DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Long Term Care Single Entry Point System Rule Concerning Sections 8.390, 8.391, 8.392, 8.393, and 8.394
Rule Number: MSB 16-04-12-A
Division / Contact / Phone: LTSS / Julie Reed / 5425

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 16-04-12-A, Revision to the Medical Assistance Long Term Care Single Entry Point System Rule Concerning Sections 8.390, 8.391, 8.392, 8.393, and 8.394
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, 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 with the proposed text starting at 8.390 through the end of 8.393.6.B.1.i. This rule is effective June 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Long Term Care Single Entry Point System Rule Concerning Sections 8.390, 8.391, 8.392, 8.393, and 8.394
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STATEMENT OF BASIS AND PURPOSE

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

   The Long Term Care Single Entry Point System Rule regulates the work of Single Entry Point Agencies throughout the state of Colorado.The purpose of updating this rule is to ensure that it reflects the most current processes and that all language is necessary, clear and non-duplicative. The update of this rule coincides with the Department's regulatory efficiency review process.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-6-105

Initial Review **04/14/17** Final Adoption **05/12/17**
Proposed Effective Date **06/30/17** Emergency Adoption

DOCUMENT #02

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Long Term Care Single Entry Point System Rule Concerning Sections 8.390, 8.391, 8.392, 8.393, and 8.394
Rule Number: MSB 16-04-12-A
Division / Contact / Phone: LTSS / Julie Reed / 5425

REGULATORY ANALYSIS

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

   The classes of persons who will be affected by the proposed rule include the Single Entry Point Agencies that administer Long Term Care programs as well as individuals receiving services as part of Long Term Care programs.

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

   The proposed rule should clarify how Single Entry Point agencies administer Long Term Care programs and should better align with current practices.

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 implementation and enforcement of the proposed rule should not create any costs to the Department or have an anticipated effect on State revenues.

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

   The probable benefit of the proposed rule is more efficient case management administered by Single Entry Point Agencies. There is not a probable cost to implementing this rule.

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

   There are not 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.

There were not any alternative methods considered for achieving the purpose for the proposed rule because the purpose of the rule change is to ensure that it reflects the most current processes and that all language is necessary, clear and non-duplicative.

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 ~~care~~ services and supports to access appropriate ~~long term care~~ services and supports.

~~**8.390.2 LEGAL AUTHORITY**~~

~~Pursuant to C.R.S. 26-4-522, the state department is authorized to provide for a statewide Single Entry Point system.~~

8.390.1 DEFINITIONS

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

B. ~~B.~~ Assessment means a comprehensive evaluation with the ~~client~~ individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) ~~and an evaluation~~conducted by the case manager, with supporting diagnostic information from the individual's ~~client's~~ medical provider to determine the ~~client's~~ individual's level of functioning, service needs, available resources, and potential funding resources. Case Managers shall use the ULTC 100.2 to complete assessments.

~~C. Care Planning means the process of individual receiving services and appropriate collaterals, goals and individual choices appropriate service providers, based on the client individual seeking or receiving services' assessment and knowledge of the individual and of community resources.individual seeking or receiving services~~

C. ~~D.~~ Case Management means the assessment of an individual receiving long-term ~~care~~ services and supports' ~~client's~~ needs, the development and implementation of a support ~~care~~ plan for such individual~~client~~, referral and related activities, ~~-~~ the coordination and monitoring of long-term ~~care~~ service delivery, the evaluation of service effectiveness, and the periodic reassessment of such individual's ~~client's~~ needs.

D. Corrective Action Plan means a written plan, which includes the specific actions the agency shall take to correct non-compliance with regulations, and which stipulates the date by which each action shall be completed.

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.

~~E. Corrective Action Plan means a written plan, which includes the specific actions the agency shall take to correct non-compliance with standards, and which stipulates the date by which each action shall be completed.~~

F. ~~F.~~ Department shall mean the Colorado Department of Health Care Policy and Financing.

G. ~~G.~~ Failure t~~T~~o Satisfy t~~T~~he Scope o~~O~~f Work means incorrect or improper activities or inactions by the Single Entry Point agency in terms of its contract with the Department~~.~~

H. ~~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 functional criteria for a Long Term Services and Supports (LTSS) Program as determined by the Department.

J. ~~I.~~ Functional Needs Assessment means a comprehensive evaluation with the ~~client~~ individual seeking services and appropriate collaterals (such as family members, friends and/or caregivers) and a written evaluation ~~on a state prescribed form~~ by the case manager utilizing the ULTC 100.2, with supporting diagnostic information from the individual's ~~client's~~ medical provider, to determine the individual's ~~client's~~ level of functioning, service needs, available resources, potential funding resources~~,~~ and medical necessity for admission or continued stay in certain ~~long term care~~ ~~LTSS~~Long Term Services and Supports (LTSS) P~~p~~rograms.

K. Home and Community Based Services (HCBS) Programs means the specific HCBS programs for which Single Entry Point agencies shall provide case management services, ~~specifically~~ including Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI).

L. Information Management System (IMS) ~~shall~~ means an automated data management system approved by the Department ~~State~~ 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.

M. ~~J.~~ 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 ~~care~~ 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 ~~long term care client~~ assessment of the individual seeking services.

N. Long Term Services and Supports (LTSS) ~~shall~~ 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.

O. LTSS Program means a publicly funded program including, but not limited to, ~~Adult Foster Care (AFC), Home Care Allowance (HCA),~~ Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (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).

~~K. On-Going Case Management means the evaluation of the effectiveness and appropriateness of services and supports on a, on an on-going basis, through contacts with the individual receiving servicesclient, appropriate collaterals, and service providers.~~

P. 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. ~~L. Private Pay Client means~~ Private Pay Individual means an individual for whom reimbursement for case management services is received from sources other than a Department ~~a state~~ administered program, including the individual's own financial resources.

R. Professional Medical Information Page (PMIP) means the medical information signed by a licensed medical professional used as a component of the Assessment (ULTC-100.2) to determine the client's need for institutional care.

S. Reassessment means a periodic comprehensive reevaluation with the individual receiving services, appropriate collaterals and case manager, with supporting diagnostic information from the individual's medical provider to re-determine the individual's level of functioning, service needs, available resources and potential funding resources.

~~N. Reassessment means a periodic comprehensive reevaluation with the individual receiving servicesclient, and appropriate collaterals and an evaluation by the case manager, with supporting diagnostic information from the individual's client's medical provider to re-determine the individual's client's level of functioning, service needs, available resources, and potential funding resources.~~

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

U. ~~P.~~ 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 ~~current or potential long-term care~~LTSS ~~client~~ can obtain ~~long-term care~~LTSS information, screening, assessment of need~~,~~ and referral to appropriate ~~long-term care~~ LTSS programs and case management services.

~~Q. Single Entry Point District means two or more counties, or a single county, that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of long term care services.~~

V. ~~R.~~ Single Entry Point Agency means the organization selected to provide intake, screening, referral, eligibility determination, and case management functions for persons in need of ~~long term care services and supports~~ LTSS within a Single Entry Point District. ~~Single Entry Point agencies may function as a Utilization Review Contractor.~~

W. Single Entry Point District means two or more counties, or a single county, that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of LTSS.

X. ~~S.~~ State Designated Agency means a S~~s~~ingle ~~e~~Entry P~~p~~oint agency designated to perform specified functions that would otherwise be performed by the county department(s) of social services.

Y. 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.

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

~~T. Utilization Review Contractor shall mean an entity or entities contracted with the Department of Health Care Policy and Financing to provide assessment, case management, training, monitoring, and/or utilization control for the following programs: Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI), Home and Community-Based Services for Persons with Mental IllnessCommunity Mental Health Supports (HCBS-MICMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Children's Home and Community Based Services (CHCBS), Medicaid Nnursing Ffacility Ccare, Program for All Inclusive Care for the Elderly (PACE), Estate Recovery, Private Duty Nursing (PDN) and Long Term Home Health, Children's Extensive Support, Hospital Back-up and PASARR. Single Entry Points are one type of Utilization Review Contractor.~~

~~U. Utilization Management shall mean the use of techniques designed to approve or deny admission or continued stay in selected long term care programs, based on the clinical necessity, amount and scope, appropriateness, efficacy, or efficiency of health care services, procedures, or settings. Techniques applicable to this Section 8.390 include prospective review/prior authorization, certification, concurrent review, or retrospective review.~~

8.390.2 LEGAL AUTHORITY

Pursuant to C.R.S. 25.5.6.105~~6-4-522~~, the S~~state~~tate D~~d~~epartment is authorized to provide for a statewide Single Entry Point system.

8.390.~~3~~2 CHARACTERISTICS OF INDIVIDUALS RECEIVING SERVICES IN LTSS PROGRAMS ~~SINGLE ENTRY POINT CLIENTS~~

~~Persons shall access the above listed long term care programs through the single entry point agency that serves the single district in which they reside.~~

~~8.390.3.A..21 Client characteristics.~~

A. An individual ~~who desires access to long term care services~~served by the SEP Agency shall meet the following criteria:

1~~A~~. The individual ~~shall~~ requires skilled, maintenance and/or supportive services long term; ~~and~~

2~~B~~. The individual has functional impairment in activities of daily living (ADL)~~,~~ and/or a need for supervision, necessitating ~~long term care services~~LTSS provided in a nursing facility,

an alternative residential setting, ~~alternative, or~~ the individual's home or other services and supports in the community; ~~and~~

~~3~~C. ~~If the individual has a primary diagnosis of developmental disability or mental illness, the individual's needs are primarily for long term care services~~LTSS, authorization to receive ~~services through a publicly funded program shall be in accordance with the program's specific eligibility criteria., in accordance with specific program eligibility criteria; and~~

~~34~~D. The individual receives or is eligible to receive medical assistance (Medicaid) and/or financial assistance under one or more of the following programs: Old Age Pension, Aid to Blind, Aid to Needy Disabled, Supplemental Security Income, or Colorado Supplemental, or as a 300% eligible, as defined at 8.485.50.T ~~below~~, receiving LTSS ~~long term care services~~ in a nursing facility or through one of the ~~Home and Community-Based Services~~HCBS Pprograms ~~listed below at 8.390.22~~.

~~8.390.3.B.22 Clients of Ppublicly Ffunded Pprograms.~~

~~1.~~ ~~Single Entry Point agencies shall provide case management to clients of publicly funded long term care programs including, but not limited to, Medicaid Nnursing Ffacility Ccare, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI), Home and Community-Based Services for Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Children's Home and Community Based Services (CHCBS), Home Care Allowance, Adult Foster Care, and Older American's Act case management services.~~

~~8.390.31.C.23~~ **~~Utilization Review Contractors~~Management**

~~1A.~~ ~~Case Managers shall be authorized to make~~ provide Utilization Management ~~functional eligibility determinations for to clients of publicly-funded long term care programs including, but not limited to, Medicaid Nnursing Ffacility ccare, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons Living with Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services for Persons with a Spinal Cord Injury (SCI), Home and Community-Based Services for Community Mental Health Supports (CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Program for All-Inclusive Care for the Elderly (PACE), Children's Home and Community Based Services (CHCBS), Estate Recovery, Home and Community-Based Services for People with Mental Illness (HCBS-MI), Private Duty Nursing (PDN) and Long Term Home Health, PASARR, and Hospital Back-up, and Children's Extensive Support Waiver.~~

~~8.390.3.D.24~~ **~~Program-Sspecific Eeligibility Ccriteria.~~**

~~1.~~ ~~Authorization to receive services through a publicly funded program shall be in accordance with the program's~~ specific ~~eligibility criteria.~~

8.391 SINGLE~~INGLE~~ ENTRY~~NTRY~~ POINT~~OINT~~ DISTRICT~~ISTRICT~~ DESIGNATION~~ESIGNATION~~

8.391.1.A. District Designation Requirements

Single Entry Point (SEP) districts shall meet the following requirements:

1. Counties composing a multi-county district shall be contiguous.

2. A single county may be designated a district provided the county serves a monthly average of 200 or more individuals for LTSS programs.

3. Multi-county districts shall not be required to serve a minimum number of individuals receiving services.~~SEP~~

4. Each district shall assure adequate staffing and infrastructure by the district's SEP~~Single Entry Point~~ agency, including at least one full-time case manager employed by the SEP agency, to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.

8.391.1.B~~A~~.~~10~~ Changes in Single Entry Point District Designation

1~~A~~. In order to change SEP~~Single Entry Point~~ district designation, a county or district shall submit an application to the Department, six (6) months prior to commencement date of the proposed change. The application shall include the following information:

a. The geographic boundaries of the proposed SEP ~~Single Entry Point~~ district;

b. Assurances that the proposed district meets all criteria set forth in Department rules for SEP~~Single Entry Point~~ district designation;

c. The designation of a contact person for the proposed district; and

d. A resolution supporting the application passed by the county commissioners of each county or parts of counties in the proposed district.

2~~B~~. The application shall be approved provided the proposed district meets the SEP ~~Single Entry Point~~ district designation requirements.

~~8.391.1.B.11 District Designation Requirements~~

~~Single Entry Point districts shall meet the following requirements:~~

~~1A. Counties composing a multi-county district shall be contiguous.~~

~~2B. A single county may be designated a district provided the county serves a monthly average of 200 or more clients from the following community-based programs: Adult Foster Care, Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI), Home and Community-Based Services for Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Children's Home and Community Based Services(CHCBS),, Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for People Persons with a Brain Injury (HCBS-BI), and/or Older American's Act case management services.~~

~~3C. Multi-county districts shall not be required to serve a minimum number of clients.~~

~~4~~D. ~~Each district shall have at least one full-time case manager employed by the Single Entry Point agency that serves the district.~~

~~5~~E. ~~Each district shall assure adequate staffing by the district's Single Entry Point agency to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.~~

~~**NOTE:** Section 8.391.12 was deleted effective December 2, 2002.~~

8.391.2 Single Entry Point Agency Selection

A. Except as otherwise provided herein, upon a change in SEP district designation or upon expiration of the district's existing SEP agency contract, a SEP district may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the SEP agency for the district. Once the SEP functions in a district are provided through a contract between the Department and an entity other than as listed above, the SEP agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.

B. The agency selected by the SEP district shall serve as the SEP agency for the district unless the agency selected by the district has previously had its SEP agency contract terminated by the Department.

C. The SEP district's selection shall be delivered to the Department no less than six (6) months prior to the effective date of the change in district designation or expiration of the contract with the district's existing SEP agency.

D. If the SEP district has not delivered to the Department its selection within the timeframe specified in subsection (C) of this rule, the SEP agency for the district shall be selected by the Department pursuant to applicable state statutes and regulations.

8.391.3 Single Entry Point Contract

A. A SEP agency shall be bound to the terms of the contract between the agency and the Department including quality assurance standards and compliance with the Department’s rules for SEP agencies and for LTSS Programs.

8391.4 Certification of Single Entry Point Agencies

1. A SEP agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.

~~a.~~ a. Certification as a SEP agency shall be based on an evaluation of the agency's performance in the following areas:

~~i.~~ i. The quality of the services provided by the agency;

~~ii.~~ ii. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;

~~iii.~~ iii. The agency's performance of administrative functions, including reasonable costs per individual receiving services, timely reporting,

managing programs in one consolidated unit, on-site visits to individuals, community coordination and outreach and individual monitoring;

iv. Whether targeted populations are being identified and served;

v. Financial accountability; and

vi. The maintenance of qualified personnel to perform the contracted duties.

b. The Department or its designee shall conduct reviews of the SEP agency.

c. At least sixty (60) days prior to expiration of the previous year's certification, the Department shall notify the SEP agency of the outcome of the review, which may be approval, provisional approval, or denial of certification.

8.391.4.A. Provisional Approval of Certification

1. In the event a SEP agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of individuals receiving services.

2. The agency will receive notification of the deficiencies, a request to submit a corrective action plan to be approved by the Department and upon receipt and review of the corrective action plan, at the Department's option, a second sixty-day (60) provisional certification may be approved.

3. The Department or its designee shall provide technical assistance to facilitate corrective action.

8.391.4.B. Denial of Certification

In the event certification as a SEP agency is denied, the procedure for SEP agency termination or non-renewal of contract shall apply.

~~**8.391.20 SINGLE ENTRY POINT AGENCY SELECTION**~~

~~A. Except as otherwise provided herein, upon a change in SEP Single Entry Point district designation or upon expiration of the district's existing Single Entry PointSEP agency contract, a Single Entry PointSEP district may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the Single Entry PointSEP agency for the district. Once the Single Entry PointSEP functions in a district are provided through a contract between the Department and an entity other than as listed above, the Single Entry PointSEP agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.~~

~~B. The agency selected by the Single Entry PointSEP district shall serve as the Single Entry PointSEP agency for the district unless the agency selected by the district has previously had its Single Entry PointSEP agency contract terminated by the Department.~~

~~C. The Single Entry PointSEP district's selection shall be delivered to the Department no less than sixty (60) days prior to the effective date of the change in district designation or expiration of the contract with the district's existing Single Entry PointSEP agency.~~

D. If the Single Entry PointSEP district has not delivered to the Department its selection within the timeframe specified in subsection (3) of this rule, the Single Entry PointSEP agency for the district shall be selected by the Department pursuant to applicable state statutes and regulations.

