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Title of Rule: Revision to the Medical Assistance Rule Concerning Dental Therapists in Federally Qualified Health Centers, Section 8.700.1.B
Rule Number: MSB 23-04-25-A
Division / Contact / Phone: Health Policy / Alex Lyons / 303-866-2865

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 23-04-25-A, Revision to the Medical Assistance Rule Concerning Dental Therapists in Federally Qualified Health Centers, Section 8.700.1.B.

3. This action is an adoption of: an amendment

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

   Sections(s) 8.700.1.B

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 8.700.1.B with the proposed text beginning at 8.700.1.B through the end of 8.700.1.B. This rule is effective November 30, 2023.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule Concerning Dental Therapists in Federally Qualified Health Centers, Section 8.700.1.B
Rule Number: MSB 23-04-25-A
Division / Contact / Phone: Health Policy / Alex Lyons / 303-866-2865

STATEMENT OF BASIS AND PURPOSE

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

   This rule clarifies that dental therapists are included within the definition of a visit to a Federally Qualified Health Center and thus can be reimbursed for services performed in that setting.

   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 12-220-102 through 12-220-508, C.R.S. and Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2023)

Initial Review	**09/08/23**	Final Adoption	**10/13/23**
Proposed Effective Date	**11/30/23**	Emergency Adoption	

DOCUMENT #

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Title of Rule: Revision to the Medical Assistance Rule Concerning Dental Therapists in Federally Qualified Health Centers, Section 8.700.1.B
Rule Number: MSB 23-04-25-A
Division / Contact / Phone: Health Policy / Alex Lyons / 303-866-2865

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 main beneficiaries of this proposed rule will be dental therapists, who will be able to be reimbursed for their services within federally qualified health centers (FQHCs). Additionally, underserved communities will likely benefit from having a wider range of dental professionals available to provide dental services in FQHCs. The costs, as with Medicaid programs generally, will be borne by a combination of state and federal funds.

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

   Clarifying that dental therapists can be reimbursed for their services in FQHCs will incentivize such professionals to work in that setting, which will expand the number of dental professionals available for Health First Colorado members.

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

   There will be a cost to the Department for administering the payments for this program. The primary cost for licensing dental therapists and monitoring their compliance is carried by the Department of Regulatory Agencies (DORA).

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

   The costs of taking this action include the Department's and DORA's costs for administering the licensing and regulatory process for dental therapists and paying for the services they provide. The benefit of the proposed rule is that it would expand the provision of dental services in Colorado, including in underserved, particularly rural areas. The benefit of inaction is that the aforementioned administrative costs could be saved, while the cost is that services will not be broadened for Medicaid members.

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

   There is likely no less costly way to clarify that dental therapists can be reimbursed for their services within federally qualified health centers other than to specify them in the section of the Medical Assistance Rule that lists providers qualified to provide dental services.

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 by the Department because this measure is the result of a legislative mandate (Colorado Senate Bill 22-219) and taking this action is necessary for fulfilling the purposes of the law.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

8.700.1.A. Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2023). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2023) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

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

1. A visit includes a one-on-one or face-to-face encounter, or an interactive audio, interactive video, or interactive data communication encounter in accordance with Section 8.095, between a center client and a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado providing services set forth in Section 8.700.3.A. The supervised person must hold a candidate permit as a licensed professional counselor or a candidate permit as a licensed marriage and family therapist, or a candidate permit as a psychologist, or a candidate permit as a clinical social worker candidate (SWC), or a be a licensed social worker. Group sessions do not generate a billable encounter for any FQHC services.

8.700.1.C. The visit definition includes interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) encounters in accordance with Section 8.095.

1. Any health benefits provided through interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission) must meet the same standard of care as in-person care in accordance with Section 8.095.

