units of 15 minutes or a unit of 2 or more hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 8 units or two (2) hours per day of services. Units of 2 hours or more can only be delivered in-person. A provider cannot bill for 15-minute units of ADS if a unit of 2-hour BI ADS was provided on the same day.

C. ADS Centers are permitted to utilize funding from other Federal sources, such as the Child and Adult Care Food Program (CACFP), in addition to the Medicaid per diem. If such funding is utilized, a Center must acknowledge the use of multiple funding sources and demonstrate that Federal funds are not used in a duplicative manner to Medicaid-funded services.

D. Only providers certified as a Specialized Adult Day Services Center are permitted to receive the SADS reimbursement rate, for participants needing SADS. The SADS reimbursement rate applies to every participant at a SADS Center, even if the participant does not have a specialized diagnosis.

E. Certified SADS providers may provide Non-Center-Based Adult Day Services, including Telehealth ADS, billing only for Basic Adult Day Services using the 15-minute unit, up to 3 hours per day. The SADS provider may bill the maximum of 15-minute units for Basic ADS in combination with no more than 1 unit of 3-5 hour SADS on the same day, as long as services were rendered at separate times.

F. Providers shall not bill for services on the same day of service for a participant in an HCBS residential program, unless the following criteria have been met:

1. ADS and residential services have been authorized by the Department and are included on the prior authorization request (PAR);

2. Participant's diagnoses must meet the criteria for a SADS Center;

3. Documentation from the participant's physician demonstrating the required specialized services in the SADS Center are necessary because of the qualifying diagnosis(es), are essential to the care of the participant, and are not included in the residential per diem;

4. Documentation that the extensive rehabilitative therapies and therapeutic needs of the participant are not being met by the residential program and are not included in the residential per diem; and

5. Documentation from the participant's physician recommending SADS and how it will meet the previously mentioned needs.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 23-04-24-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

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

2. Title of Rule: MSB 23-04-24-A, Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000.

3. This action is an adoption of: new rules

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

   Sections(s) 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*

Replace the current text at 8.8000 with the proposed text beginning at 8.8000 through the end of 8.8000. This rule is effective July 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 23-04-24-A
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STATEMENT OF BASIS AND PURPOSE

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

   Create rules to administer the Rural Provider Access and Affordability Stimulus Grant Program established through the enactment of Senate Bill 22-200 including a methodology to determine which rural providers are qualified for grant funds, permissible uses of grant money, and reporting requirements for grant recipients.

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:

   American Rescue Plan Act of 2021 (ARPA), Public Law 117-2

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023);
   Section 25.5-1-207 (5), C.R.S. (2022)

Initial Review
Proposed Effective Date **07/30/23**
Final Adoption **06/09/23**
Emergency Adoption

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning the Rural Provider Access and Affordability Stimulus Grant Program, Section 8.8000
Rule Number: MSB 23-04-24-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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.

   Colorado hospitals in rural communities and their associated clinics will benefit from the proposed rule by helping these providers modernize their information technology systems which tend to lag behind their urban and suburban counterparts. Residents of rural Colorado will benefit as the program will support reducing health care costs in communities, add jobs, stimulate the economy, improve access to care, and mitigate rural health disparities.

   The funding for the Rural Provider Access and Affordability Stimulus Grant Program comes from federal funds with no cost to the state or local communities.

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 Rural Provider Access and Affordability Stimulus Grant Program will drive financial sustainability for hospitals and clinics in rural areas of Colorado by investing $9.6 million in health care affordability and health care access related projects:

   - $4.8 million in health care affordability projects, such as shared analytics platforms, telehealth supports, and enabling shared care management between rural providers

   - $4.8 million in health care access projects, such as extending hours for primary and behavioral health care, telemedicine including remote monitoring supports, new or expanded access sites including surgery, chemotherapy, and advanced imaging

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 General Assembly appropriated $400,000 to the Department to administer the Rural Provider Access and Affordability Stimulus Grant Program when it enacted Senate Bill 22-200. These funds are sufficient to administer the program and no

costs to other agencies are expected. The funds for the Rural Provider Access and Affordability Stimulus Grant Program are federal funds from the American Rescue Plan Act of 2021 (ARPA) and there is no impact on state revenues.