NOTE: Sections 8.391.21 - 8.391.38 were deleted effective December 2, 2002.

8.392 FINANCING OF THE SINGLE ENTRY POINT SYSTEM

8.392.1 Single Entry Point agencies shall be established as separate administrative units for the purpose of providing case management services.

8.392.1.A2 REIMBURSEMENT METHODOLOGYReimbursement Methodology

1A. Reimbursement for Single Entry PointSEP functions shall be determined by the number of counties included in a district and by the number of individuals clients served, subject to the availability of funds in the Department's annual appropriation for each SEP Agency.

.

1a. A Single Entry PointSEP agency that serves a multi-county district shall annually receive a base amount for each county included in the district, plus an amount for each individual client served, to be determined annually by the Department.

b2. A Single Entry PointSEP agency that serves a district composed of only one county shall not receive the base amount, but shall receive an amount for each individual client served each year.

c3. The amount for each individual client shall be based on the number of individuals clients served in LTSS programs. in one or more of the following programs: Adult Foster Care (AFC), Home Care Allowance, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI), Home and Community-Based Services for Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Children's Home and Community Based Services (CHCBS), Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA), Home and Community-Based Services for Personsople With a Brain Injury (HCBS-BI), and Older American's Act case management services.

8.392.1.B3 COST ALLOCATIONCost Allocation

1A. The Department shall make monthly payments to each designated Single Entry PointSEP agency using a methodology which shall be specified in the contract between the state and the agency.

2B. Each fiscal year, the Department allocates funds for services provided by SEP agencies from the Department's appropriation. Payments to SEP agencies shall not exceed this allocation unless additional funds are appropriated by the General Assembly.At the beginning of each fiscal year, the Department allocates funds for services provided by Single Entry PointSEP agencies from the Department's appropriation. Payments to

~~Single Entry Point~~SEP agencies ~~shall not exceed this allocation unless additional funding is appropriated by the General Assembly.~~

3~~C~~. At the end of the contract year, actual individual ~~client~~ and activity counts are reconciled against projected individual ~~client~~ and activity counts. This process may result in either funds owed to the Department for payments made in excess of services delivered, or funds owed to SEP agencies for services delivered in excess of funds received. At the conclusion of the reconciliation process the Department issues reconciliation statements to collect for overpayments or adjusts for underpayments up to the aggregate amount allocated.

43~~D~~. ~~—~~Allowable agency expenditures are those which the Department deems allowed or required, in accordance with the following federal rules: CFR Title 45, Part 74, Appendix C; Office of Management and Budget ~~Circular A-87~~2 CFR Part 200 Super Circular, January ~~1981~~2014;~~,~~ and U.S. Department of Health and Welfare, December 1976, Cost Principles and Procedures for Establishing Cost Allocation Plans and Indirect Cost Rates for Grants and Contracts with the Federal Government (OASC-10).

a. These federal regulations are subject to change, and any change in regulations shall be instructed by the Department ~~or its designee~~.

~~This rule does not include later amendments to or editions of the incorporated material. Copies are available for public inspection during regular business hours, and may be obtained at cost or examined from the Director of the Controller Division, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO; or may be examined at any State Publications Depository Library.~~

54~~E~~. ~~Single Entry Point~~SEP agencies may be audited by representatives of the Department, its designee~~,~~ and/or independent audit firms, in accordance with state and federal rules.

65~~F~~. ~~Pre-audits made in the Department may result in reducing the Single Entry Point~~SEP ~~agency's reimbursement by the amount of any incorrect payments. Post audits made by the field audit staff verify the correctness of payments and may result in additional adjustments in reimbursement.~~Payments are audited by the Department and may result in adjustments to reimbursement.

76~~G~~. ~~Single Entry Point~~SEP agencies shall maintain documentation to support the actual costs of operation. Quarterly reports submitted to the Department shall document time expended by SEP Agency employees on specified programs, in accordance with ~~a state~~a Department prescribed time analysis method.

87~~H~~. For ~~Utilization Management~~case management functions, the Department shall make monthly payments to each designated ~~Single Entry Point~~SEP agency using a methodology which shall be specified in the contract between the Department and the agency.

8.392.1.C~~4~~ ~~PRIVATE PAY CLIENTS~~Private Pay Individuals ~~Clients~~

~~Single Entry Point~~SEP agencies may~~shall~~ provide case management services to private pay individuals seeking or receiving services at the agency's discretion. ~~clients within two years from agency start-up.~~

~~A~~1. ~~The Single Entry Point agency may~~must serve private pay clients who are able to make payment in full on a fee-for-service basis and may serve private pay clients on a sliding fee basis.

~~B~~2. ~~If the Single Entry Point agency chooses to serve private pay clients on a sliding fee basis, the Single Entry Point agency shall be responsible for obtaining supplemental funds to cover the cost of case management services for these clients.~~

~~C~~3. ~~The Single Entry Point agency shall establish separate accounting cost centers for the reporting of private pay clients as separate and distinct from clients of publicly funded programs.~~

~~D~~4. ~~The services provided to private pay clients shall be subject to the same standards as that~~ apply to clients who are recipients or applicants for state administered programs, ~~including the collection of comparable client specific data.~~

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.~~AA.~~ ~~ADMINISTRATION OF A SINGLE ENTRY POINT AGENCY~~Administration of a Single Entry Point

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

~~a1~~A. The ~~Single Entry Point~~SEP agency shall serve persons in need of ~~long term care services~~LTSS programs defined in Section 8.390.3;~~, regardless of impairment or disability, in accordance with program criteria, except that persons~~except persons

~~b~~individuals~~seeking or receiving services, individual~~individual~~in need of specialized assistance such as services for developmental disabilities or mental illness may be referred by a Single Entry Point agency to programs under the Colorado Department of Human Services;~~

~~2~~B. The ~~Single Entry Point~~SEP agency shall have the capacity to accept multiple funding source public dollars;

~~3~~C. ~~The Single Entry Point agency shall have the capacity to file for and receive payment from private insurance carriers, and charge and collect fees for services from clients;~~

~~Dc34.~~. The ~~Single Entry Point~~SEP agency ~~shall~~ may ~~have the capacity to~~ contract with individuals~~,~~ ~~with~~ for-profit entities~~,~~ and ~~with~~ not-for-profit entities to provide some or all ~~Single Entry Point~~SEP functions;

~~d45~~E. The ~~Single Entry Point~~SEP agency ~~shall~~ may ~~have the capacity to~~ receive funds from public or private foundations and corporations~~; and~~ and

~~e56~~F. The ~~Single Entry Point~~SEP agency shall be required to publicly disclose all sources and amounts of revenue.

2. For individuals with intellectual or developmental disabilities seeking or receiving services, the SEP will refer to the appropriate Community Center Board (CCB) for programs that serve this population. In the event that the individual is eligible for both a

program administered by the SEP and by the CCB, the individual will have the right to choose in which program that he or she will participate.

8.393.1.BB.11 Community Aadvisory Ccommittee.

1. The Single Entry PointSEP agency shall, within thirty (30) days of designation, establish a community advisory committee for the purpose of providing public input and guidance for Single Entry PointSEP agency operation.

a1A. The membership of the Ccommunity Aadvisory Ccommittee shall include, but not be limited to, regional representation from the district's county commissioners, area agencies on aging, medical professionals, long term care service LTSS providers, long term care LTSS ombudsman, human service agencies, county government officials, and long term care consumersindividuals receiving LTSS.

b2B. The Ccommunity AAaadvisory Ccommittee shall provide public input and guidance to the Single Entry PointSEP agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall Single Entry PointSEP agency operations, service quality, individual client satisfaction, and other related professional problems or issues.

8.393.1.CC.12 Personnel Ssystem.

1. The Single Entry PointSEP agency shall have a system for recruiting, hiring, evaluating, and terminating employees.

a1A. Single Entry PointSEP agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.

b2B. The Single Entry PointSEP agency shall maintain current maintain written job descriptions for all positions.

8.393.1.D.D.13 Accounting Ssystem.

1. The Single Entry PointSEP agency shall follow generally accepted accounting practices and comply with all rules and regulations for accounting practices set forth by the State.

a1A. In addition, the Single Entry PointSEP agency shall assure the following:

ia1. Funds are used solely for authorized purposes;

iib2. All financial documents are filed in a systematic manner to facilitate audits;

iiic3. All prior years' expenditure documents are maintained for use in the budgeting process and for audits; and

ivd4. Records and source documents are made available to the Department, its representative, or an independent auditor for inspection, audit, or reproduction during normal business hours.

b2B. The Single Entry PointSEP agency shall be audited annually and shall submit the final report of the audit to the Department within six (6) months after the end of the state's fiscal year. The Single Entry PointSEP agency shall assure timely and appropriate resolution of audit findings and recommendations.

c3. SEPs are subrecipients of federal funding and therefor are subject to federal subrecipient requirements. See the Office of Management and Budget of OMB Super Circular, 2 C.F.R. 200.330-32 (2013). A-133.

ia. Subrecipient (the SEP agency) means a non-Federal entity that receives a Subaward from a Recipient (the Department) to carry out part of a Federal program, but does not include an individual that is a beneficiary of such program. A Subrecipient may also be a recipient of other Federal Awards directly from a Federal Awarding Agency.

8.393.1.E.E.14 Liability Iinsurance Ccoverage.

The Single Entry PointSEP agency shall maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements for contract agencies.

8.393.1.FF. .15 Information Mmanagement.

1. The Single Entry PointSEP agency shall, in a format specified by the StateDepartment, be responsible for the collection and reporting of summary and individualclient-specific data including but not limited to information and referral services provided by the agency, program eligibility determination, financial eligibility determination, support care planning, service authorization, critical incident reporting, monitoring of health and welfare, monitoring of services, resource development, and fiscal accountability, and, if applicable, utilization management.

a1A. The Single Entry PointSEP agency shall have computer hardware and software, compatible with the Department's computer systems, and with such capacity and capabilities as prescribed by the Department.

b2B. The Single Entry PointSEP agency shall have adequate staff support to maintain a computerized information system in accordance with the Department's requirements.

c3. The SEP agency shall have adequate phone and IMSs to manage the administrative requirements necessary to fulfill the responsibilities of the SEP.

8.393.1.GG. .16 Recordkeeping.

1. The Single Entry PointSEP agency shall maintain individual client records in accordance with program requirements.

1a. The case manager shall use the Department-prescribed IMS for purposes of, including the documentation of all case activities, the monitoring of service delivery, and service effectiveness. If applicable, the individualclient's designated representative (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation.

22. If the individual client is unable to sign a form requiring his/her signature due to a medical condition, any mark that the individual client is capable of making will be accepted in lieu of a signature. If the individual client is not capable of making a mark, the signature of a family member or other person designated to represent the individual client will be accepted.

8.393.1.HH.17 Confidentiality of information.

The Single Entry PointSEP agency shall protect the confidentiality of all applicant and recipient records of individuals seeking and receiving services in accordance with State statute (CRS 26-1-114 as amended). Release of information forms obtained from the individual client must be signed, and dated, and kept in the clients record. Release of information forms and shall be renewed at least annually, or sooner if providers changethere is a change of provider. Fiscal data, budgets, financial statements and reports which do not identify individuals clients by name or Medicaid ID number are open records.

8.393.1.II.18 Individual Client Rights.

1. The Single Entry PointSEP agency shall assure the protection of the individual receiving services'client's rights individual receiving services' as defined by the Department under applicable programs.

a1A. The Single Entry PointSEP agency shall assure that the following rights are preserved for all individualsclients of the Single Entry PointSEP agency, whether the individual client is a recipient of a state administered program or a private pay individualclient:

ia1. The individual client and/or the individual's client's designated personal representative is fully informed of the individual's client's rights and responsibilities;

iib2. The individual client and/or the individual's client's designated personal representative participates in the development and approval, and is provided a copy, of the individual's client's care plan Support Care Plan;

iiic3. The individual client and/or the individual's client's designated personal representative selects service providers from among available qualified and appropriate willing providers;

in the individual's client's Single Entry PointSEP district;

ivd4. The individual client and/or the individual's client's designated personal representative has access to a uniform complaint system provided for all individuals clients of the Single Entry PointSEP agency; and

ve5. The clientindividual who applies for or receives publicly funded benefits and/or the individual's client's designated personal representative has access to a uniform appeal process, which meets the requirements of Section 8.393.26 8.057, when benefits or services are denied or reduced and the issue is appealable.

22B. At least annually, the Single Entry PointSEP agency shall survey a random sample of individuals receiving services clients to determine their level of satisfaction with services provided by the agency.

aa1. The random sample of individuals ~~clients~~ shall constitute ten (10) individuals ~~clients~~ or ten percent (10%) of the ~~Single Entry Point~~SEP agency's average monthly caseload, whichever is higher.

bb2. If the ~~Single Entry Point~~SEP agency's average monthly caseload is less than ten (10) individuals~~clients~~, all individuals ~~clients~~ shall be included in the survey.

cc3. The individual ~~client~~ satisfaction survey shall conform to guidelines provided by the Department.

dd4. The results of the individual ~~client~~ satisfaction survey shall be made ~~-~~available to the Department and shall be utilized for the ~~Single Entry Point~~SEP agency's quality assurance and resource development efforts.

~~e3C~~. The ~~Single Entry Point~~SEP agency shall assure that consumer information regarding ~~long term care services~~LTSS is available for all individuals ~~clients~~ at the local level.

8.393.1.~~JJ.19~~ Access

1. There shall be no physical barriers which prohibit individual ~~client~~ participation, in accordance with the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.

~~a1A~~. The ~~Single Entry Point~~SEP agency shall not require individuals receiving services ~~clients~~ to come to the agency's office in order to receive ~~assessments~~SEP services.~~, utilization management services, or case management services.~~

~~b2B~~. The ~~Single Entry Point~~SEP agency shall comply with anti-discriminatory provisions, as defined by federal and Department rules.

~~c3C~~. The functions to be performed by a ~~Single Entry Point~~SEP ~~(SEP)~~ agency shall be based on a case management model of service delivery.

8.393.1.K. Staffing Patterns

1. The Single Entry Point agency shall provide staff for the following functions: receptionist/ clerical, administrative/ supervisory, case management, and medical consulting services.

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

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

c. The case management function shall include, but not be limited to, all of the case management functions previously defined in Section 8.393.1.M. for SEP

case management services, as well as resource development, and attendance at staff development and training sessions.

d. Medical consultant services functions shall include, but not be limited to, an employed or contracted physician and/or registered nurse who shall provide consultation to SEP agency staff regarding medical and diagnostic concerns and Adult Long Term Home Health prior authorizations.

8.393.1.L. Qualifications of Staff

1. The SEP agency's supervisor(s) and case manager(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

a. Case managers shall have at least a bachelor's degree in one of the human behavioral science fields (such as human services, nursing, social work, psychology, etc.).

b. An individual who does not meet the minimum educational requirement may qualify as a Single Entry Point agency case manager under the following conditions:

i. Experience as a caseworker or case manager with LTSS population, in a private or public social services agency may substitute for the required education on a year for year basis.

ii. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

iii. The SEP Agency shall request a waiver/memo from the Department in the event that the case manager does not meet minimum educational requirements. A copy of this waiver/ memo stating Department approval will be kept in the case manager's personnel file that justifies the hiring of a case manager who does not meet the minimum educational requirements.

c. The case manager must demonstrate competency in all of the following areas:

i. Application of a person centered approach to planning and practice;

ii. Knowledge of and experience working with populations served by the SEP Agency;

iii. Interviewing and assessment skills;

iv. Knowledge of the policies and procedures regarding public assistance programs;

v. Ability to develop support plans and service agreements;

vi. Knowledge of LTSS and other community resources; and

vii. Negotiation, intervention and interpersonal communication skills.

d. The Single Entry Point agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of LTSS.

8.393.1.M. Functions of the Case Manager.

1. The Single Entry Point agency's case manager(s) shall be responsible for: intake/screening/referral, assessment/reassessment, development of support plans, on-going case management, monitoring of the 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 a face-to-face contact with the individual at least every six (6) months, or more frequently if warranted by the individual's condition or the rules of the LTSS Program in which the individual is enrolled, and shall update the ULTC 100.2 and Support Plan in the IMS to reflect any changes in condition or services.

c. The case manager shall complete a new ULTC-100.2 during a face-to-face reassessment 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.

d. The case manager shall monitor the delivery of services and supports identified within the Support Plan 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 with respect to the Support Plan and the Prior Authorization Request (PAR).

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.