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Title of Rule: Revision to the Post-Eligibility Treatment of Income Rules, Sections 8.486.60, 8.509.17, 8.515.85.O
Rule Number: MSB 23-05-23-A
Division / Contact / Phone: Office of Community Living / Meg Janeba / 4741

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 23-05-23-A, Revision to the Post-Eligibility Treatment of Income Rules, Sections 8.486.60, 8.509.17, 8.515.85.O
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) 8.486.60, 8.509.17, and 8.515.85.O, 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 8.486.60 with the proposed text beginning at 8.486.60 through the end of 8.486.60. Replace the current text at 8.509.17 with the proposed text beginning at 8.509.17 through the end of 8.509.17.C.3. Replace the current text at 8.515.85 with the proposed text beginning at 8.515.85.A through the end of 8.515.85.O.3.c. This rule is effective November 30, 2023.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Post-Eligibility Treatment of Income Rules, Sections 8.486.60, 8.509.17, 8.515.85.O
Rule Number: MSB 23-05-23-A
Division / Contact / Phone: Office of Community Living / Meg Janeba / 4741

STATEMENT OF BASIS AND PURPOSE

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

   The Department is making changes to the regulations pertaining to the process for Post Eligibility Treatment of Income (PETI). PETI is the calculation used to determine the member's obligation (payment) for the payment of services. This applies to all individuals receiving services within an Assisted Care Facility (ACF) or Supported Living Program (SLP) through the Home and Community-Based Service (HCBS) Elderly, Blind, and Disabled (EBD), Brain Injury (BI), and Community Mental Health Supports (CMHS) waivers.

   The Department received budgetary approval in 2022 to increase the maximum Personal Needs Allowance (PNA) amount, allowing members to maintain a larger portion of their income. To operationalize this change, the Department must modify the order of operation in which the PETI is calculated by case managers.

   The sections of rule impacted by these changes include 10 CCR 2505-10 8.486.60, 8.509.17, and 8.515.85.O which dictate the process for Case Management Agencies (CMAs) to complete PETI worksheets for the EBD, BI, and CMHS waivers. With the revisions to the rules, the regulatory process for PETI will align with the PETI worksheet updates and calculations made by the CMAs. The Benefits and Services Management Division has worked extensively with the Operations & Administration Division, and the Case Management & Quality Performance Division, the Finance Office, and the Health Information Office to develop the new worksheet, instructions, and training for CMAs.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. § 435.726

Initial Review	**09/08/23**	Final Adoption	**10/13/23**
Proposed Effective Date	**11/30/23**	Emergency Adoption	

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4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, 25.5-4-401; 25.5-6-309; 25.5-6-606(2); 25.5-6-704(4)(a) C.R.S. (2022).

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Post-Eligibility Treatment of Income Rules, Sections 8.486.60, 8.509.17, 8.515.85.O
Rule Number: MSB 23-05-23-A
Division / Contact / Phone: Office of Community Living / Meg Janeba / 4741

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.

   Members on the Community Mental Health Supports (CMHS), Brain Injury (BI), and Elderly, Blind, and Disabled (EBD) waivers receiving residential services from an Assisted Care Facility (ACF) or Supported Living Program (SLP) will be affected by the rule change. The Department received budgetary approval in 2022 to increase the maximum Personal Needs Allowance (PNA) amount for members in the above residential settings. This class of members will be positively impacted by this change, allowing them to maintain a larger portion of their income through the Post Eligibility Treatment of Income (PETI) calculation.

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

   Post Eligibility Treatment of Income (PETI) means the calculation used to determine the member's obligation (payment) for the payment of services. It also determines their maximum Personal Needs Allowance (PNA) amount, which can be used for items such as glasses, cell phones, etc. This rule change will provide members the ability to maintain more of their income for the above purposes, rather than paying as much for their residential services. This will provide a significant qualitative impact to members and increase quality of life, as well as health and welfare.

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

   No known costs associated with this change. All costs have been accounted for through the new appropriations completed through the budget request process.

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

   The costs of the proposed rule have been covered through a legislative budget increase. The benefits of the proposed rule are that members will have the ability to

maintain more of their income for personal needs, allowing them purchase things like glasses and cell phones which support a member's ability to access services and function to their highest ability. Without the changes to the regulations, the Department is unable to implement the changes to the PNA and revise the PETI calculations. Members would not have access to the additional discretionary funds and may not be able to purchase items like glasses and cell phones.

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 in order to implement the appropriated changes.

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.

8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

8.486.60 ~~CALCULATION OF CLIENT PAYMENT~~ POST-ELIGIBILITY TREATMENT OF INCOME (PETI)

A. Definition

1. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the member's obligation (payment) for the payment of residential services.