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

   Adopting the proposed rules to administer the Rural Provider Access and Affordability Stimulus Grant Program will allow the Department to grant $9.6 million of federal funds to rural providers as directed by the General Assembly to improve health care affordability and access and stimulate the economies in rural Colorado.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, 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.

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no less costly or intrusive methods for achieving the purpose of the proposed rule.

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

   Because the legislation directs the Medical Services Board to promulgate rules so the Department can administer the grant program, there are no alternatives to rule making than the proposed rule. The proposed rule includes those elements necessary to administer the grant program and were developed and supported by the Rural Provider Access and Affordability Advisory Committee established by the legislation.

8.8000 Rural Provider Access and Affordability Stimulus Grant Program

8.8000.A PURPOSE AND LEGAL BASIS

1. Pursuant to C.R.S. § 25.5-1-207, the Rural Provider Access and Affordability Stimulus Grant Program provides grants to qualified providers to improve health care affordability and access to health care services in rural communities and to drive financial sustainability for rural hospitals and clinics.

8.8000.B DEFINITIONS

1. Advisory Committee means the rural provider access and affordability advisory committee as defined in section 25.5-1-207 (3), C.R.S.

2. Department means the Colorado Department of Health Care Policy and Financing.

3. Health Care Access Project means a project that expands access to health care in Rural Communities including but not limited to:

    a. Extending hours for access to primary care or behavioral health services,

    b. Investing in dual track emergency department management,

    c. Expanding access to Telemedicine including remote monitoring support,

    d. Providing new or replacement Hospital beds,

    e. Expanding access to long term care and recovery care in skilled nursing facilities, and

    f. Creating or expanding sites that provide surgical care, chemotherapy, imaging, and advanced imagining including computerized tomography scans.

4. Health Care Affordability Project means a project that modernizes the information technology infrastructure of Qualified Rural Providers including but not limited to:

    a. Creating a shared analytics platform and care coordination platforms among Qualified Rural Providers, and

    b. Enabling technologies, including telehealth and e-consult systems, that allow Qualified Rural Providers to communicate, share clinical information, and consult electronically to manage patient care.

5. Hospital means a hospital licensed or certified pursuant to section 25-1.5-103 (1)(a), C.R.S. or an affiliate owned or controlled as defined in section 25.5-4-402.8 (1)(b), C.R.S., by the hospital.

6. Qualified Rural Provider means a Hospital located in a Rural Community in Colorado that has a lower net patient revenue or fund balance compared with other Rural Hospitals~~.~~.

7. Rural Community means a county with a population of fewer than fifty thousand residents; or a municipality with a population of fewer than twenty-five thousand residents if the municipality is not contiguous to a municipality with a population of twenty-five thousand or more residents.

8. Rural Stimulus Grant means funding received from the rural provider access and affordability grant program established in section 25.5.1-207, C.R.S.

9. Telemedicine means the delivery of medical services as defined at section 12-240-104 (6), C.R.S.

8.8000.C GRANT AWARD PROCEDURES

1. Rural Stimulus Grants will be awarded through an application process.

    a. A request for grant application form shall be issued by the Department and posted for public access on the Department's website at https://hcpf.colorado.gov/research-data at least 30 days prior to the application due date.

    b. A Qualified Rural Provider may submit applications for more than one project or may submit a joint application with another Qualified Rural Provider.

2. The application will include:

        a. Project overview.

        b. Proposed budget including:

            i. Total funds requested not to exceed $650,000 per project per applicant,

            ii. Itemized direct expenses,

            iii. Indirect expenses limited to federal Negotiated Indirect Costs Rate Agreement (NICRA) or de minimis rate of 10 percent if the applicant does not have an NICRA,

            iv. If applicable, documentation of quotes or estimates for construction, equipment, or other expenditures, and

            v. If applicable other sources of funding that will be utilized to complete the proposed project.

        c. Project timeline to commence no earlier than July 1, 2023 and to conclude no later than December 31, 2026.

        d. Description of Qualified Rural Provider's diversity, equity, and inclusion strategy and how diverse community needs are met by the project.

        e. Demonstration of financial need.