8.393.1.N. Functions of the Single Entry Point Agency Supervisor

1. SEP agencies shall provide adequate supervisory staff who shall be responsible for:

a. Supervisory case conferences with case managers, on a regular basis;

b. Approval of indefinite lengths of stay, pursuant to 8.402.15;

c. Regular, systematic review and remediation of case records and other case management documentation, on at least a sample basis;

d. Communication with the Department when technical assistance is required by case managers, and the supervisor is unable to provide answers after reviewing the regulations;

e. Allocation and monitoring of staff to assure that all standards and time frames are met; and

f. Assumption of case management duties when necessary.

8.393.1.O. Training of Single Entry Point Agency Staff

1. SEP agency staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for SEP agencies.

a. Prior to agency start-up, the SEP agency staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:

i. Background information on the development and implementation of the SEP system;

ii. Mission, goals, and objectives of the SEP system;

iii. Regulatory requirements and changes or modifications in federal and state programs;

iv. Contracting guidelines, quality assurance mechanisms, and certification requirements; and

v. Federal and state requirements for the SEP agency.

b. During the first year of agency operation, in addition to an agency's own training, the Department or its designee will provide in-service and skill development training for SEP agency staff. Thereafter, the SEP agency will be responsible for in-service and staff development training.

8.393.1.P. Provision of Direct Services

1. The SEP agency may be granted a waiver by the Department to provide direct services provided the agency complies with the following:

a. The SEP agency shall document at least one of the following in a formal letter of application for the waiver:

i. The service is not otherwise available within the SEP district or within a sub-region of the district; and/or

ii. The service can be provided more cost effectively by the SEP agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or sub-region of the district.

b. The SEP agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report, at such time and on a form as prescribed by the Department, which includes a cost comparison of the service with other service providers in the area in order to document continuing cost effectiveness.

c. The SEP agency shall assure the Department that efforts have been made, and will continue to be made, to develop the needed service within the SEP district or within the sub-region of the district, as a service external to the SEP agency. The SEP agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.

d. The direct service provider functions and the SEP agency functions shall be administratively separate.

e. In the event other service providers are available within the district or sub-region of the district, the SEP agency case manager shall document in the individual's case record that the individual has been offered a choice of providers.

8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

~~For administration of Home Care Allowance (HCA) and/or Adult Foster Care (AFC) service-receiving individuals, see 3.570, "HOME CARE ALLOWANCE, SPECIAL POPULATIONS HOME CARE ALLOWANCE, ADULT FOSTER CARE, AND BURIAL" through 3.589, "COUNTY DEPARTMENT AND SEP REQUIREMENTS AND RESPONSIBILITIES".~~

~~A.~~ The ~~Single Entry Point~~SEP agency shall provide intake and screening for LTSS Programs, information and referral ~~-~~assistance to other services and supports, eligibility determination, case management and, if applicable, Utilization Management services in compliance with standards established by the Department.

~~B.~~ The ~~Single Entry Point~~SEP agency shall provide sufficient staff to meet all performance standards. In the event a ~~Single Entry Point~~SEP agency sub-contracts with an individual or entity to provide some or all service functions of the ~~Single Entry Point~~SEP agency, the sub-contractor shall serve the full range of ~~Single Entry Point~~LTSS programs. Subcontractors must abide by the terms of the ~~Single Entry Point~~SEP agency's contract with the Department, and are obligated to follow all applicable federal and state rules and regulations. The ~~Single Entry Point~~SEP agency is responsible for subcontractor performance.

~~C.~~ ~~8.393.2.A~~**A.** **Protective S**~~s~~**ervices**~~.~~

1. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of abuse, 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 and/or the local law enforcement agency.

~~8.393.2.B. D. Pilot ProjectsPrograms.~~

~~1. Effective July 1, 2001, the Single Entry Points shall be permitted under a pilot projectprogram administered by the Department to perform the following activities as negotiated under agreement with the Department:~~

~~a1. Approve authorizations for admission and continued stay into the Home and Community Based Services - Elderly, Blind, and Disabled (HCBS-EBD), and Home and Community Based Services - Persons Living with AIDS (HCBS-PLWA) Programs.~~

~~b2. Approve authorizations for admission and continued stay into nursing facilities, Program of All-Inclusive Care for the Elderly, the Brain Injury Program, and the Home and Community Based Services - Mentally Ill programCommunity Mental Health Supports. Such authorization shall only be permitted when both the SEP and the provider submitting the request for authorization agree to voluntarily participate in the pilot. Such agreement from the provider shall be indicated on the provider's official letterhead, signed by a representative of the provider legally authorized to act on behalf of the provider, and submitted to the SEP and the Department.~~

~~c3. Approvals made pursuant to §8.393.2 D (1) and (2) shall follow 8.401.15 A.~~

~~d4. Submit data as necessary to support the structure of long term care data systems.~~

8.393.2.~~B~~B~~C~~.~~21~~Intake/~~s~~Screening/R~~r~~eferral

1~~A~~. The intake/screening/referral function of a ~~Single Entry Point~~SEP agency shall include, but not be limited to, the following activities:

~~a~~1. The completion of the intake/screening/referral function using the Department's IMS;

i. S~~S~~EPs may ask referring agencies to complete and submit an intake and screening form to initiate the process; ~~Part A of the Department prescribed Long Term Care Single Entry Point Intake Form~~ referral ~~documents;~~

~~c~~b~~2~~. The provision of information and referral to other agencies as needed;

~~d~~c~~3~~. A screening to determine ~~The determination of~~ whether or not ~~the appropriateness of a referral for a comprehensive long term care~~ a functional eligibility~~client~~ assessment is needed;

~~e~~d~~4~~. The identification of potential payment source(s), including the availability of private funding resources; and

~~f~~e~~5~~. The implementation of a ~~Single Entry Point~~SEP agency procedure for prioritizing urgent inquiries.

B2. If a referral to Single Entry Point long term care services is determined to be appropriate, Part B of thethe remainder of the Intake Form shall be completed with the applicant or applicant's representative, within two (2) working days of the completion date on the screening/referral form. (Part A).

2C. When long term care servicesLTSS are to be reimbursed through one or more of the publicly-funded long term careLTSS programs administered by the Single Entry PointSEP system, the Single Entry PointSEP staff shall:

a. Verify the individual's demographic information collected during the intake; and

b. Coordinate the completion of financial eligibility determination:

i. Verify the individual's applicant's current financial eligibility status; or, or

b2.ii. Refer the individual's applicant to the county department of social services of the individual's client's county of residence for application,; or or

c3.iii. Provide the individual applicant 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. Conduct and document follow-up activities on to complete the functional eligibility determination and coordinate the completion of the financial eligibility determinationreturn of forms.

c3D. The determination of the individual's applicant's financial eligibility shall be completed by the county department of social services for the county in which the individual applicant resides, pursuant to Section 8.100.7 A-U.

d4E. Individuals Applicants shall be notified The notification of to applicants at the time of their application for publicly funded long term care services and supports that they have the right to appeal actions of the Single Entry PointSEP agency, the Department of Health Care Policy and Financing, or contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

5e. The county department shall notify the SEP agency of the Medicaid application date for the individual seeking services upon receipt of the Medicaid application.

6f. The county shall not notify the SEP agency for individuals being discharged from a hospital or nursing facility or Adult Long Term Home Health.

6F. Single Entry Point staff shall obtain the client's or representative's signature on the Intake Form.

8.393.2.CD.22 Initial Assessment

1. For additional guidance on the ULTC-100.2, as well as the actual tool itself, please see 10 C.C.R. 2505-10 Section 8.401.1. GUIDELINES FOR LONG TERM CARE SERVICES

a1A. The county department shall notify the Utilization Review Contractor/Single Entry Point (URC/SEP) Ccase Management Agency (CMA) manager of the Medicaid application date for the client upon receipt of the Part I and II of the Medicaid application. The county shall not notify the SEP/URC for clients being discharged from a hospital or nursing facility or Long Term Home Health. The URC/SEP case managerSEP agencyCMA shall complete the ULTC 100.2Department-prescribed assessment toolULTC 100.2 assessment within the following time frames:

i. For an individual who is not being discharged from a hospital or a nursing facility, the individual assessment 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.

ii. 1.For an individual who is not being discharged from a hospital or a nursing facility, the individual client evaluation shall be completed within ten (10) working days.

2. For a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the URC/SEP case managerCMASEP agency shall complete the evaluation assessment within five (5) working days after notification by the nursing facility.

iii. 3. For a resident who is being admitted to the nursing facility from the hospital, the URC/SEP case managerCMASEP agency shall complete the assessmentevaluation, including a PASRR Level 1 Screen within two (2) working days after notification.

1)i. For PASRR Level 1 Screen regulations, refer to 10 C.C.R 2505-10 8.401.181., PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERIVCES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

b. 4. For an individual client who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the URC/SEPCMASEP agency case manager shall complete the assessment evaluation within five (5) working days after notification by the nursing facility.

c. 5. For an individual client who that is being transferred from a hospital to an HCBS program, the URC/SEPCMASEP agency case manager shall complete the assessment evaluation within two (2) working days after notification from the hospital. .

2. Under no circumstances shall the start date for functional eligibility based on the ULTC 100.2 be backdated by the SEP. See section 8.486.30, ASSESSMENT, Under no circumstances shall late PAR revisions be approved by the State or its agent. See Section 8.485.90, STATE PRIOR AUTHORIZATION OF SERVICES.

3. The ~~URC/SEP case manager~~CMA~~SEP~~ agency shall complete the ~~ULTC 100.2 Department-prescribed assessment tool~~ ULTC 100.2 ~~assessment~~for LTSS Programs, in accordance with Section ~~10 C.C.R. 2505-10~~ 8.401.1~~5~~.

a. ~~a.~~ If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may complete the ~~Department-prescribed assessment tool~~ ULTC 100.2 for CHCBS.

~~The Assessment~~assessment ~~instrument shall be completed for individuals eligible to receive services through the following programs:~~

~~1. Medicaid Nnursing Ffacility c~~Care~~

~~2. Home and Community-Based Services for the Elderly, Blind, and Disabled (HCBS-EBD);~~

~~3. Home and Community-Based Services for Persons Living With Acquired Immune Deficiency Syndrome (HCBS-PLWA);~~

~~4. Adult Foster Care;~~

~~Home Care Allowance;~~

~~5. Home and Community Based Services - Brain Injury~~

~~6. Home and Community Based Services - Mentally Ill~~Community Mental Health Supports

~~7. Home and Community Based Services - Children's~~ Children's Life Limiting Illness

~~8. Consumer Directed Attendant Support~~ Services ~~(CDASS)~~

~~9. Long Tterm Hhome Hhealth~~

~~Children's Home and Community Based Services~~

~~Home and Community-Based Services – Spinal Cord Injury (HCBS-SCI);~~

~~10. In-home services provided by the Older American's Act when the individual is in need of case management services~~

~~3~~C. ~~The ULTC 100.2 may be completed for clients who are able to pay for case management services with private resources. Any completed ULTC 100.2 shall be kept on file at the URC/SEP agency~~CMA, ~~but copies need not be sent to the Department unless specifically requested.~~

4~~4~~D. The SEP Agency shall assess the individual's functional status face-to-face at a time and location convenient to the individual.

5. The ~~URC/SEP case manager~~CMA~~SEP~~ agency shall conduct the following activities for a comprehensive ~~client~~ assessment of an individual seeking services:

~~1.~~

a. Obtain diagnostic information through 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

(HCBS-CMHS), Persons with a Brain Injury (HCBS-BI), Elderly, Blind and Disabled (HCBS-EBD), Persons with a Spinal Cord Injury (HCBS-SCI) and Children with a Life Limiting Illness (HCBS-CLLI). ~~Obtain diagnostic diagnosis(es) information from the individual's client's medical provider for individuals clients in nursing facilities, HCBS Programs for mentally ill Community Mental Health Supports (HCBS-CMHS),, Persons Living With Aids (PLWA) and brain injured Persons with a Brain Injury (HCBS-BI), Elderly Blind and Disabled (HCBS-EBD), Persons with a Spinal Cord Injury (HCBS-SCI), and Children with a Life Limiting Illness (HCBS-CLLI), and~~

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. 2.~~ Determine the individual's ~~client's~~ functional capacity during an evaluation, with observation of the individual ~~client~~ and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section ~~10 C.C.R. 2505.10 §~~8.401.1.~~8.484.20 C.~~

~~c. 3.~~ Determine the length of stay for nursing facility individuals ~~clients~~ using the Nursing Facility ~~-~~Length of Stay Assignment Form in accordance with ~~10.C.C.R. 2505.10 §~~Section 8.402.15.

~~d. 4.~~ Determine the need for ~~paid care on the ULTC 100.2 Department-prescribed assessment tool~~long term services and supports on the ULTC 100.2 during the evaluation. ~~For SP-HCA and AFCCF clients, the need for paid care score shall be used to determine the monthly HCA-authorized amount in accordance with Section 10 9 C.C.R. 2505-5 10 §38.570 and 3.580 as required by the Colorado Department of Human Services. 484.2.~~

~~5. Determine if the HCA services provided by the caregiver living with the client are above and beyond the workload of the normal family/household routine. If services are not beyond normal family/household routine, the client may not be scored as needing paid care for that service. Examples of normal family/household routine are cooking a meal for the members of the household with no special prescribed diet for the client; housekeeping for the members of the household with no heavy housekeeping for the client; washing the client's laundry with the laundry of other members of the household when there is no incontinence or illness which precludes washing household and client clothing together, shopping and running errands for the household when there is no article which has been prescribed for the health or personal care of the client and which necessitates a separate trip.~~

~~6. For HCA, score children age zero (0) through thirteen (13) years in both functional capacity and need for paid care according to the following age appropriate criteria:~~

~~a. Toileting: A child age 0 to 36 months will not be scored for bowel and bladder incontinence.~~

~~b. Mobility and Positioning: A child age 0 to 36 months will not be scored for mobility and positioning.~~

~~c. Dressing: A child age 0 to 60 months will not be scored for dressing.~~

~~d. Bathing and hygiene: A child 0 to 60 months will not be scored for bathing and hygiene.~~

~~e. Eating: A child 0 to 48 months will not be scored for eating.~~

~~f. Transfers: A child 0 to 48 months will not be scored for transfers. A child 0 to 60 months will not be scored for car seat, highchair, or crib transfers.~~

~~7. Determine the ability and appropriateness of the client's caregiver(s) and family to provide the client assistance in activities of daily living;~~

~~8. Determine the client's service needs, taking into consideration services available, or already being received, from all funding sources;~~

~~9. If the client is a resident of a nursing facility, determine the feasibility of de-institutionalization;~~

~~10. If an out-of-home placement is required, review placement options based on the client's needs, the potential funding sources, and the availability of resources within the district including, but not limited to, an adult foster care facility, an alternative care facility, a nursing facility, or another residential alternative;~~

~~11. Determine and document, on the Care Plan, client preferences in program selection;~~

~~12. Assist the client in the completion of applications for Single Entry Point administered long term care programs, if appropriate;~~

~~13. Maintain appropriate documentation for certification of program eligibility, if required for entrance into a program; or to submit such documentation to the Utilization Review Contractor, if applicable, and~~

~~14. Refer the client to alternative services, if the client does not meet the eligibility requirements for a long term care program administered by the Department.~~

e. For HCBS Programs and admissions to nursing facilities from the community, the original ULTC-100.2 copy shall be sent to the provider agencies, and a copy shall be placed in the individual's case record. At the six-month reassessment, if there are changes in the individual's condition which significantly change the payment or services amount, a copy of the ULTC-100.2 must be sent to the provider agency and a copy is to be maintained.

f. When the SEP Agency conducts an assessment of the individual's functional capacity on the ULTC-100.2, the assessment is not an adverse action which is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into a LTSS Program by the SEP based on the ULTC-100.2 thresholds for functional eligibility. The appeal process is governed by the provisions of Section 8.057

~~56D~~. The case manager shall complete the following activities for discharges from nursing facilities:

a1. For all discharges from nursing facilities to community placements through Single Entry Point agencies:

a. The nursing facility shall contact the Single Entry PointSEP agency in the district where the nursing facility is located to inform the Single Entry PointSEP agency of the discharge if placement into community services is being considered.

bb. The nursing facility and the SEP case manager shall coordinate the discharge date. The nursing facility and the Single Entry PointSEP case manager shall coordinate the discharge date, and, where when placement into the Home Care Allowance HCA or Adult Foster CareAFC programs are being considered, the completion of a new Department-prescribed assessment tool ULTC-100 100.2 to use for assessment and support care planning. The case manager shall be responsible for completion of the form.

cc2. When placement into HCBS Programs the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Persons with a Brain Injury, Persons with a Spinal Cord Injury, Community Mental Health Supports, and Children with a Life Limiting Illness programs, or the Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) program is are being considered, , the Utilization Review ContractorSEP shall determine the remaining length of stay.

i.i. If the end date for the nursing facility is indefinite, the SEP agency shall assign an end date not greater than one (1) year from the date of most recent assessment.

ii.ii. If the Department-prescribed assessment toolULTC 100.2 is less than six (6) months, tThe Utilization Review Contractor/, in accordance with 8.486.35, ASSESSMENT-DEINSTITUTIONALIZATION, shall send the Single Entry PointSEP agency shall maintain a copy of page 1 of the current nursing facility ULTC-100.2 indicating discharge to HCBS with generate a new certification page that reflects an assigned length of stay using the end date that was assigned to the nursing facility. .

b. The nursing facility and the URC/SEPCMA SEP case manager shall coordinate the discharge date, and where when placement into the Home Care Allowance or Adult Foster Care programs are being considered, the completion of a new ULTC 100.2 to use for assessment and care planning. The case manager shall be responsible for completion of the form.

iii.iii. 3. When placement into the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) Persons with a Brain Injury, Persons with a Spinal Cord Injury, Community Mental Health Supports, and Children with a Life Limiting Illness programs, and Children's Home and Community Based Services programs program, or the Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) program is being considered, Tthe URC/SEP agencyCMA SEP agency shall . complete a new ULTC-100.2Department-prescribed assessment tool ULTC 100.2 if the current ULTC 100.2's completion date is older than six (6) months. The assessment results shall be used to determine level of care and the new length of stay.

a. The URC/SEP agency shall send the Statewide UtililzationUtilization Review Contractor a copy of the current nursing facility ULTC 100.2 indicating discharge to HCBS with an assigned length of stay and new end date.

iv.iv.Ab. The SEP Agency shall send a copy of the ULTC-100.2 certification page to the eligibility enrollment specialist at the county department of social services.The nursing facility ULTC 100.2 used by the URC/SEP agencyCMA SEP to certify HCBS eligibility shall be kept in the case record. In addition, a The SEP agency shall send a copy of the Department-prescribed assessment tool's certification page must be sent to the income maintenance technicianeligibility enrollment specialist at the county department of social services, and a copy must be sent to the Department or its fiscal agent with the HCBS prior authorization request.