B. Post Eligibility Treatment of Income Application

2. When a member has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to ~~10 CCR 2505-10 s~~Section 8.100, the Department may reduce the Medicaid payment for Alternative Care Facility services according to the procedures ~~at 10 CCR 2505-10 section 8.486.60~~set forth in this section.
3. PETI is required for Medicaid members residing in Alternative Care Facilities under the Home and Community Based Services (HCBS) Elderly, Blind, and Disabled (EBD) waiver.

C. Case Management Responsibilities

~~The case manager shall calculate the client~~member payment (PETI) for 300% eligible HCBS-EBD ~~member~~clients ~~according to the following procedures:~~

~~A. For 300% eligible HCBS-EBD clients who are not Alternative Care Facility clients, the case manager shall allow an amount equal to the 300% standard as the client maintenance allowance. No other deductions are necessary and no form is required to be completed.~~

1. For 300% eligible member~~client~~s who ~~are~~ reside in an Alternative Care Facility (ACF) ~~client~~, the case manager shall complete a State-prescribed form, which calculates the ~~client~~member payment according to the following procedures:

~~1.An amount equal to the current Old Age Pension standard, including any applicable income disregards, shall be deducted from the client's gross income to be used as the client maintenance allowance, from which the state-prescribed Alternative Care Facility room and board amount shall be paid; and~~

a. The ~~M~~member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long-Term Care (LTC) Insurance amount.

b. The member's Room and Board amount shall be deducted from the gross income and paid to the provider.

c. ~~A~~The member's Personal Needs Allowance (PNA) amount is based upon a member's gross income, up to the maximum amount set by the Department.

~~2~~d. For an individual with financial responsibility for only a spouse, ~~an~~the amount protected under Spousal Protection as defined in Section 8.100.7 K shall be deducted from the member's gross income. ~~equal to the state Aid to the Needy and Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the client's gross income; or~~

e3. For an If the individualmember with is financially responsibleility for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding pan-time employment earnings of dependent children as defined at 10 CCR 2505-10 sSection 8.100.1) shall be deducted from the memberclient's gross income.; and

4f. Amounts for incurred expenses for medical or remedial care for the individualmember that are not subject to payment covered by Medicare, Medicaid, or other third party, shall be deducted from the memberclient's gross income as follows:

ai. Health insurance premiums, if health insurance coverage is documented in the eligibility system and the MMIS; deductibles or co-insurance charges if health insurance coverage is documented; and

iib. Necessary dental care not to exceed amounts equal to actual expenses incurred; and

iiic. Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred; and

ivd. Medications, with the following limitations:

1) The need for such medications shall be documented in writing by the attending physician. For this purpose, documentation on the Utilization Review Contractor certification form shall be considered adequate. The documentation shall list the medication; state why it is medically necessary; be; signed by the physician; and shall be renewed at least annually or whenever there is a changeThe member has a prescription for the medication.

2) Medications which may be purchased with the Medical Identification Card shall not be allowed as deductions.

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

4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price, unless the prescriber has specifically prescribed a name brand medication over the generic formula. .

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

eg. Other necessary medical or remedial care or items shall be deducted from the clienmembert's gross income, with the following limitations:

i.1) The need for such care must be documented in writing by the attending physician. For this purpose documentation on the Utilization Review Contractor certification form shall be considered adequate. The

documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and~~,~~ shall be renewed at least annually or whenever there is a change.

ii.~~2)~~ Any service, supply or equipment that is available under ~~regular State Plan~~ the Medicaid State Plan, with or without prior authorization, shall not be allowed as a deduction.

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

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

j. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the member's gross income.

~~5~~k. Any remaining income shall be applied to the cost of the Alternative Care Facility services, as defined at ~~10 CCR 2505-10 s~~Section 8.495, and shall be paid by the member~~client~~ directly to the ~~facility~~provider.~~; and~~

~~6~~I~~7~~. If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the member~~client~~'s income, the remaining income shall be kept by the ~~client~~member and may be used ~~as for additional personal needs or for any other use that the client member desires~~at the member's discretion.~~, except that the Alternative Care Facility shall not charge more than the Medicaid rate for Alternative Care Facility services .~~

~~C~~2. At the beginning of each support plan year and whenever there is a significant change to a member's payment obligation,~~C~~ the case managers shall inform the HCBS ~~EBD~~ Alternative Care Facility ~~client~~members~~s~~ of their ~~client~~ payment obligations ~~on a form prescribed by the state at the time of the first assessment visit; by the end of each plan period; or within ten (10) working days whenever there is a significant change in the diem payment amount.~~ ~~i~~In a manner prescribed by the Department. ~~at the beginning of each support plan year and whenever there is a significant change to their payment obligation.~~