            i. Qualified Rural Providers in the bottom 40% of net patient revenues for the three-year average of 2016, 2017, and 2018 or the bottom 6% fund balance for 2019 as determined by the Department's review of CMS 2552-10 Medicare Cost Reports are considered to meet the financial health requirement.

            ii. Other Qualified Rural Providers may submit additional financial supporting information to support their financial need.

        a. For capital investment projects, facility or equipment age.

        b. Impact to health care affordability or access to care.

i. Statement of need outlying underlying problem the funding will address.

ii. Description of how the project's goals and objectives will be sustained after the Rural Stimulus Grant funds have been expended.

iii. Description of how the project will increase access to specialty care, if applicable.

iv. Description of how project will improve care coordination, if applicable.

v. Description of partner engagement, if applicable.

3. The Advisory Committee will review Rural Stimulus Grant applications and recommend Rural Stimulus Grant awards to the Department's executive director based on the following criteria:

a. Budget and financial need.

b. Partner collaboration, support, or engagement.

c. Completeness of response.

d. Ability to execute and complete project.

e. Reasonableness of timeline.

f. Diversity, equity and inclusion and how diverse communities will be impacted by the project.

g. County Medicare and Medicaid caseload percentage of population.

h. Statement of need.

i. Sustainability of project.

j. Impact to health care affordability or access to care.

4. The Department's executive director or his or her designee shall make the final Rural Stimulus Grant awards to Qualified Rural Providers.

a. The total funding for Rural Stimulus Grants is limited to no more than $9.6 million with no more than $4.8 million for Health Care Access Projects and no more than $4.8 million for Health Care Affordability Projects.

b. The Department may change Rural Stimulus Grant amounts depending on the final number of Rural Stimulus Grants awarded, the availability of Rural Stimulus Grant funds, or the goals stated in the Rural Stimulus Grant application.

c. Rural Stimulus Grant applicants may request reconsideration of Rural Stimulus Grant awards within 5 business days of award notification in writing to the Department's executive director. The executive director will respond to the request for reconsideration within 10 business days of receipt.

d. The Department will execute a grant agreement with each Rural Stimulus Grant recipient.

5. The Department will disburse Rural Stimulus Grant funds no earlier than July 1, 2023 and no later than July 1, 2024. Any money not disbursed by July 1, 2024 will revert to the Economic Recovery and Relief Cash Fund created pursuant section 24-75-228 (2)(a), C.R.S.

6. Rural Stimulus Grant recipients will expend Rural Stimulus Grant funds by the timeline in their grant agreement and no later than December 31, 2026. Any Rural Stimulus Grant funds not expended by Rural Stimulus Grant recipients by December 31, 2026 will be recovered by the Department to be returned to the U.S. Department of the Treasury.

8.8000.D PERMISSIBLE USES OF GRANT AWARDS

1. Rural Stimulus Grant funds must be used for Health Care Affordability Projects or Health Care Access Projects to improve health care affordability and access in Rural Communities.

2. Rural Stimulus Grant funds may not be deposited into a pension fund and may not be used to service debt, satisfy a judgment or settlement, or contribute to a "rainy day" fund.

8.8000.E REPORTING REQUIREMENTS FOR GRANT RECIPIENTS

1. Recipients of Rural Stimulus Grant funds for capital expenditures must submit a written justification as set forth in 31 Code of Federal Regulations 35.6 (b)(4) to the Department.

2. For the duration of the grant agreement, Rural Stimulus Grant recipients must submit a quarterly report to the Department no later than the 10th day of the month following the end of each quarter including but not limited to a brief narrative and itemized expenditure and performance metric data.

3. Rural Stimulus Grant recipients will submit a final report to the Department within 30 calendar days following the end of the grant agreement including an overall narrative and itemization of all expenditures and performance metric data for the total Rural Stimulus Grant award.

8.8000.F RECORD RETENTION AND ACCESS

1. Rural Stimulus Grant recipients must maintain records of expenditures for a minimum of five years after funds have been expended or returned to the Department, whichever is later.

~~1.~~2. Rural Stimulus Grant recipients must allow the Department and state and federal auditors access to records related to the expenditure of Rural Stimulus Grant funds.