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

d4. If placement into the Home Care Allowance HCA program or the Adult Foster CareAFC programs is being considered, notification shall be sent to the income maintenance technicianeligibility enrollment specialist at the county department of social services.

78. 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 shall:

aa. Coordinate the admission date with the facility;

bb. 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 if a PASRR Level 2 evaluation is required;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 if a PASRR Level 2 Screen is required;

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

dd. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the Department-prescribed assessment toolULTC 100.2 is not older than six (6) months.

5. For referrals to other programs or services, the URC/SEP case managerCMA SEP shall use the ULTC 100.2 for eligibility, care planning, Utilization Management, or referral, as appropriate.

6E. For HCBS-EBD, HCBS-BI, HCBS-SCI, and HCBS-CMHS or HCBS-PLWA clients already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the URC/SEP case SEP shall

coordinate the admission date with the facility. . The case manager shall contact the Statewide Utilization Review Contractor to conduct a PASARR screening. If appropriate, the URC/SEP

~~agency~~CMA SEP ~~shall assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ULTC 100.2 is not older than six (6) months..~~

8.393.2.D. Reassessment

1. The case manager shall commence a regularly scheduled reassessment at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a reassessment of an individual receiving services within twelve (12) months of the initial individual assessment or the previous reassessment. A reassessment shall be completed sooner if the individual's condition changes or if required by program criteria.

2. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the ULTC 100.2.

3. Reassessment shall include, but not be limited to, the following activities:

   a. Obtain diagnostic information through the Professional Medical Information Page (PMIP) form, from the individual's medical provider at least annually, or sooner if the individual's condition changes or is required by program criteria;

   b. Assess the individual's functional status face-to-face at a time and location convenient to the individual;

   c. Review support plan, service agreements and provider contracts or agreements;

   d. Evaluate effectiveness, appropriateness and quality of services and supports;

   e. Verify continuing Medicaid eligibility, other financial and program eligibility;

   f. Annually, or more often if indicated, complete new support plan and service agreements;

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

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

   i. 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

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

4. The SEP shall be responsible for completing reassessments of nursing facility individuals. A reassessment 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 reassessment or if the case manager assigns a definite end date. The nursing facility shall be responsible to send the SEP agency a referral for a new assessment as needed.

5. The ULTC-100.2 shall be reviewed during each six (6) month contact and updated due to any change in the individual's condition or status. If there is no change in

the individual's status, the case manager shall document in the Department-prescribed IMS that the ULTC-100.2 has been reviewed but not updated.

6. 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.

8.393.2.~~DE~~.~~23~~ ~~Care~~ Support ~~P~~plan~~ning~~

~~A~~1. The nursing facility shall be responsible for developing a ~~care~~support plan for individuals residing in ~~the~~ nursing ~~f~~facilities~~y client~~.

2. The ~~URC/SEP case manager~~SEP agency shall develop the Support ~~C~~care ~~P~~pPlan (SP) within fifteen (15) working days after determination of program eligibility.

3. The SEP shall:

a. ~~(PCCP) to meet~~Address the functional needs identified ~~after completing the client~~ through the ~~client~~individual assessment ~~and prior to the arrangement for services~~;

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 persons who are limited English proficient;

e. Formalize the support plan agreement, including appropriate 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 Section 8.520-8.527~~8.527.11~~.;

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

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

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

k~~j~~. 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 ensure that the development of the Support Plan:

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

b. Is led by the individual, family members and/or individual's representative with the case manager;.

2B. The nursing facility shall be responsible for developing a care plan for the nursing facility client.

3.C Care Pplanning shall include, but not be limited to, the following tasks:

c. Includes people chosen by the individual;

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

a. The determination of client co-payment and documentation of client choices, in accordance with program requirements;

b.

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

c. The completion of program requirements for authorization of services;

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 Rreferral to community resources as needed and development of resources for individual individuals clients if a resource is not available within the individual's client's community.;

5D. Prudent purchase of services:

a1. The case manager shall arrange services and supports using the most cost effective methods available in considering of the individual's needs and preferences. meet the client's needs, with consideration of the client's choices, using the most cost effective methods available.

b2. When family, friends, volunteers or others services are available, willing and able to support the individual client at no cost from family, friends, volunteers, or others, these services supports shall be utilized before the purchase of services, providing these services adequately meet the individual's client's needs..

c~~3~~. When public dollars must be used to purchase services, the case manager shall encourage the individual ~~client~~ to select the lowest cost provider of service when quality of service is comparable.

dd~~4~~. The case manager shall assure there is no duplication in services provided by ~~single entry point~~SEP programs and any other public 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 support plan.

8.393.2.F. Cost Containment

1. If the case manager expects that the services required to support the individual receiving services' needs will exceed the Department-determined Cost Containment Review Amount, the Department or its agent will review the support plan to determine if the individual's request for services is appropriate and justifiable based on the individual's condition and quality of life and 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~~F.~~.~~24~~ On-Gg~~oing Cc~~ase Mm~~anagement~~

1~~A~~. The ~~major goals~~ functions of the on-going case manager ~~of on-going case management~~ shall be ~~to~~:

a. ~~1~~a. ~~Monitor the quality of care provided to clients;~~ 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. Support Plan ~~d~~Development: The case manager shall work with individuals to design and update Support Plans 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, including any subsequent revisions based on the changing needs of individuals;

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

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.

~~b2. Identify changes in the client's needs that may require a full reassessment or a change in the care plan;~~

~~c3. Identify and resolve any problems with service delivery; and~~

~~d4. Make changes in service plans as appropriate to client needs.~~

2. ~~2B.~~ The case manager shall assure quality of ~~care~~ services and supports and the health and welfare of the individual by monitoring service providers to ensure~~,~~ the appropriateness, timeliness and amount of services provided~~, the amount of care, the timeliness of service delivery, and to~~and to promote individual safety, ~~client~~ satisfaction and quality of life. The case manager shall take~~,~~ and the safety of the client, and by taking corrective actions as needed.

3. The SEP Agency must also observe the individual's residence with the individual present to establish the residence is a safe environment at least annually.

a. If the case manager does not observe the individual's residence at the annual face-to-face reassessment, the case manager to shall align the annual visit to the individual's residence with a six (6) month face-to-face contact.

b. If the case manager makes an observation in the individual's residence that is inconsistent with the ULTC-100.2 and/or Support Plan, the case manager shall update the assessment and/or Support Plan to reflect the observation.

~~43C~~. On-going case management shall include, but not be limited to, the following tasks:

a. ~~1.~~ Review of the individual's ~~client's care~~ support plan and service agreements;

b. ~~2.~~ Contact with the individual ~~client~~ concerning ~~the~~ individuals' safety, quality of life and ~~client's~~ satisfaction with services provided;

c. ~~3.~~ Contact with service providers ~~concerning~~ to coordinate, arrange or adjust service~~s, coordination~~, ~~effectiveness and appropriateness,~~ to address quality issues or concerns and ~~as well as concerning~~to resolve ~~-~~any complaints raised by ~~the~~ individuals ~~client~~ or others;

~~d. 4. Contact with appropriate individuals and/or agencies in the event any issues or complaints have been presented by the client or others;~~

~~e.~~d. ~~5.~~ Conflict resolution and/or crisis intervention, as needed;

~~f.~~e. ~~6.~~ Informal assessment of changes in individual ~~client~~ functioning, service effectiveness, service appropriateness~~,~~ and service cost-effectiveness;

~~g.~~f. ~~7.~~ Notification of appropriate enforcement agencies, as needed; and

h.g. 8. Referral to community resources as needed.

54D. 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 rules (Staff Manual Volume 3, Section 3.810) and Department of Health Care Policy and Financing (Staff Manual Volume 8, Section 8.076).

65E. The case manager shall contact the individual client at least quarterly, or more frequently as determined by the individual's client's needs or as required by the program.

76F. The case manager shall review the ULTC 100.2Department-prescribed assessment toolULTC 100.2 and the Care Support Plan with the client individual every six (6) months. The review shall be conducted by telephone or at the individual's client's place of residence, place of service or other appropriate setting as determined by the individual's client's needs or preferences.

78. The case manager shall complete a new Department-prescribed assessment toolULTC 100.2 when there is a significant change in the individual's condition or when the individual changes LTSS programs.

9.

87G. The case manager shall contact the service providers, as well as, the individual to monitor service delivery as determined by the individual's needs or as required by the specific service requirements.The case manager shall contact the service providers to monitor service delivery as determined by the individual's client's needs or as required by the specific service requirements.

1098. Case Manager shall report critical incident within 24 hours of notification within the State Approved IMS. This report must include:

a. Individual's name;

b. Individual's identification number;

c. HCBS Program;

cd. Incident type;

e.d. Date and time of incident;

f e. Location of incident, including name of facility, if applicable;

g. Inindividuals involved; and

fh. Description of Resolution.

8.393.2.G. Service Adequacy

1. During the Support Planning process in conjunction with the initial assessment or reassessment, the individual seeking or receiving services shall not be eligible for the HCBS program if the case manager determines the individual's needs are more extensive than the HCBS program services are able to support and/or that the individual's health and safety cannot be assured in a community setting.

a. If the case manager determines that the individual is ineligible for an HCBS Program, the case manager shall document the following:

a. The results of an Adult Protective Services assessment;

bi. Obtain aA statement from the individual's physician attesting to the individual's mental competency status; and

iic. Obtain aAny other documentation necessary to support the determination; and.

iii. Inform individuals of their appeal rights pursuant to Section 8.057.

24. The individual may be eligible for the HCBS program at reassessment if the case manager determines that HCBS program services are able to support the individual's needs and the individual's health and safety can be assured in a community setting.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 or whenever a case is transferred from one SEP agency to another, or when a case is closed.

8.393.2.I. Resource Development Committee

1. The SEP agency shall assume a leadership role in facilitating the development of local resources to meet the LTSS needs of individuals receiving services who reside within the SEP district served by the SEP agency.

2. Within 90 days of the effective date of the initial contract, the SEP agency's community advisory committee shall appoint a resource development committee.

3. The membership of the resource development committee shall include, but not be limited to, representation from the following local entities: Area Agency on Aging (AAA), county departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards, vocational rehabilitation agencies, and individuals receiving long-term services.

4. In coordination with the resource development efforts of the Area Agency on Aging (AAA) that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.

a. The resource development plan shall include:

i. An analysis of the LTSS resources available within the SEP district;

ii. Gaps in LTSS resources within the SEP district;

iii. Strategies for developing needed resources; and

iv. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support and a time frame for accomplishing stated objectives.

b. The data generated by the SEP agency's intake/screening/referral, individual assessment, documentation of unmet individual needs, resource development for individuals and data available through the Department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.

5. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the Department.

8.393.3 DENIALS/DISCONTINUATIONS/ADVERSE ACTIONS

8.393.3.A. Denial Reasons and Notification Actions

1. Individuals seeking or receiving services shall be denied or discontinued from services under publicly funded programs administered by the SEP system if they are determined ineligible due to any of the reasons below. Individuals shall be notified of any of the adverse actions and appeal rights as follows:

a. Financial Eligibility

i. The eligibility enrollment specialist from the county department of social services shall notify the individual of denial for reasons of financial eligibility, and shall inform the individual of appeal rights in accordance with Section 8.057. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the Department.

1) If the individual is found to be financially ineligible for LTSS programs, the SEP shall notify the individuals of the adverse action and inform the individual of their appeal rights in accordance with Section 8.057.

b. Functional Eligibility and Target Group

i. The SEP agency shall notify the individual of the denial and appeal rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual does not meet the functional eligibility threshold for LTSS Programs or nursing facility admissions; or

2) The individual does not meet the target group criteria as specified by the HCBS Program.

c. Receipt of Services

i. The SEP agency shall notify the individual of the denial and appeals rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual has not received services for thirty (30) days;

2) The individual has two (2) times in a thirty (30) day consecutive period, refused to schedule an appointment for assessment, six (6) month visit or after an inter-district transfer, or, has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period; or

3) The individual or individual's representative refuses to sign the Intake form, Support Plan form, Release of Information form, or other forms as required to receive services or if the SEP agency does not receive the completed Professional Medical Information Page (PMIP) form.

d. Institutional Status

i. The SEP agency shall notify the individual of denial or discontinuation by sending the Notice of Services Status (LTC-803) when the case manager determines that the individual does not meet the following program eligibility requirements.

1) The individual is not eligible to receive services while a resident of a nursing facility, hospital, or other institution; or

2) The individual who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.

e. Cost-Effectiveness/Service Limitations

i. During the Support Planning process in conjunction with the initial assessment or reassessment, the individual seeking or receiving services shall not be eligible for the HCBS program if the case manager determines the individual's needs are more extensive than the HCBS program services are able to support, that the individual's health and safety cannot be assured in a community setting and/or if the cost containment review process is met as outlined in Section 8.393.2.F.

1) If the case manager determines that the individual is ineligible for an HCBS Program, the case manager shall:

a) Obtain any other documentation necessary to support the determination; and

b) Inform induvial of their appeal rights pursuant to Section 8.057.

2. The Notice Services Status (LTC-803) shall be completed in the IMS 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.

3. In the event the individual appeals a denial or discontinuation action, with the exception of reasons related to financial eligibility, the case manager shall attend the appeal hearing to defend the denial or discontinuation action.

8.393.3.B. Case Management Actions Following a Denial or Discontinuation

1. In the case of denial or discontinuation, the case manager shall provide appropriate referrals to other community resources, as needed, within one (1) working day of discontinuation.

2. The case manager shall notify all providers on the case plan within one (1) working day of discontinuation.

3. The case manager shall follow procedures to close the individual's case in the IMS within one (1) working day of discontinuation for all HCBS Programs.

4. If a case is discontinued before an approved HCBS Prior Authorization Request (PAR) has expired, the case manager shall submit to the Department or its fiscal agent, within five (5) working days of discontinuation, a copy of the current PAR form on which the end date is adjusted (and highlighted in some manner on the form); and the reason for discontinuation shall be written on the form.

8.393.3.C. Notification

1. The SEP agency shall notify the county eligibility enrollment specialist of the appropriate county department of social services:

   a. At the same time that it notifies the individual seeking or receiving services of the adverse action;

   b. When the individual has filed a written appeal with the SEP agency; and

   c. When the individual has withdrawn the appeal or if a final agency decision has been entered.

2. The SEP agency shall provide information to individuals seeking and receiving services regarding their appeal rights when individuals apply for publicly funded LTSS or whenever the individual requests such information, whether or not adverse action has been taken by the SEP agency.

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 effecting the individual receiving services' participation in SEP agency-administered 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 DETERMINATION

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

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

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

3. If the assessment indicates approval, SEP agency shall notify the appropriate parties in accordance with Section 8.393.3.A.2 and 8.383.4.4.

4. If the assessment indicates denial, the SEP agency shall notify the appropriate parties in accordance with 8.393.3.A.2 and 8.383.4.

5. If the individual or individual's designated representative appeals, the SEP shall process the 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 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 individuals residence.