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

3. Copies of ~~client~~member payment forms shall be kept in the ~~client~~member files at the ~~single entry point~~case management agency. A copy of the form may be requested by the Department for monitoring purposes. ~~, and shall not be mailed to the State of its agent except as required for a prior authorization request, according to 10 CCR 2505-10 section 8.509.31(G), or if requested by the state for monitoring purposes.~~

8.509 HOME AND COMMUNITY-BASED SERVICES FOR COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS)

8.509.17 ~~CLIENT PAYMENT OBLIGATION~~POST- ELIGIBILITY TREATMENT OF INCOME (PETI)

A. Definition

1. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the member's obligation (payment) for the payment of services.

B. Post Eligibility Treatment of Income Application

1. When a ~~Client~~member has been determined eligible for Home and Community-based Services (HCBS) under the 300% income standard, according to Section 8.100~~, of Staff Manual Volume 8,~~ the Department~~State~~ may reduce Medicaid payment for Alternative Care Facility (ACF) services according to the procedures for calculation of PETI at Section 8.509.31~~, E, of Staff Manual Volume 8.~~

2. PETI is required for Medicaid members residing in Alternative Care Facilities under the Home and Community Based Services (HCBS) Community Mental Health Support (CMHS) waiver.

C. Case Management Responsibilities

~~The case manager shall calculate the member payment (PETI) for 300% eligible HCBS members according to~~

1. For 300% eligible m~~M~~embers who are Alternative Care Facility (ACF) members, the case manager shall complete a State-prescribed form, which calculates the m~~M~~ember payment according to the following procedures:

a. The ~~M~~member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long--Term Care (LTC) Insurance amount.

The ~~M~~member's Room and Board amount shall be deducted from the gross income and paid to the provider.

b. ~~A~~The member's Personal Needs Allowance (PNA) amount is based upon a member's gross income, up to the maximum amount set by the Department.

For a member~~n individual~~ with financial responsibility for only a spouse, the amount protected under Spousal Protection as defined in Section 8.100.7 K shall be deducted from the member's gross income.

If the ~~individual~~member is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level amount

c. less any income of the spouse and/or dependents (excluding income from part-time employment earnings of a dependent child, as defined at Section~~s~~ 8.100.1, who is either a full-time student or a part-time student) shall be deducted from the member's gross income.

d. Amounts for incurred expenses for medical or remedial care for the member that are not covered by Medicare, Medicaid, or other third party shall be deducted from the member's gross income as follows:

i. Health insurance premiums, deductibles or coinsurance charges if health insurance coverage is documented.
ii. Necessary dental care not to exceed amounts equal to actual expenses incurred.
iii. Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred.
iv. Medications, with the following limitations:
a) The member has a prescription for the medication.
b) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.
c) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price, unless the prescriber has specifically prescribed a name brand medication over the generic formula.

e. Other necessary medical or remedial care or items shall be deducted from the member's gross income, with the following limitations:
i. The need for such care must be documented in writing by the attending physician. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.

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

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

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

g. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the member's gross income.

h. Any remaining income shall be applied to the cost of the ACF services, as defined at ~~10 CCR 2505-10 s~~Section 8.509.31.E, and shall be paid by the member ~~client~~ directly to the provider.~~; and~~

i. If there is still income remaining after the entire cost of ACF~~Alternative Care Facility~~ services are paid from the m~~M~~ember's income, the remaining income shall be kept by the m~~M~~ember and may be used ~~for additional personal needs or for any other use that the mMember desires~~at the member's discretion.

2. Case managers shall inform HCBS ACF services members of their payment obligations in a manner prescribed by the Department at the beginning of each support plan year and whenever there is a significant ~~-~~change to their payment obligation.

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

3. Copies of member~~client~~ payment forms shall be kept in the member~~client~~ files at the case management agency.~~,~~ A copy of the form may be requested by the Department for monitoring purposes.~~and shall not be mailed to the State of its agent except as required for a prior authorization request, according to 10 CCR 2505-10 section 8.509.31(G), or if requested by the state for monitoring purposes.~~

8.515 HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH BRAIN INJURY (HCBS-BI)

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 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 functional eligibility for the Home and Community-based Services – Brain Injury (HCBS-BI) waiver, development and implementation of an individualized and person-centered Service Plan for the Client, coordination and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such Client's needs.

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 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.

16. Protective Oversight is defined as monitoring and guidance of a Client to assure ~~his/her~~their 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 for HCBS-BI waiver by a certified case management agency;

   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.

8.515.85.C SUPPORTIVE LIVING PROGRAM INCLUSIONS

1. SLP services consist of structured services designed to provide:

   a. Assessment;

   b. Protective Oversight and supervision;

   c. Behavioral Management and Education;

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

i. Interpersonal and social skill development;

ii. Improved household management skills; and

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

e. Community Participation;

f. Transportation between therapeutic activities in the community;

g. Activities of Daily Living (ADLs);

h. Personal Care and Homemaker services; and

i. Health Maintenance Activities.

2. Person-Centered Care Planning

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.

8.515.85.D PROVIDER LICENSING AND CERTIFICATION REQUIREMENTS

1. To be certified as an SLP provider, the entity seeking certification must be licensed by CDPHE as an Assisted Living Residence (ALR) pursuant to 6 CCR 1011-1, Ch. 7, except as provided below.

a. Subject to Department approval, providers that have been in continuous operation at the same address prior to 1987 may continue to furnish SLP services under a Home Care Agency (HCA) license pursuant to 6 CCR 1011-1, Ch. 26 instead of the ALR license.

i. Providers furnishing SLP services under a Department-approved exception are required to comply with this § 8.515.85, regardless of licensure type.

ii. Providers furnishing SLP services under a Department-approved exception are required to comply with the medication administration requirements pursuant to both the HCA licensure requirements found at 6 CCR 1011-1, Chapters 7 and 26, and Section 25-1.5-301 through 304, C.R.S. 6 CCR 1011-1, Ch. 7, Section 14, (2018) is hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103 (12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. In addition to the requirements of § 8.515.85.D.1, SLP providers must also receive SLP Certification from CDPHE. CDPHE issues or renews a Certification when the provider is in full compliance with the requirements set out in these regulations. Certification is valid for three years from the date of issuance unless CDPHE revokes, suspends, or takes other disciplinary action against the licensee, or the certification is voluntarily relinquished by the provider.

3. No Certification shall be issued or renewed by CDPHE if the owner, applicant, or administrator of the SLP has been convicted of a felony or of a misdemeanor, which felony or misdemeanor involves moral turpitude or involves conduct that the Department determines could pose a risk to the health, safety, or welfare of residents of the assisted living residence.

8.515.85.E PROVIDER RESPONSIBILITIES

SLP providers must follow all person-centered planning initiatives undertaken by the State to ensure Client choice.

8.515.85.F HCBS PROGRAM CRITERIA

1. In accordance with 42 C.F.R. § 441.530, Home and Community-based settings must:

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

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

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

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

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

f. Be a specific, physical place that can be owned, rented or occupied under a legally enforceable agreement by the individual receiving services, and the

individual has, at a minimum, the same responsibilities and protections from eviction that tenants have under the landlord tenant law of the State, county, city or other designated entity;

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

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

i. Ensure each Client has the right to receive and send packages. No Client's outgoing packages shall be opened, delayed, held, or censored by any person;

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

i. Enable Clients to have visitors of their choosing at any time; and

j. Be physically accessible.

2. Exceptions

The Department may grant exceptions to HCBS Program Criteria listed in § 8.515.85.F.1, a through h, when reasonable, as follows:

a. Requirements of program criteria may be modified if supported by a specific assessed need and justified in the person-centered care plan. The following requirements must be documented in the person-centered care plan:

i. Identify a specific and individualized assessed need.

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

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

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

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

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

vii. Include the informed consent of the individual.

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

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

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

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

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

When a Client needs assistance with challenging behavior, including a Client whose behavior is dangerous to himself, herself, or others, or when the Client engages in behavior that results in significant property destruction, the SLP must create detailed service and support plans that describe how to appropriately address these behaviors.

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

Requirements for a lockable entrance door may be modified if supported by a specific assessed need and justified in the person-centered service plan.