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

i. ULTC 100.2, 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 procedure 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 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 Alternative Care Facility (ACF), the transferring SEP agency shall forward copies of individual records to the Alternative Care Facility (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 within ten (10) working days after notification of the individual's relocation,

f. The receiving SEP agency shall complete a face-to-face 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 SEP agency individuals.

g. The receiving SEP agency shall review the support plan and the ULTC 100.2 and change or coordinate services and providers as necessary.

h. If indicated by changes in the support plan, the receiving SEP agency shall revise the 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.~~8.393.2.H. Cost Containment~~

~~1. If the case manager expects that the services required to support the individual receiving services' needs will exceed the Cost Containment Amount, the Department or its agent will review the service plan to determine if the individual's request for services is appropriate and justifiable based on the individual's condition and quality of life, and 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.I. Reassessment

1A. The case manager shall commence a regularly scheduled reassessment at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a reassessment of an individual receiving services client within twelve (12) months of the initial individual client assessment or the previous reassessment. A reassessment shall be completed sooner if the individual's client's condition changes or if required by program criteria.

2B. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the ULTC 100.2 Department-prescribed assessment tool. When a new ULTC 100.2 is completed for a HCA, SP-HCA or AFC client, a copy shall be sent to the county department of social services and to the Department within thirty (30) days of the reassessment in accordance with Section 3.570 and 3.580, 9 C.C.R.-2505-5 as required by the Colorado Department of Human Services..

3C. Reassessment shall include, but not be limited to, the following activities:

1. Obtain diagnoses from the individual's client's medical provider at least annually, or sooner if the individual's client's condition changes or isf required by program criteria;

2. Assess the individual's client's functional status face-to-face at the client's place of residencea time and location convenient to the individual;.

3. Review care support plan, service agreements, and provider contracts or agreements;

4. Evaluate service effectiveness, appropriateness and quality of careservices and supports, and appropriateness of services;

5. Verify continuing Medicaid eligibility, other financial and program eligibility;

5. Annually, or more often if indicated, complete new care support plan and service agreements;

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

8. Maintain appropriate documentation, including type and frequency of long term care servicesLTSS the individual client is receiving for certification of continued program eligibility, if required by the program for a continued stay review;.

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

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

4D. The URC/SEP agency SEP shall be responsible for completing reassessments of nursing facility individualsclients. A reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, or if the individual client requests a reassessment or if the case manager assigns a definite end date.

8.393.2.J. Case Recording/Documentation

A1. The Single Entry Point agency shall maintain records, including a copy of the intake form, on every individual for whom an intake was completed. The records must indicate the dates on which the referral was first received, and the dates of all actions taken by the Single Entry Point agency. Reasons for all assessment decisions and program targeting decisions must be clearly stated in the records.

B12. The Single Entry PointSEP agency shall maintain client case records on each Single Entry Point client and shall complete and maintain all required records included in the State approved information management system (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..

C32. The case record and/or information management systemIMS shall include:

a1. Identifying information, including the individual's client's state identification (Medicaid) number and social security number (SSN);

b2. All State-required forms; and

c3. Documentation of all case management activity required by these regulations.

D43. Case management documentation shall meet all the following standards:

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

2. Entries must be written at the time of the activity or shortly thereafter;

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

4. Entries must be made in permanent ink or enteredentered into the information management systemIMS;

5. The client must be identified on every page;

6. The person making each entry must be identified;

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

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

9. 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.;

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

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

12. 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 Single Entry PointSEP agency's control, the circumstances shall be documented in the case record. These circumstances shall be taken into consideration upon monitoring of Single Entry PointSEP agency performance. However, under no circumstances shall the continued stay review ULTC-100 forms be backdated by the utilization review contractorSEP, according to Section 8.486.33, ASSESSMENT, or late PAR revisions be approved by the State or its agent, according to Section 8.485.93, STATE PRIOR AUTHORIZATION OF SERVICES.

54E. Summary recording to update a case record shall be done entered into the IMS at least every six months or whenever a case is transferred from one Single Entry PointSEP agency to another, or when a case is closed. The location of the six-month summary within the case file may be determined by the Single Entry Point agency, however, the location must be consistent across all client files.

8.393.2.K..27 Completion of Single Entry Point Forms

A1. The Notice of of Services StatusAction (LTC-803) form, or an Advisement Letter, shall be sent for all applicable programs at the time of initial eligibility, when there is a significant change in the client's payment or services, an adverse action, or at the time of discontinuation. The Single Entry Point client shall receive a copy of the LTC-803,, or Advisement Letter, and a copy shall be placed in the client's case record.

B2. The Department-prescribed assessment tool ULTC-100.2 shall be completed at the time of initial assessment, reassessment and when there is a significant change in the individual's client's condition, and shall be updated at each six-month summary recording.

C3. For the AFC, and HCA, and SP-HCA Programs, the original Department-prescribed assessment tool ULTC-100.2 shall be sent to the Department at the time of the initial assessment and each annual reassessment. For HCBS Programs, and admissions to nursing facilities from the community, the original Department-prescribed assessment tool ULTC-100.2 copy shall be sent to the Utilization Review Contractor, as applicable, or kept by the the Single Entry PointSEP agency, and a. A copy shall be placed in the individual's client's case record. At the six-month record update, if there are changes in the individual's client's condition which significantly change the payment or services amount, a copy of the Department-prescribed assessment tool ULTC-100.2 must be sent to

the Department or the Utilization Review Contractor, as applicable or kept by the Single Entry PointSEP agency and a copy is to be maintained.

C4D. When receiving a Department-prescribed assessment tool ULTC-100.2 from other entities, including but not limited to nursing facilities and hospitals, for utilization management activities, the Utilization Review Contractor SEP shall review the completeness of the Department-prescribed assessment toolULTC-100.2. If such the Department-prescribed assessment tool ULTC-100.2 is not sufficiently complete, according to Department-approved criteria, to conduct the utilization management review, then the Utilization Review ContractorSEP shall notify the originating entity within two business days of receipt that the Department-prescribed assessment tool ULTC-100.2 is incomplete and that a review will not be completed without the requested additional information.

8.393.38.393.28 A. DENIALS/DISCONTINUATIONS/ADVERSE ACTIONS

8.393.3.A Denial Reasons and Notification Actions

Please refer to 9 C.C.R. 2503-5 3.570 through 3.589 for denial reasons and notification actions for Home Care Allowance and Adult Foster Care programs.

Individuals seeking or receiving services Clients shall be denied or discontinued from services under publicly funded programs administered by the Single Entry PointSEP system if they are determined ineligible due to any of the reasons below. Individuals Clients shall be notified of any of the adverse the actions and appeal rights as follows:

1. Financial Eligibility

The income maintenance technicianeligibility enrollment specialist shall notify the individual client of denial for reasons of financial eligibility, and shall inform the individual client of appeal rights in accordance with Section 8.057. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the State.

a. If the individual is found to be financially ineligible for LTSS programs, the SEP shall notify the individual and shall inform the individual of appeal rights in accordance with Section 8.057.

2. Level of CareFunctional Eligibility and Target Group

a. Home and Community-Based Services Programs, and nursing facility admissions from the community:

For denials and discontinuations related to functional eligibility determination and target group criteria, tThe Utilization Review Contractor SEP shall notify the individuals by sending the State-prescribed form (803) to inform them client of denial for reasons related to determination of level of care and target group eligibilityand their appeal rights, and shall inform the client of appeal rightsshall attend the appeal hearing to defend the denial or discontinuation. 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 clients who request a utilization review to the utilization review contractor

b. Home Care Allowance and Adult Foster Care Programs:

The Single Entry Point agency shall notify the applicant on the State-prescribed form ([LTC-803)] of the denial and appeal rights, and the case manager shall attend the appeal hearing to defend a denial or discontinuation, when:

i.1) Home Care Allowance functional capacity and/or Need Forfor Paid Care scores do not meet minimum requirements.

ii.2) The applicant does not meet the Appropriateness for Placement Criteria for Adult Foster Care.

3. Receipt of Services

The Single Entry PointSEP agency shall notify the individual client, via the LTC-803, of the denial and appeals rights by sending the 803, and shall attend the appeal hearing to defend the denial or discontinuation, when:

a. The individual client has not received services for one month;

b. The individual applicant has two (2) times in a thirty (30) day consecutive period, refused to schedule an appointment for assessment, 6-month visit or after an inter-district transfer, or, has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period; or

c. The client or authorized representative refuses to use the Home Care Allowance or Adult Foster Care payment to pay for services, or uses the payment for services not identified in the service agreement; or

dc. The individual client or authorized individual's representative refuses to sign the Intake form, Care Support Plan form, Release of Information form, or other forms as required to receive services.

4. Institutional Status

The Single Entry PointSEP agency shall notify the individual client of denial or discontinuation by sending, via the LTC-803, when the case manager determines that the individual client does not meet the following program eligibility requirements.. The case manager shall attend the appeal hearing to defend the denial or discontinuation, when:

a. The individual client is not eligible to receive services while a resident of a nursing facility, hospital, or other institution.

b. The individual client who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.

c. An applicant for Home Care Allowance (HCA) or Special Populations Home Care Allowance (SP-HCA) is residing in an Adult Foster Care or Alternative Care Facility; or a client receiving HCA or SP-HCA has resided in such a facility more than thirty (30) days as required in 10 C.C.R.2505-10 Section 3.588.

5. Cost-Effectiveness/Service Limitations

The Single Entry PointSEP agency shall notify the individual client of denial or discontinuation by sending, via the LTC-803 form, when the case manager determines that the individual client cannot be safely served given the type

and/or amount of services available, or, if applicable, is not eligible due to the cost of Home Health and HCBS services exceeding the individual cost containment amount determined at 8.485.61 E. The case manager shall attend the appeal hearing to defend the denial or discontinuation action.

To support a denial or discontinuation for safety reasons related to cost-effectiveness or insufficient services being available, the case manager must document the results of an Adult Protective Services assessment, a statement from the individual's client's physician attesting to the individual's client's mental competency status, and all other available information which that will support the determination that the individual 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 the case manager making the denial.

[Insert clause regarding service reduction here, along with associated appeals rights; check if this topic is covered elsewhere]

6. The Notice of Action (803) form shall be completed in the IMS 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. The individual shall receive a copy of the 803.

7. In the event the individual appeals a denial or discontinuation action, with the exception of reasons related to financial eligibility, the case manager shall attend the appeal hearing to defend the denial or discontinuation action.

8.393.3.B.8.393.28 B. Case Management Actions Following a Denial or Discontinuation

1. In the case of denial or discontinuation, the case manager shall provide appropriate referrals to other community resources, as needed, within one (1) working day of discontinuation.

2. The case manager shall notify all providers on the case plan within one (1) working day of discontinuation.

3. The case manager shall follow procedures to close the individual's case in the IMS within one (1) working day shall notify the Utilization Review Contractor on a Department-prescribed form within thirty (30) calendar days of discontinuation for all HCBS Programs.

4. If a case is discontinued before an approved HCBS Prior Authorization Request (PAR) has expired, the case manager shall submit to the Department or its fiscal agent, within five (5) working days of discontinuation, a copy of the current PAR form on which the end date is adjusted (and highlighted in some manner on the form); and the reason for discontinuation shall be written on the form.

8.393.3.C.8.393.28 C. ADVISEMENT LETTERSAdvisement Letters

When clients are denied or discontinued from publicly funded programs administered by the Single Entry Point agency, for reasons not related to the eligibility requirements at Section 8.393.28 D, the Single Entry Point agency shall follow the procedures below:conform to the following procedures:

1. Death

Clients who have passed away die shall be discontinued from the program, effective upon the day after the date of death. No advisement letter shall be sent when the basis for discontinuation is death of the client.

2. Move Out of State

Clients who move out of Colorado shall be discontinued effective upon the day after the date of the move. The case manager shall send the client a State-prescribed Advisement Letter advising the client that the case has been closed. Clients who leave the state on a temporary basis, with intent to return to Colorado, according to Income Maintenance Staff Manual Section 3.140.2, RESIDENCE, shall not be discontinued unless one or more of the other eligibility criteria are no longer met.

3. Voluntary Withdrawal from the Program

Clients who voluntarily withdraw from a program shall be discontinued from the program effective upon the day after the date on which the client's request is documented, or the date on which the client enters a nursing facility, other long term care institution, or another HCBS program. The case manager shall send the client a State-prescribed Advisement Letter advising the client that the case has been closed.

4. Residing in an Unlicensed Personal Care Boarding Home

When a client is residing in an unlicensed personal care boarding home, the case manager after confirming with the Colorado Department of Public Health and Environment that the facility is unlicensed, shall inform the client and client's designated representative, if any, of the need to relocate within thirty (30) days in order to continue to receive services. The case manager shall deny or discontinue the client from the publicly funded program effective the thirty-first (31st) day after advising the client of the need to relocate, by sending the client an Advisement Letter advising the client that the case has been closed.

8.393.3.CD.8.393.28 D. Notification

The Single Entry PointSEP agency shall notify the eligibility enrollment specialist income eligibility section of the appropriate county department of social services:

1. At the same time that it notifies the applicant or client individual seeking or receiving services of the adverse action;

2. When the applicant or individual client has filed a written appeal with the Single Entry PointSEP agency; and

3. When the applicant or individual client has withdrawn the appeal or if a final agency decision has been entered.

8.393.3.E.28 E. When the Single Entry PointSEP agency conducts an assessment of the individual seeking or receiving services' applicant's or client's functional capacity

on the Uniform Long Term Care Client Assessment InstrumentULTC 100.2 Department-prescribed assessment tool, for review by the utilization review contractor, the assessment is not an adverse action which is directly appealable. The individual's applicant's or client's right to appeal arises only when an individual is denied enrollment into a LTSS Program by the SEP based on the Department-prescribed assessment tool thresholds for functional eligibility, notice of adverse action is given by the Utilization Review ContractorSEP regarding denial of certification for applicable long term care programs. The appeal process is governed by the provisions of Section 8.059.12., titled "Appeals Related to the Utilization Review Contractors" in this Staff Manual.

8.393.3.F.28 F. The Single Entry PointSEP agency shall provide information to individuals seeking and receiving services applicants and clients regarding their appeal rights when individuals applicants apply for publicly funded long term care servicesLTSS or whenever the individual client requests such information, whether or not adverse action has been taken by the Single Entry PointSEP agency.

8.393.4.29 COMMUNICATION

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

A. The case manager shall inform the income maintenance technicianeligibility enrollment specialist of any and all changes effecting the individual receiving services' client's participation in Single Entry PointSEP agency-administered programs, including changes in income, within one (1) working day after the case manager learns of the change. The case manager shall provide the technician with copies of the first pagecertification page of the all (utilization review contractor) approved Department-prescribed assessment tool ULTC-100.2 form.s within one working day after receipt from (utilization review contractor).

B. If the individual client has an open adult protective services case at the county department of social services, the case manager shall keep the individual's client's caseworker eligibility enrollment specialist informed of the individual's client's status and shall participate in mutual staffing of the individual's client's case.

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

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

E. The Single Entry Point agency.

8.393.2955 Functional Eligibility DeterminationUTILIZATION MANAGEMENT

In addition to any utilization management requirements specified elsewhere in these rules, Tthe Single Entry PointSEP Agency, if assuming utilization management duties, or another Utilization Review Contractor, as applicable, shall be responsible for the following:

A. For Utilization Management Activities Using a Functional Needs Assessment

1. The Utilization Review ContractorSEP logs in Functional Needs Assessment Reviews completed by the Single Entry Point agency and Functional Needs Assessments Reviews received from other entities on the same day as completion/receipt on the Department approved log form.

.Ensuring that the Department-prescribed assessment tool is completed in the IMS in accordance with 8.401.1 and justifies that the individual seeking or receiving services should be approved or disapproved for admission or continued stay to an applicable LTSS program.

If a ULTC 100.2 is complete, scoring must be completed with inwithin three (3) business days for hospital discharge and brain injury reviews, all other reviews must be completed within ten (10) business days of receipt.

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

3. The Utilization Review Contractor determines if the score indicates that the client should be approved or disapproved for admission or continued stay to an applicable long term care program and notes the recommendation in case file.

34. If the assessment indicates approval, SEP agency shall notify the appropriate parties in accordance with 8.393.3.A.2 and 8.383.4.the Utilization Review Contractor assures that approval is noted and that the appropriate parties are notified, which includes including requesting client, client's designated representative, and if applicable, and the requesting provider.

45. If the assessment indicates denial, the Utilization Review ContractorSEP agency shall notify the appropriate parties in accordance with 8.393.3.A.2 and 8.383.4. Such notification shall include directions for filing an appeal with the Office of Administrative Courts pursuant to Section 8.057.

If the individual client or individual's client's designated representative appeals, the the Utilization Review ContractorSEP shall process the such request, according to Recipient Appeals 8.057.

8.393.6.3 INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

8.393.6.A.31 Intercounty Ttransfers.

Single Entry PointSEP agencies shall complete the following procedures to transfer individuals receiving case management services clients to another county within the same Single Entry PointSEP district:

A1. Notify the income maintenance technicianeligibility enrollment specialist of the individual's client's plans to relocate to another county and the date of transfer, and instruct the technician to follow the procedures for intercounty transferswith financial transfer details at Section 8.100.3.C. (Department of Human Services, Staff Manual, Volume 3, Section 3.140.3).