8.515.85.G STAFFING

1. The SLP provider shall ensure sufficient staffing levels to meet the needs of Clients.

2. The operator, staff, and volunteers who provide direct Client care or protective oversight must be trained in precautions and emergency procedures, including first aid, to ensure the safety of the clientele.

3. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 6, 7, and 8, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5) C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

4. Within one month of the date of hire, the SLP provider shall provide adequate training for staff on each of the following topics:

   a. Crisis prevention;

   b. Identifying and dealing with difficult situations;

   c. Cultural competency;

   d. Infection control; and

   e. Grievance and complaint procedures.

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

6. All staff training shall be documented. Copies of person-centered care plan training and related documentation must be submitted to the Department upon request. Prior to any subsequent change in the training curriculum, the provider must submit copies to the Department for review and approval.

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

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

9. The SLP shall ensure that provision of services is not dependent upon the use of Clients to perform staff functions. Volunteers may be utilized in the home but shall not be included in the provider's staffing plan in lieu of employees.

10. The SLP provider shall maintain written personnel policies and shall provide a copy of these policies to each staff member upon employment. The administrator or designee shall explain such policies during the initial staff orientation period.

11. The SLP provider shall conduct a criminal background check through the Colorado Bureau of Investigation for all staff, prospective staff, and volunteers. The provider shall not employ any person convicted of an offense that could pose a risk to the health, safety, and welfare of Clients. The provider shall bear all costs related to obtaining a criminal background check.

8.515.85.H CLIENT RIGHTS AND PROPERTY

1. Clients shall have all rights stated in § 8.515.85.F.1.

2. Any provider that chooses to handle Client funds and property must maintain policies and practices for management of Client funds and property that are consistent with those at 6 CCR 1011-1, Ch. 7, Section 11.10.

3. Upon Client request, a Client shall be entitled to receive, and the provider shall promptly deliver, available money or funds held in trust.

8.515.85.I FIRE SAFETY AND EMERGENCY PROCEDURES

1. Applicants for initial provider Certification shall meet the applicable standards of the rules for building, fire, and life safety code enforcement as adopted by DFPC.

   a. The Department may grant an exception to this provision for a provider qualified under § 8.515.85.D.1.c, if the provider holds a current certificate of compliance from the local fire authority.

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

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

5. SLP providers must train all staff and Clients on emergency plans and procedures at intervals throughout the year. Providers shall conduct fire drills at least once every six (6) months, during the evening and overnight hours while Clients are sleeping. All such practices and training shall be documented and reviewed every six (6) months. Such documentation shall include any difficulties encountered and any needed adaptations to the plan. Such adaptations shall be implemented immediately upon identification.

8.515.85.J ENVIRONMENTAL AND MAINTENANCE REQUIREMENTS

1. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 15,16, 17, and 19, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. The interior and exterior environment of the SLP residence shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Sections 20, 21, 22, 23, and 24, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

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

4. SLP providers shall develop and implement procedures for the following:

   a. Handling of soiled linen and clothing;

   b. Storing personal care items;

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

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

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

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

7. Each Client shall have access to telephones, both to make and to receive calls in privacy.

8.515.85.K COMPLAINTS AND GRIEVANCES

Each Client will have the right to voice grievances and recommend changes in policies and services to both the Department and/or the SLP provider. Complaints and grievances made to the Department shall be made in accordance with the grievance and appeal process in § 8.209.

8.515.85.M RECORDS

1. The SLP provider shall adhere to regulations at 6 CCR 1011-1, Ch. 7, Section 18, (2018) which are hereby incorporated by reference. The incorporation of this regulation excludes later amendments to, or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S. the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request. Copies are also available from CDPHE at 4300 Cherry Creek Drive South, Denver, CO 80246.

2. Supportive Living Providers shall develop policies and procedures to secure Client information against potential identity theft. Confidentiality of medical records shall be maintained in compliance with 45 C.F.R. § 160.101, et seq.

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

8.515.85.N REIMBURSEMENT

1. SLP services shall be reimbursed according to a per diem rate, using a methodology determined by the Department.

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

3. The Department shall establish a maximum allowable room and b**o**ard charge for Clients in the SLP. Increases in payment shall be permitted in a dollar-for-dollar relationship to any increase in the Supplemental Security Income grant standard if the Colorado Department of Human Services also raises grant amounts.