2B. If the individual's client's current service providers do not provide services in the area where the individual client is relocating, make arrangements in consultation with the individual client for new service providers.

3C. If the individual client is moving from one county to another county to enter an Alternative Care Facility, forward copies of the following individual client records to the Alternative Care Facility, prior to the individual's client's admission to the facility:

a1. Uniform Client Assessment Instrument (Department-prescribed assessment toolULTC-100.2), certified by a Utilization Review Contractorthe SEP.;

b2. Client Payment Form for Alternative Care Facility clientsThe individual's updated draft Prior Authorization Request (PAR) and/or Post Eligibility Treatment of Income (PETI) form; and

c3. Verification of Medicaid eligibility status.

8.393.6.B..32 Inter-district Ttransfers.

Single Entry PointSEP agencies shall complete the following procedure in the event an individual receiving services client transfers from one Single Entry PointSEP district to another Single Entry PointSEP district:

1A. The transferring Single Entry PointSEP agency shall contact the receiving Single Entry PointSEP agency by telephone and give notification that the individual client is planning to transfer, negotiate a transfer date, and provide all necessary information.

B2. If the transfer is from one county to another county, the The transferring Single Entry PointSEP agency shall notify the income maintenance technicianeligibility enrollment specialist of the individual's client's plan to transfer and the transfer date, and technician shall follow rules described in Section and instruct the technician to follow procedures for intercounty transfers (Section 3.140.38.100.3.C. , Volume 3; and Section 8.110.39, Volume 8). The receiving Single Entry PointSEP agency shall coordinate the transfer with the income maintenance technicianeligibility enrollment specialist of the new county.

C3. The transferring Single Entry PointSEP agency shall make available in the IMS forward copies of the individual's client's case records, including forms required by the publicly funded program, to the receiving Single Entry PointSEP agency prior to the relocation, if possible, or in no case later than five (5) working days after the client's relocation.

D4. If the individual client is moving from one Single Entry PointSEP district to another Single Entry PointSEP district to enter an Alternative Care Facility, the transferring Single Entry PointSEP agency shall forward copies of individual client records to the Alternative Care Facility, prior to the individual's client's admission to the facility, in accordance with the procedures for intercounty transfers.

5. 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 within ten (10) working days after notification of the individual's relocation.

E5. The receiving Single Entry PointSEP agency shall complete a face-to-face meeting with the individual client and a case summary update within ten (10) working days after notification of the individual's client's relocation, in accordance with assessment procedures for Single Entry PointSEP agency individualsclients.

F6. The receiving Ssingle eEntry PpointSEP agency shall review the care support plan and Department-prescribed assessment toolULTC-100.2, and change or coordinate services and providers as necessary.

G7. If indicated by changes in the support care plan, the receiving Single Entry PointSEP agency shall revise the support care plan and service prior authorization forms as required by the publicly funded program.

H8. Within thirty (30) calendar days of the individual's client's relocation, the receiving Single Entry PointSEP agency shall forward to the Department, or its designeefiscal agent, revised forms as required by the publicly funded program.

8.393.74 STAFFING OF A SINGLE ENTRY POINT AGENCY

8.393.7.A.41 Staffing Ppatterns.

The Single Entry Point agency shall provide staff for the following functions: receptionist/clerical, administrative/ supervisory, case management, and medical consulting services.

1A. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, assisting Single Entry Point agency staff with clerical duties, and entering data into an information management systemIMS.

B2. The administrative/supervisory function of the Single Entry PointSEP agency shall include, but not be limited to, supervision of staff, training and development of agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, review and signing of all HCA and AFC ULTC-100.2's Department-prescribed assessment tools, resource development, marketing, liaison with the Department, and, as needed, providing case management services in lieu of the case manager.

C3. The case management function shall include, but not be limited to, all of the case management functions previously defined for Single Entry PointSEP case management services, as well as resource development, and attendance at staff development and training sessions.

D4. Effective October 1, 2001, the contracted medical consultant services functions shall include, but not be limited to, an employed or contracted physician and/or registered nurse who shall provide consultation to Single Entry PointSEP agency staff regarding medical and diagnostic concerns and Adult Llong Tterm Hhome Hhealth prior authorizations.

8.393.7.B.42 Qualifications of Sstaff.

The Single Entry PointSEP agency's supervisor(s) and case manager(s) shall meet minimum standards for education and/or experience and shall be able to demonstrate competency in pertinent case management knowledge and skills.

1A. Case managers shall have at least a bachelor's degree in one of the human behavioral science fields (such as human services, nursing, social work, psychology, etc.).

B2. An individual who does not meet the minimum educational requirement may qualify as a Single Entry Point agency case manager under the following conditions:

a1. The determination as to the qualification as of a case manager shall be made jointly by the Single Entry Point agency and the Department;

2a. Experience as a caseworker or case manager with the long term care client population, in a private or public social services agency may substitute for the required education on a year for year basis; and

3b. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field.

c. The SEP agency shall maintain a memo in the case manager's personnel file that justifies the hiring of a case manager that does not meet the minimum educational requirements for the Department or its designee's review.

3C. The case manager shall be required to demonstrate competency in all of the following areas:

a1. Knowledge of and ability to relate to populations served by the Single Entry PointSEP agency;

2b. Client iInterviewing and assessment skills;

3c. Knowledge of the policies and procedures regarding public assistance programs;

4d. Ability to develop care plans and service agreements;

5e. Knowledge of LTSSlong term care and other community resources; and

6f. Negotiation, intervention, and interpersonal communication skills.

4D. The Single Entry Point agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of long term care.

8.393.7.C.43 Functions of the cCase mManager.

The Single Entry Point agency's case manager(s) shall be responsible for: all case management services provided by the Single Entry Point agency including: collection of information and referral, intake/screening/referral, assessment of clientsindividuals seeking or receiving services, development of care support plans, on-going case management, monitoring of clientsindividuals, reassessments, resource development for individual clients, and case closure.

1A. The case manager shall contact the client individual at least once within each quarterly period, or more frequently if warranted by the client's individual's condition and as determined by the LTSS Program.

B2. The case manager shall have a face-to-face contact with the client individual at least every six months, or more frequently if warranted by the individual's client's condition or the LTSS Program, and shall update the Department-prescribed assessment tool and Support Plan in the IMS, updating the Uniform Long Term Care Client Assessment InstrumentULTC 100.2 and placing a copy in the client file.

C3. The case manager shall reassess the individual client annually, or more frequently if warranted by the individual's client's condition or if required by the LTSS Pprogram criteria, completing a new Department-prescribed assessment tool completing a new Uniform Long Term Care Client Assessment InstrumentULTC 100.2.

D4. The case manager shall monitor the delivery of services and supports identified within the Support Plan and the Prior Authorization Request. This includes monitoring:

provided to the client, and shall monitor the contract between the client and the provider when required by the publicly funded program.

1a. The case manager shall monitor tThe quality of care services and supports provided;, and

2b. The case manager shall monitor tThe health and safety of the individual; andclient.

c. The utilization of services with respect to the Support Plan and the Prior Authorization Request.

E5. The following criteria may be used by the case manager to determine the client's individual's level of need for case management services:

1a. Availability of family, volunteer, or other support;,

2b. Overall level of functioning;,

3c. Mental status or cognitive functioning;,

4d. Duration of disabilities,;

5e. Whether the client individual is in a crisis or acute situation,;

6f. The individual's client's perception of need and dependency on services,; and

7g. The individual's client's move to a new housing alternative, if applicable; and.,

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

8.393.7.D..44 Functions of the Single Entry Point Aagency Ssupervisor

1. Single Entry PointSEP agencies shall provide adequate supervisory staff who shall be responsible for:

Aa. Supervisory case conferences with case managers, on a regular basis;

Bb. Review and signing of all HCA and AFC Department-prescribed assessment toolsULTC-100.2's;; and

c. rRegular, systematic review and remediation of case records and other case management documentation, on at least a sample basis;

Cd. Communication with the Department when technical assistance is required by case managers, and the supervisor is unable to provide answers after reviewing the regulations;

De. Allocation and monitoring of staff to assure that all standards and time frames are met in a reasonable percentage of cases; and

Ef. Assumption of case management duties when necessary.

8.393.7.E..45 Training of Single Entry Point aAgency Sstaff.

Single entry pointSEP agency staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for Single Entry PointSEP agencies.

1A. Prior to agency start-up, the Single Entry PointSEP agency staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:

a1. Background information on the development and implementation of the Single Entry PointSEP system;

2b. Mission, goals, and objectives of the Single Entry PointSEP system;

3c. Regulatory requirements and changes or modifications in federal and state programs;

4d. Contracting guidelines, quality assurance mechanisms, and certification requirements; and

5e. Federal and state requirements for the Single Entry PointSEP agency.

2B. During the first three years of agency operation, in addition to an agency's own training, the Department or its designee will provide in-service and skill development training for Single Entry PointSEP agency staff on an annual basis. Thereafter, the Single Entry PoinSEPt agency will be responsible for in-service and staff development training.

8.393.85 RESOURCE DEVELOPMENT

8.393.8.A.51 Resource Ddevelopment Ccommittee.

The Single Entry PointSEP agency shall assume a leadership role in facilitating the development of local resources to meet the long term careLTSS needs of

individuals receiving services clients who reside within the Single Entry PointSEP district served by the Single Entry PointSEP agency.

A1. Within 90 days of the effective date of the initial contract, the Single Entry PointSEP agency's community advisory committee shall appoint a resource development committee.

B2. The membership of the resource development committee shall include, but not be limited to, representation from the following local entities: area agencies on aging, county departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards for the developmentally disabled, vocational rehabilitation agencies, and long term care consumersindividuals receiving long-term services.

C3. In coordination with the resource development efforts of the area agency(ies) on aging that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.

1a. The resource development plan shall include:

ia. An analysis of the long term careLTSS resources available within the Single Entry PointSEP district;

iib. Gaps in long term careLTSS resources within the Single Entry PointSEP district;

iiic. Strategies for developing needed resources: and

div. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support, and a time frame for accomplishing stated objectives.

b2. The data generated by the Single Entry PointSEP agency's information and referral, intake/screening/referral, individual client assessment, documentation of unmet individual client needs, resource development for individual individuals clients, and data available through the Department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.

3D. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the Department.

8.393.8.B..52 Certification of Sservice Pproviders.

The Single Entry PointSEP agency shall be responsible for the certification of aAdult fFoster cCare facilities within the Single Entry PointSEP district, in accordance with Department rules for aAdult fFoster cCare (Section 8.483, et seq., of this Staff Manual).

8.393.96 PROVISION OF DIRECT SERVICES

8.393.9.A.61 Waiver Ccriteria. Provision of Direct Services

The Single Entry PointSEP agency may be granted a waiver by the Department to provide direct services provided the agency complies with the following:

1A. The Single Entry PointSEP agency shall document at least one of the following in a formal letter of application for the waiver:

1a. The service is not otherwise available within the Single Entry PointSEP district or within a sub-region of the district; and/or

2b. The service can be provided more cost effectively by the Single Entry PointSEP agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or sub-region of the district.

B2. The Single Entry PointSEP agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report, at such time and on a form as prescribed by the Department, which includes a cost comparison of the service with other service providers in the area in order to document continuing cost effectiveness.

C3. The Single Entry PointSEP agency shall assure the Department that efforts have been made, and will continue to be made, to develop the needed service within the Single Entry PointSEP district or within the sub-region of the district, as a service external to the Single Entry PointSEP agency. The Single Entry PointSEP agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.

D4. The direct service provider functions and the Single Entry PointSEP agency functions shall be administratively separate.

E5. In the event other service providers are available within the district or sub-region of the district, the Single Entry PointSEP agency case manager shall document in the individual's client's case record that the individual client has been offered a choice of providers.

8.394 ACCOUNTABILITY MECHANISMS FOR SINGLE ENTRY POINT AGENCIES

8.394.1 PERFORMANCE Single Entry Point ContractBASED CONTRACT

A Single Entry PointSEP agency shall be bound to the terms of the contract between the agency and the Department, including quality assurance standards and compliance with the Department's rules for Single Entry PointSEP agencies and for publicly fundedLTSS Pprograms.

8.394.2 CERTIFICATION OF SINGLE ENTRY POINT AGENCIES

A Single Entry PointSEP agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.

A1. Certification as a Single Entry PointSEP agency shall be based on an evaluation of the agency's performance in the following areas:

1a. The quality of the services provided by the agency;

2b. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;

3c. The agency's performance of administrative functions, including reasonable costs per individual receiving servicesclient, timely reporting, managing programs in one consolidated unit, on-site visits to individualsclients, community coordination and outreach, and individual client monitoring;

4d. Whether targeted populations are being identified and served;

5e. Financial accountability.; and

6f. The maintenance of qualified personnel to perform the contracted duties.

B2. The Department or its designee shall conduct reviews of the Single Entry PointSEP agency.

C3. At least sixty (60) days prior to expiration of the previous year's certification, the Department shall notify the Single Entry PointSEP agency of the outcome of the review, which may be approval, provisional approval, or denial of certification.

8.394.2.A.21 Provisional Aapproval of Ccertification.

In the event a Single Entry PointSEP agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of individuals receiving servicesclients.

A1. The agency will receive notification of the deficiencies, and a request to submit a corrective action plan to be approved by the Department, and uUpon receipt and review of the corrective action plan, at the Department's option, a second sixty-day provisional certification may be approved.

B2. The Department or its designee shall provide technical assistance to facilitate corrective action.

8.394.2.B.22 Denial of Ccertification.

In the event certification as a Single Entry PointSEP agency is denied, the procedure for Single Entry PointSEP agency termination or non-renewal of contract shall apply as outlined in (Section 8.391.22).

NOTE: Sections 8.394.3 - 8.394.4 were deleted effective December 2, 2002.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Persons Requesting Long-Term Care through Home and Community Based Services (HCBS) or the Program of All-Inclusive Care for the Elderly (PACE), Section 8.100.7.B.1
Rule Number: MSB 17-02-23-B
Division / Contact / Phone: Eligibility / Eric Stricca / 4475

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 17-02-23-B, Revision to the Medical Assistance Rule Concerning Persons Requesting Long-Term Care through Home and Community Based Services (HCBS) or the Program of All-Inclusive Care for the Elderly (PACE), Section 8.100.7.B.1
3. This action is an adoption of:	an amendment

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

   Sections(s) 8.100.7.B.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.7.B.1.c.i with the proposed text beginning at 8.100.7.B.1.c.i through the end of 8.100.7.B.1.c.i. The rule is effective June 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Persons Requesting Long-Term Care through Home and Community Based Services (HCBS) or the Program of All-Inclusive Care for the Elderly (PACE), Section 8.100.7.B.1
Rule Number: MSB 17-02-23-B
Division / Contact / Phone: Eligibility / Eric Stricca / 4475

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 change implements HB 16-1321 which directs the Department to allow individuals who are financially eligible under the Working Adults with Disabilities Buy-In category to receive Home and Community Based Services (HCBS) under the Brain Injury and Spinal Cord Injury waivers if the level of care is met for the respective waiver.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 USC § 1396n

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-6-1403 (2016)

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

DOCUMENT #

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Persons Requesting Long-Term Care through Home and Community Based Services (HCBS) or the Program of All-Inclusive Care for the Elderly (PACE), Section 8.100.7.B.1
Rule Number: MSB 17-02-23-B
Division / Contact / Phone: Eligibility / Eric Stricca / 4475

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 Medicaid currently has a buy-in program for working adults with disabilities. The existing buy-in program allows adults with a qualifying disability who earn incomes of less than 450 percent of the Federal Poverty Level to obtain Medicaid coverage by paying a premium (i.e., to buying into Medicaid) based on a sliding payment scale. This bill extends the Medicaid buy-in program to adults that are eligible to receive home- and community-based services under the BI waiver, and the SCI waiver. The BI and SCI waiver provide services to persons with brain and spinal cord injuries, also with the goal of allowing clients to remain in their homes. To participate, adults must meet certain financial and program criteria.

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 38 clients will participate in the new Medicaid buy-in program in FY 2017-18 and 41 clients will participate in FY 2018-19. Out of these participating clients, 5 clients in FY 2017-18 and 6 clients in FY 2018-19 will be new clients, the remainder (33 in FY 2016-17 and 35 in FY 2017-18) will be existing waiver clients that transition from the regular waiver program to the buy-in program

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

   The bill increases net costs in HCPF by $138,027 in FY 2016-17, $135,314 in FY 2017-18, and $174,834 in FY 2018-19. First-year costs are for information technology system modifications. Future-year costs represent the costs of new clients that gain Medicaid coverage through the new Medicaid buy-in program. In addition, by shifting existing clients from the regular waiver programs to the Medicaid buy-in, General Fund costs for this population are reduced and replaced by Hospital Provider Fee Cash Fund and client premiums which increases the cash fund revenue to HCPF by $28,956 in FY 2017-18 and by $31,242 in FY 2018-19.