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

8.515.85.O ~~CALCULATION OF CLIENT PAYMENT~~ POST-ELIGIBILITY TREATMENT OF INCOME (PETI)

1. Definition

   a. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the member's obligation (payment) for the payment of services.

2. Post-Eligibility Treatment of Income Application

   a. When a ~~Client~~member has been determined eligible for ~~HCBS-BI~~ Home and Community Based Services (HCBS) under the 300% income standard~~§~~,

according to ~~10CCR 2505-10 s~~Section 8.100, the Department~~State~~ may reduce Medicaid payment for Supported Living Program ~~residential~~ services according to the procedures at ~~10 CCR 2505-10 s~~Section 8.515.85.C

b. PETI is required for Medicaid members residing in Supported Living Programs under the Home and Community Based Services (HCBS) Brain Injury (BI) waiver

3. Case Management Responsibilities

~~The case manager shall calculate the Client payment (PETI) for 300% eligible HCBS-BI Client~~members ~~according to the following procedures:~~

a. For 300% eligible member~~Client~~s who ~~receive residential services~~reside in a Supported Living Program (SLP), the case manager shall complete a State-prescribed form which calculates the ~~Client~~member payment according to the following procedures:

i. The ~~M~~member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long--Term Care (LTC) Insurance amount.

ii. The member's Room and Board amount shall be deducted from the gross income and paid to the provider

iii. The~~A~~ member's Personal Needs Allowance (PNA) amount is based upon a members gross income, up to the maximum amount set by the Department.

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

~~ii. For an individual with financial responsibility for others:~~

iv. ~~If the~~For an individual ~~is~~ with financial~~ly~~ responsibility~~le~~ for only a spouse, ~~an amount equal to the state Aid to the Needy Disabled (AND) standard, less the amount of any spouse's income, shall be deducted from the Client's gross income; or~~ the amount protected under Spousal Protection as defined in S~~s~~ection 8.100.7 K shall be deducted from the member's gross income.

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

iv~~ii~~. Amounts for ~~Expenses~~ incurred expenses for medical or remedial care for the member~~individual~~ that are not covered ~~subject to payment~~ by Medicare, Medicaid, or other third party shall be deducted from the member~~Client~~'s gross income as follows:

a~~1~~) ~~If health insurance coverage is documented in the eligibility system, H~~health insurance premiums, deductibles and co-insurance charges~~,~~ if health insurance coverage is documented.~~;~~ ~~and~~

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

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

d~~4~~) Medications, with the following limitations:

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

~~b)~~ ~~The cost for medications which may be purchased with the Client's Medicaid Identification Card shall not be allowed as deductions.~~

2~~c~~) ~~The cost for m~~Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.

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

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

vii.~~5)~~ ~~The cost for o~~Other necessary medical or remedial care shall be deducted from the member~~Client~~'s gross income, with the following limitations:

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

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

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

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

viii. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the member's gross income.

vi~~i~~v. Any remaining income shall be applied to the cost of the SLP ~~residential~~ services, as described at Section~~§~~ 8.515.85.C, and shall be paid by the ~~Client~~member directly to the provider~~facility~~.~~; and~~

~~v~~x. If there is still income remaining after the entire cost of ~~residential~~Supported Living Program services are paid from the member~~Client~~'s income, the remaining income shall be kept by the ~~Client~~member and may be used at the member's discretion~~asfor additional personal needs or for any other use that the member~~Client desires.~~, except that the residential service provider shall not charge more than the Medicaid rate for that service~~.

b. Case managers shall inform HCBS~~ BI~~ SLP service ~~Client~~members ~~receiving residential services~~ of their ~~Client~~ payment obligations ~~on a form~~in a manner prescribed by the ~~state~~ Department at the ~~time of the first assessment visit, by the end of each plan period.~~beginning of each support plan year and ~~W~~whenever there is a significant change to their ~~in the Client~~ payment obligation. ~~amount that affects the Client's payment obligation, the case manager must inform the Client of the change in payment within ten (10) working days,.~~

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

c. Copies of ~~Client~~member payment forms shall be kept in the ~~Client~~member files at the case management agency.~~,~~ A copy of the form may be requested by the Department for monitoring purposes.~~and shall not be mailed to the State or its agent, except as required for a prior authorization request under § 8.515.7, or if requested by the state for monitoring purposes.~~