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

   Without implementing this rule, HCPF would be out of compliance with state law. Therefore inaction is not possible.

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

   There are no less costly or intrusive methods.

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

   There are no alternative methods.

8.100.7.B. Persons Requesting Long-term Care through Home and Community Based Services (HCBS) or the Program of All Inclusive Care for the Elderly (PACE)

1. HCBS or PACE shall be provided to persons who have been assessed by the Single Entry Point/Case Management Agency to have met the functional level of care and will remain in the community by receiving HCBS or PACE; and

   a. are SSI (including 1619b) or OAP Medicaid eligible; or

   b. are eligible under the Institutionalized 300% Special Income category described at 8.100.7.A; or

   c. are eligible under the Medicaid Buy-In Program for Working Adults with Disabilities described at 8.100.6.P. For this group, access to HCBS:

      i) Is limited to the Elderly, Blind and Disabled (EBD), ~~and~~ Community Mental Health Supports (CMHS), Brain Injury (BI) and Spinal Cord Injury (SCI) waivers; and

      ii) Is contingent on the Department receiving all necessary federal approval for the waiver amendments that extend access to HCBS to the Working Adults with Disabilities population described at 8.100.6.P.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning the definition of a Caretaker Relative at Section 8.100.1
Rule Number: MSB 17-02-23-A
Division / Contact / Phone: Health Information Office / Ana Bordallo / 303-866-3558

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 17-02-23-A, Revision to the Medical Assistance Rule Concerning the definition of a Caretaker Relative at Section 8.100.1
3. This action is an adoption of: new rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) § 8.100.1 , Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.100.1 with the proposed text starting at unnumbered paragraph 18 through the end of unnumbered paragraph 18. The rule is effective June 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning the definition of a Caretaker Relative at Section 8.100.1
Rule Number: MSB 17-02-23-A
Division / Contact / Phone: Health Information Office / Ana Bordallo / 303-866-3558

STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule changes amend 10 CCR 2505-10 §8.100.1 to incorporate changes to the definition of a Caretaker Relative as defined in the Code of Federal Regulations. This policy change will align the definition of Caretaker Relative to our Medicaid State Plan Amendment. These changes include: revisions to the current definition of Caretaker Relative by updating language to include any adult with whom the child is living and who assumes primary responsibility for the dependent child's care.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR §435.4

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);

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

DOCUMENT #

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning the definition of a Caretaker Relative at Section 8.100.1
Rule Number: MSB 17-02-23-A
Division / Contact / Phone: Health Information Office / Ana Bordallo / 303-866-3558

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.

   With this proposed rule a Caretaker Relative with whom the child is living with and who assumes primary responsibility for the dependents' child's care can be affected if the Caretaker doesn't indicate they are primary responsible for the child. The benefit of this rule change is to ensure a Caretaker Relative may be eligible for the MAGI Parent/Caretaker Relative category, if they assume responsibility for the dependent child living in the home.

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

   The proposed rule will require a caretaker relative to indicate if they are the primary caretaker for the child living in the home to be eligible for the Parent/Caretaker category or the MAGI adult category. This rule change will not increase eligibility because the Colorado Benefits Management System (CBMS) is currently in compliance with our State Plan Amendment definition.

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

   The proposed rule change aligns Colorado regulation with the Medicaid state plan. The Department already implemented the policy outlined in this document on January 1, 2014, when the state plan was amended to change the definition of caretaker relative. Therefore, there would not be any costs to the Department or any other agency due to the implementation and enforcement of the proposed rule, nor would there be any effect on state revenues.

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

   The cost of inaction is that there continues to be a discrepancy between the Medicaid state plan and Colorado regulation for this issue. There are no benefits of inaction.

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

   There is no alternative method 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.

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

8.100.1 Definitions

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

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

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

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

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

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

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

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

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

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

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

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

Application Date is the date the application is received and date-stamped by the eligibility site or the date the application was received and date-stamped by an Application Assistance site or Presumptive Eligibility site. In the absence of a date-stamp, the application date is the date that the application was signed by the client.

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

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

Burial Spaces are burial plots, gravesites, crypts, mausoleums, urns, niches and other customary and traditional repositories for the deceased's bodily remains provided such spaces are owned by the

individual or are held for his or her use, including necessary and reasonable improvements or additions to or upon such burial spaces such as: vaults, headstones, markers, plaques, or burial containers and arrangements for opening and closing the gravesite for burial of the deceased.

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

Caretaker Relative is a person who is related to the dependent child or any adult with whom the dependent child is living and who assumes responsibility for the dependent child's care. ~~any relation by blood, marriage or adoption who is within the fifth degree of kinship to the dependent child, such as: a parent; a brother, sister, uncle, aunt, first cousin, first cousin once removed, nephew, niece, or persons of preceding generations denoted by prefixes of grand, great, great great, or great-great-great; a spouse of any person included in the above groups even after the marriage is terminated by death or divorce; or stepparent, stepbrother, stepsister, step-aunt, etc.~~

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Community Spouse is the spouse of an institutionalized spouse.

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

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

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

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

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

Difficulty of Care Payments is a payment to an individual as compensation for providing additional care to an individual who qualifies for foster care and lives in the home of the care provider. This additional care must be required due to a physical, mental, or emotional handicap suffered by the foster care individual.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

PACE - Program of All-inclusive Care for the Elderly is a unique, capitated managed care benefit for the frail elderly provided by a not-for-profit or public entity. The PACE program features a comprehensive medical and social service delivery system using an interdisciplinary team approach in an adult day health center that is supplemented by in-home and referral services in accordance with participants' needs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Managed Care Grievance and Appeals, Section 8.209
Rule Number: MSB 17-01-18-A
Division / Contact / Phone: Delivery System and Payment Innovation / Colleen McKinney / x5128

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 17-01-18-A, Revision to the Medical Assistance Rule Concerning Managed Care Grievance and Appeals, Section 8.209

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) 8.209 p. 52-61, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the text at 8.209 with the proposed text beginning at 8.209 through the end of 8.209.7.K. The rule is effective June 30, 2017.

*to be completed by MSB Board Coordinator

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Rule Number: MSB 17-01-18-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).

   The proposed revisions to Section 8.209 will ensure full compliance with 42 CFR 438 Subpart F- Grievance and Appeal System.

   The rule proposes the following revisions to Section 8.209:

   • Includes Prepaid Ambulatory Health Plans (PAHPs) as being required to follow the same grievance and appeals process as MCOs and PIHPs

   • Adds numbers to the definitions in accordance with guidance from the Secretary of State

   • Includes a definition of Managed Care Organization to align with federal definitions

   • Changes "Action" to "Adverse Benefit Determination" and the accompanying definition to align with federal definitions

   • Redefines "Fair Hearing" as "State Fair Hearing"

   • Removes the definition for "Timely Filing," as the term is not used anywhere in the rule, and moves the information to the appropriate section in the rule

   • Changes the timeline for a member to file an appeal from 30 calendar days to 60 calendar days of receiving a notice of adverse benefit determination

   • Clarifies that the health plan is responsible for following an oral appeal with a written record of the appeal

   • Changes the expedited appeal timeline from 3 working days to 72 hours

   • Requires the member to exhaust the health plan level appeals process before being able to request a state fair hearing

   • Changes the timeline for a member to request a state fair hearing from 30 calendar days to 120 calendar days of receiving the health plan's notice of appeal determination

Initial Review	**04/14/17**	Final Adoption	**05/12/17**
Proposed Effective Date	**06/30/17**	Emergency Adoption	

DOCUMENT #07

- Includes information for when a member may request a State Fair Hearing due to the health plan not adhering to notice and timing requirements

- Removes the timeline for a member to file a grievance

- Requires the health plan to use the State established method when notifying a member of their grievance resolution

- Removes the definition of "Quality of Care Complaint," as the term is not used anywhere in the rule and is covered through the definition of "Grievance"

- Includes the requirements of the information kept in each Grievance and Appeal record to align with federal regulations

- Clarifies what individuals can review and decide Grievances and Appeals

- Changes certain words to reflect the language used in the rule and by the Department

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:

Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions related to Third Party Liability; Final Rule 81 FR 27498 (May 6, 2016)

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2015);
25.5-5-406, C.R.S. (2016)

DO NOT PUBLISH

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REGULATORY ANALYSIS

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

   The people who will be affected by the proposed rule are Medicaid members who receive health care services through a MCO, PIHP, or PAHP. The Department does not anticipate any costs of implementing the proposed rule. All members under these managed care plans will benefit from a standardized grievance and appeals process.

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

   The proposed rule will benefit the members under MCO, PIHP, and PAHP plans, as the grievance and appeals timeline will be the same across these health plans. Members will benefit from extended timelines to file an appeal and request a state fair hearing. Members will also benefit from being able to file a grievance at any time. The proposed rule might negatively impact members due to members now being required to exhaust their health plan's internal appeals process before requesting a state fair hearing. Currently, a member can request a state fair hearing at any time. This may slightly increase the need for the Department to provide clarification to members and providers.

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

   The Department does not anticipate any costs related to the implementation and enforcement of this rule. There is no anticipated effect on state revenue.

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

   If the proposed rule does not go into effect, the 16 managed care contracts affected by this rule change would be out of compliance with federal regulations, thus potentially placing the state under disciplinary measures with CMS.

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

   The rule must be changed for the Department's managed care contracts to stay in compliance with federal regulation.

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

   No other alternative methods were considered, as this rule change must be done to comply with federal regulations.

8.209 MEDICAID MANAGED CARE ~~GRIEVANCE~~ GRIEVANCE AND ~~APPEAL~~APPEAL PROCESSES

8.209.1 GENERAL PROVISIONS

Medicaid members or their Designated Client Representatives enrolled in Managed Care Organizations (MCOs) may access and utilize the Medicaid Managed Care ~~Grievance~~Grievance and ~~Appeal~~Appeal Systems. The ~~Grievance~~Grievance and ~~Appeal~~Appeal Systems shall include a ~~grievance~~ Grievance process and an ~~appeal~~ Appeal process for handling ~~grievances~~ Grievances and ~~appeals~~ Appeals at the MCO ~~or,~~ Prepaid Inpatient Health Plan (PIHP), or Prepaid Ambulatory Health Plan (PA~~I~~HP) level and access to the State ~~fair~~ Fair ~~hearing~~ Hearing process for ~~appeals~~Appeals.

8.209.2 DEFINITIONS

8.209.2.A. ~~Action~~ Adverse Benefit Determination shall mean:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit;

2. The reduction, suspension or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a service;

4. The failure to provide services in a timely manner;

5. The failure to act within the timeframes provided in § 8.209.4 below; ~~or~~

6. The denial of a Medicaid member's request to exercise his or her right to obtain services outside the network for members in rural areas with only one MCO~~.~~; or

7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

8.209.2.B. ~~Appeal~~Appeal shall mean, for the purposes of this Section 8.209 only, a request for review by an MCO, PIHP, or PAHP of an ~~action~~ ~~a~~Adverse ~~b~~Benefit ~~d~~Determination.

8.209.2.C. Designated Client Representative shall mean any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or ~~appeals~~ Appeals about health care benefits and services.

~~Fair Hearing shall mean the formal adjudication process for appeals described at 10 CCR 2505-10, §8.057.~~

8.209.2.D. ~~Grievance~~Grievance shall mean an oral or written expression of dissatisfaction about any matter other than an ~~action~~Adverse Benefit Determination, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights.

8.209.2.E. Managed Care Organization (MCO) shall mean an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 CFR 438.2, and that is:

1. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 CFR 489; or

2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary of the U.S. Department of Health and Human Services to also make the services it provides to its Medicaid members as accessible (in terms of timelines, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and meets the solvency standards of 42 CFR 438.116.

8.209.2.F. Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.209.2.G. Prepaid Ambulatory Health Plan (PAHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; does not provide, arrange for, or otherwise has a responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

~~Quality of Care Complaint shall mean any grievance made in regards to the professional competence and/or conduct of a physician or other health care provider, which could adversely affect the health, or welfare of a member.~~

8.209.2.H. State Fair Hearing shall mean the formal adjudication process for Appeals described at 10 CCR 2505-10, §8.057.

~~Timely Filing shall mean filing on or before the later of the following: within ten days of the MCO or PIHPMCO, PIHP, or PAHP postmarking the notice of action adverse benefit determination; or the intended effective date of the MCO's or PIHP'sMCO's, PIHP's, or PAHP's proposed action.~~

8.209.3 ~~GRIEVANCE~~GRIEVANCE ~~-~~SYSTEM

8.209.3.A. The ~~Grievance~~Grievance System is the overall system that includes ~~grievances~~ Grievances and ~~appeal~~Appeals~~s~~ handled at the ~~MCO and PIHP~~MCO, PIHP, and PAHP level and access to the ~~State fair hearing~~State Fair Hearing process for ~~appeal~~Appeals.

8.209.3.B. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall provide a ~~Department~~ Department-approved description of the ~~grievance~~Grievance, ~~appeal~~Appeal and State ~~fair~~ Fair ~~hearing~~ Hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the ~~MCO or PIHP~~MCO, PIHP, or PAHP. The description shall include:

1. The member's right to a ~~State fair hearing~~State Fair Hearing for ~~appeal~~Appeals.
   a. The method to obtain a hearing, and
   b. The rules that govern representation at the hearing.
2. The member's right to file ~~grievance~~Grievances and ~~appeal~~Appeals.
3. The requirements and timeframes for filing ~~grievance~~Grievances and ~~appeal~~Appeals.
4. The availability of assistance in the filing process.

5. The toll-free numbers that the member can use to file a ~~grievance~~Grievance or an ~~appeal~~Appeal by telephone.

6. The fact that, when requested by a member:

a. Benefits will continue if the member files an ~~appeal~~Appeal or a request for ~~State fair hearing~~State Fair Hearing within the timeframes specified for filing; and

b. The member may be required to pay the cost of services furnished while the ~~appeal~~Appeal is pending if the final decision is adverse to the member.

8.209.3.C. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall maintain record of ~~grievance~~Grievances and ~~appeal~~Appeals and submit a quarterly report to the Department. The record of each Grievance and Appeal shall include:

1. A general description of the reason for the Grievance or Appeal;

2. The date the Grievance or Appeal was received;

3. The date of each review;

4. The resolution at each level of the Grievance or Appeal, if applicable;

5. The date of resolution at each level of the Grievance or Appeal; and

6. The name of the member for whom the Grievance or Appeal was filed.

8.209.4 ~~APPEAL~~APPEAL PROCESS

8.209.4.A. Notice of ~~Action~~Adverse Benefit Determination

1. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall send the member written notice for each ~~action~~ ~~a~~Adverse ~~b~~Benefit ~~d~~Determination. The notice shall be in writing and shall be available in English and the prevalent non-English languages spoken by members throughout the State. “Prevalent” means a non-English language spoken by a significant number or percentage of members in the service area as identified by the State.

2. The notice shall state the following:

a. The ~~action~~ Adverse Benefit Determination the ~~MCO or PIHP~~MCO, PIHP, or PAHP or its contractor has taken or intends to take;

b. The reasons for the ~~action~~ ~~a~~Adverse ~~b~~Benefit ~~d~~Determination, including the right of the member to be provided upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the member’s Adverse Benefit Determination. Such information includes medical necessity criteria and any processes, strategies, or evidentiary standards used in setting coverage limits;

c. The member’s or the Designated Client Representative's right to file an ~~MCO or PIHP~~MCO, PIHP, or PAHP ~~appeal~~Appeal;

d. The date the ~~appeal~~Appeal is due;

e. The member’s right to request a ~~State fair hearing~~State Fair Hearing;

f. The procedures for exercising the right to a State ~~fair~~ Fair ~~hearing~~Hearing;

g. The circumstances under which expedited resolution is available and how to request it;

h. The member's right to have benefits continue pending resolution of the ~~appeal~~Appeal, and how to request that benefits be continued; and

i. The circumstances under which the member may be required to pay the cost of these services.

3. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall mail the notice of ~~action a~~Adverse ~~b~~Benefit ~~d~~Determination within the following timeframes:

a. For termination, suspension or reduction of previously authorized Medicaid covered services, at least ten (10) calendar days before the date of ~~action~~Adverse Benefit Determination, except in the following circumstances:

i) The ~~MCO or PIHP~~MCO, PIHP, or PAHP may shorten the period of advance notice to five (5) calendar days for the date of ~~action~~ Adverse Benefit Determination if:

1) The ~~MCO or PIHP~~MCO, PIHP, or PAHP has facts indicating probable fraud by the member; and

2) The facts have been verified, if possible, through secondary sources.

ii) The ~~MCO or PIHP~~MCO, PIHP, or PAHP may mail notice not later than the date of ~~action~~ Adverse Benefit Determination if:

1) The ~~MCO or PIHP~~MCO, PIHP, or PAHP has factual information confirming the death of the member;

2) The ~~MCO or PIHP~~MCO, PIHP, or PAHP receives a clear written statement signed by the member stating that:

a) He or she no longer wishes services; or

b) Gives information that requires termination or reduction of services and indicates that he/she understands that this is the result of supplying the information;

iii) The member has been admitted to an institution where he/she is ineligible under the plan for further services;

iv) The member's whereabouts are~~is~~ unknown and the post office returns mail directed to him or her indicating no forwarding address;

v) The ~~MCO or PIHP~~MCO, PIHP, or PAHP establishes the fact that the member has been accepted for Medicaid services by another local jurisdiction, state, territory, or commonwealth;

vi) A change in the level of medical care is prescribed by the member's physician;

vii) The notice involves an ~~action~~ Adverse Benefit Determination made with regard to the preadmission screening requirements of 1919(e) (7) of the Social Security Act; or

viii) Notice may be made as soon as practicable before transfer or discharge when:

1) The safety of individuals in the facility would be endangered;

2) The health of individuals in the facility would be endangered;

3) The resident's health improves sufficiently to allow a more immediate transfer or discharge;

4) An immediate transfer or discharge is required by the resident's urgent medical needs; or

5) A resident has not resided in the facility for 30 days.

b. For denial of payment, at the time of any ~~action~~ Adverse Benefit Determination affecting the claim.

c. For standard service authorization decisions that deny or limit services, within ten (10) calendar days. For expedited service authorizations, within ~~three~~ seventy-two (72~~3~~) ~~days~~hours.

i) If the ~~MCO or PIHP~~MCO, PIHP, or PAHP extends the timeframe for making a service authorization decision, it must give the member written notice of the reason for extending the timeframe and inform the member of the right to file a ~~grievance~~Grievance to disagree with the timeframe extension.

ii) The ~~MCO or PIHP~~MCO, PIHP, or PAHP must carry out its determination as expeditiously as the member's health condition requires, and no later than the date the extension expires.

8.209.4.B. The member of an ~~MCO or PIHP~~MCO, PIHP, or PAHP shall file an ~~appeal~~Appeal within ~~thirty~~sixty (~~30~~60) calendar days from the date of the ~~MCO's or PIHP's~~MCO's, PIHP's, or PAHP's notice of ~~action~~ ~~a~~Adverse ~~b~~Benefit ~~d~~Determination.

8.209.4.C. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall give members reasonable assistance in completing any forms required by the ~~MCO or PIHP~~MCO, PIHP, or PAHP, putting oral requests for a ~~State fair hearing~~State Fair Hearing into writing and taking other procedural steps, including, but not limited to, providing interpretive services and toll-free numbers that have adequate TTY/TTD and interpreter capability.

8.209.4.D. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall send the member written acknowledgement of each ~~appeal~~Appeal within two (2) working days of receipt, unless the member or designated client representative requests an expedited resolution.

8.209.4.E. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall ensure that the individuals who make decisions on ~~appeal~~Appeals are individuals who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual, and who have the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease if deciding any of the following: an ~~appeal~~Appeal of a denial that is based on lack of medical

necessity, a ~~grievance~~Grievance regarding denial of expedited resolution of an ~~appeal~~Appeal, or a ~~grievance~~Grievance or ~~appeal~~Appeal~~s~~ that involves clinical issues.

8.209.4.F The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall accept ~~appeal~~Appeals orally or in writing, and the MCO, PIHP, or PAHP shall be responsible for following an oral ~~appeal~~Appeal with a written ~~appeal~~Appeal, which shall then be signed by the member or ~~d~~Designated ~~c~~Client ~~r~~Representative unless an expedited ~~appeal~~Appeal resolution is requested. An oral Appeal shall establish the date of the Appeal.

8.209.4.G The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall provide the member a reasonable opportunity to present evidence, and allegations of fact or law, in person as well as in writing. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall inform the member of the limited time available in the case of expedited resolution.

8.209.4.H The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall provide the member and the ~~designated~~ Designated ~~client~~ Client ~~representative~~ Representative opportunity, before and during the ~~appeal~~Appeal process, to examine the member's case file, including medical records and any other documents and records considered during the ~~appeal~~Appeal process.

8.209.4.I. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall include as parties to the ~~appeal~~Appeal, the member and the ~~designated~~ Designated ~~client~~ Client ~~representative~~ Representative or the legal representative of a deceased member's estate.

8.209.4.J. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall resolve each ~~appeal~~Appeal, and provide notice as expeditiously as the member's health condition requires, not to exceed the following:

1. For standard resolution of an ~~appeal~~Appeal and notice to the affected parties, ten (10) working days from the day the ~~MCO or PIHP~~MCO, PIHP, or PAHP receives the ~~appeal~~Appeal.

2. For expedited resolution of an ~~appeal~~Appeal and notice to affected parties, ~~three~~ seventy-two (~~3~~72) ~~working days~~hours after the ~~MCO or PIHP~~MCO, PIHP, or PAHP receives the ~~appeal~~Appeal.

8.209.4.K. The ~~MCO or PIHP~~MCO, PIHP, or PAHP may extend timeframes for the resolution of ~~appeal~~Appeals by up to fourteen (14) calendar days:

1. If the member requests the extension; or

2. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shows that there is a need for additional information and that the delay is in the member's best interest. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall give the member prior written notice of the reason for delay if the timeframe is extended.

8.209.4.L. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall notify the member in writing of the resolution of an ~~appeal~~Appeal. For notice of an expedited resolution, the ~~MCO or PIHP~~MCO, PIHP, or PAHP shall also make reasonable efforts to provide oral notice.

8.209.4.M. The written notice shall include the results of the disposition/resolution process and the date it was completed.

1. For ~~appeal~~Appeals not resolved wholly in favor of the member, the written notice shall include:

a. The right to request a ~~State fair hearing~~State Fair Hearing and how to do so;

b. The right to request and to receive benefits while the hearing is pending, and how to make the request; and

c. That the member may be held liable for the cost of those benefits if the hearing decision upholds the ~~MCO's or PIHP's~~MCO's, PIHP's, or PAHP's ~~action~~~~appeal~~Appeal determination.

8.209.4.N. The member of an ~~MCO or PIHP~~MCO, PIHP, or PAHP ~~need not~~shall exhaust the ~~MCO or PIHP~~MCO, PIHP, or PAHP level ~~appeal~~Appeal process before requesting a ~~state fair hearing~~State Fair Hearing. The member shall request a ~~state fair hearing~~State Fair Hearing within ~~thirty~~ one hundred and twenty (~~30~~120) calendar~~s~~ days from the date of the ~~MCO's or PIHP's~~MCO's, PIHP's, or PAHP's notice of ~~action~~~~appeal~~Appeal determination.

8.209.4.O. If the MCO, PIHP, or PAHP fails to adhere to the notice and timing requirements regarding resolution and notification of an Appeal, the member is deemed to have exhausted the Appeals process and may request a State Fair Hearing.

8.209.4.~~O~~P. In cases where the parent or guardian of a member submits a request for a ~~third~~ third-party review to the Department of Human Services under 27-~~10.3-104 (1)(b)~~67-104 C.R.S. of the Child Mental Health Treatment Act, the member, parent or guardian and the MCO or PIHP shall have the right to request a ~~state fair hearing~~State Fair Hearing. The request for the ~~state fair hearing~~State Fair Hearing shall be submitted to the Division of Administrative Hearings within thirty (30) calendar days from the date of the determination. The ~~state fair hearing~~State Fair Hearing shall be considered a ~~recipient~~ member ~~appeal~~Appeal.

8.209.4.~~P~~Q. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall establish and maintain an expedited review process for ~~appeal~~Appeals when the ~~MCO or PIHP~~MCO, PIHP, or PAHP determines, or the provider indicates, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain or regain maximum function.

8.209.4.~~Q~~R. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall ensure that punitive action is not taken against a provider who requests an expedited resolution or supports a member's ~~appeal~~Appeal.

8.209.4.~~R~~S. If the ~~MCO or PIHP~~MCO, PIHP, or PAHP denies a request for expedited resolution, it shall transfer the ~~appeal~~Appeal in the timeframe for standard resolution, make reasonable effort to give the member prompt oral notice of the denial and send a written notice of the denial for an expedited resolution within two (2) calendar days.

8.209.4.~~S~~T. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall, consistent with federal law, provide for the continuation of benefits while the ~~MCO or PIHP~~MCO, PIHP, or PAHP level ~~appeal~~Appeal and the ~~State fair hearing~~State Fair Hearing are pending if:

1. ~~the~~The member files the ~~appeal~~Appeal ~~timely~~ (a) within ten (10) calendar days of the MCO, PIHP, or PAHP sending the notice of Adverse Benefit Determination, or (b) on or before the intended date of the MCO's, PIHP's, or PAHP's proposed Adverse Benefit Determination, whichever is later~~,~~;

2. ~~the~~ The ~~appeal~~Appeal involves the termination, suspension or reduction of a previously authorized course of treatment~~,~~;

3. ~~the~~ The services were ordered by an authorized provider~~,~~;

4. ~~the~~ The original period covered by the original authorization has not expired; and

~~and~~

5. T~~t~~he member requests extension of benefits.

~~1. This provision does not apply to Child Health Plan Plus (CHP+) members per 42 CFR 457.1260.~~

8.209.4.~~T~~U. If at the member's request, the ~~MCO or PIHP~~MCO, PIHP, or PAHP continues or reinstates the member's benefits while the ~~appeal~~Appeal is pending, the benefits shall be continued until the member withdraws the ~~appeal~~Appeal, ten days pass after the ~~MCO or PIHP~~MCO, PIHP, or PAHP mails the notice providing the resolution of the ~~appeal~~Appeal against the member, a ~~State fair hearing~~State Fair Hearing office issues a final agency decision adverse to the member, or the time period or service limits of a previously authorized service ~~has~~ have been met.

~~1. This provision does not apply to Child Health Plan Plus (CHP+) members per 42 CFR 457.1260.~~

8.209.4.~~U~~V. If the final resolution of the ~~appeal~~Appeal upholds the ~~MCO's or PIHP's~~MCO's, PIHP's, or PAHP's ~~action~~Adverse Benefit Determination, the ~~MCO or PIHP~~MCO, PIHP, or PAHP may recover the cost of the services furnished to the member while the ~~appeal~~Appeal is pending to the extent that the services were furnished solely because of the requirements of this rule.

8.209.4.~~V~~W. If the final resolution of the ~~appeal~~Appeal reverses the ~~MCO's or PIHP's~~MCO's, PIHP's, or PAHP's ~~action~~ Adverse Benefit Determination to deny, limit or delay services that were not furnished while the ~~appeal~~Appeal was pending, the ~~MCO or PIHP~~MCO, PIHP, or PAHP shall authorize or provide the disputed services promptly and as expeditiously as the member's health condition requires.

8.209.4.~~W~~X. If the final resolution of the ~~appeal~~Appeal reverses the ~~MCO's or PIHP's~~MCO's, PIHP's, or PAHP's ~~action~~ Adverse Benefit Determination to deny authorization of services and the member received the services while the ~~appeal~~Appeal was pending, the ~~MCO or PIHP~~MCO, PIHP, or PAHP must pay for those services.

8.209.5 ~~GRIEVANCE~~GRIEVANCE PROCESS

8.209.5.A The member of the ~~MCO or PIHP~~MCO, PIHP, or PAHP ~~shall~~ can ~~have thirty (30) calendar days from the date of the incident to~~ file a ~~grievance~~Grievance expressing his/her dissatisfaction with any matter other than an ~~action~~aAdverse ~~b~~Benefit ~~d~~Determination at any time.

8.209.B. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall send the member written acknowledgement of each ~~grievance~~Grievance within two (2) working days of receipt.

8.209.5.C. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall ensure that the individuals who make decisions on ~~grievance~~Grievances are individuals who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual, and who have the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease if deciding a ~~grievance~~Grievance that involves clinical issues.

8.209.5.D. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall accept ~~grievance~~Grievances orally or in writing.

1. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall dispose of each ~~grievance~~Grievance and provide notice as expeditiously as the member's health condition requires, not to exceed fifteen (15) working days from the day the ~~MCO or PIHP~~MCO, PIHP, or PAHP receives the ~~grievance~~Grievance.

8.209.5.E. The ~~MCO or PIHP~~MCO, PIHP, or PAHP may extend timeframes for the disposition of ~~grievance~~Grievances by up to fourteen (14) calendar days:

1. If the member requests the extension; or

2. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shows that there is a need for additional information and that the delay is in the member's best interest. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall give the member prior written notice of the reason for delay if the timeframe is extended.

8.209.5.F. The ~~MCO or PIHP~~MCO, PIHP, or PAHP shall notify the member in writing of the disposition of a ~~grievance~~Grievance in the format established by the Department.

8.209.5.G. The written notice shall include the results of the disposition/resolution process and the date it was completed.

8.209.5.H. If the member is dissatisfied with the disposition of a ~~grievance~~Grievance provided by the MCO, ~~or~~ PHIP, or PAHP, the member may bring the unresolved ~~grievance~~Grievance to the Department.

1. The Department will acknowledge receipt of the ~~grievance~~Grievance and dispose of the issue.

2. The disposition offered by the Department will be final.

8.209.6 OMBUDSMAN ASSISTANCE CONCERNING SERVICES FOR CLIENTS ENROLLED IN ~~MANAGED CARE ORGANIZATIONS~~MCOS, PIHPS, and PAHPS

A. An Ombudsman under contract with the Department of Health Care Policy and Financing shall provide Ombudsman assistance concerning services for ~~clients~~ members enrolled in Medicaid ~~managed care organizations (MCOs).~~MCOs, PIHPS, and PAHPs.

B. Upon request, the Ombudsman shall respond to and analyze a ~~complaint~~ Grievance from a ~~client~~ member enrolled in a Medicaid ~~managed care organization (MCO),~~ MCO, PIHP, or PAHP, or that ~~client's~~ member's ~~designated~~ Designated ~~client~~ Client ~~representative~~ Representative ~~(DCR)~~, by:

1. Assisting the ~~client~~ member or ~~DCR~~ Designated Client Representative to articulate the ~~complaint~~Grievance, to understand the options available to resolve the ~~complaint~~ Grievance and his/her rights and responsibilities, and to negotiate the appropriate ~~complaint~~ Grievance process for his/her MCO, PIHP, or PAHP;

2. Acting as the ~~client's~~ member's ~~DCR~~ Designated Client Representative if the ~~client~~ member requests except that the Ombudsman shall not act as the ~~DCR~~ Designated Client Representative in any ~~State fair hearing~~State Fair Hearing as described at 10 CCR 2505-10, §8.057;

3. Facilitating problem resolution with the MCO, PIHP, or PAHP, or its network providers;

4. Referring ~~clients~~ members to other agencies as appropriate, including agencies that can directly assist ~~clients~~ members in a ~~State fair hearing~~State Fair Hearing;

5. Conducting and reporting ~~client~~ member satisfaction studies and/or quality assessment surveys authorized by the Department to measure ~~client~~ member experience and satisfaction with Ombudsman staff and services;

6. Providing ~~clients~~ members with information on the exclusions and limitations that may be imposed on care, services, equipment and supplies under the Medicaid benefits structure;

7. Having a practical understanding of all applicable provisions of Title X, Article 16, C.R.S. and Medicaid Volume 8 rules; and

8. Avoiding any relationship or circumstance which creates or gives the appearance of a conflict of interest.

8.209.7 COMPLIANCE REQUIREMENTS FOR ALL MCOS, PIHPS, PAHPS AND THE OMBUDSMAN

A. MCOs, PIHPs, PAHPs, and the Ombudsman shall recognize and ensure ~~clients'~~ members' rights to make and file ~~complaints~~ Grievances and to ~~appeal~~Appeal ~~adverse~~ Adverse Benefit ~~determinations~~ Determinations through the ~~complaint~~ Grievance and ~~appeal~~Appeal process for any reason.

B. For ~~clients~~ members with a disability, if the medical necessity of a requested procedure has not been established by the MCO, PIHP, or PAHP, the requesting physician must be consulted in person or by telephone before a final determination is made. If the requesting physician is not available, another network provider of the ~~client~~member/~~DCR's~~ Designated Client Representative's choice shall be consulted. Such consultation shall be referenced in the notice. If the requesting physician is not available and the ~~client~~member/~~DCR~~ Designated Client Representative does not choose another network provider within two working days of the MCO's, PIHP's, or PAHP's request to make such a choice, the MCO, PIHP, or PAHP may proceed without consultation.

C. MCOs, PIHPs, PAHPs, and the Ombudsman shall develop written procedures for accepting, processing, and responding to all ~~complaints~~ Grievances and Appeals from Medicaid ~~clients~~members. For MCOs, PIHPs, and PAHPs, summaries of these procedures shall be disseminated to all participating providers and shall include summaries in the Member Handbook as described in Department contract requirements. The MCO, PIHP, or PAHP shall provide its complete ~~complaint~~ Grievance and ~~appeal~~Appeal procedures to subcontractors and ensure subcontractor compliance with these rules and the MCO's, PIHP's, or PAHP's procedures. MCOs, PIHPs, PAHPs, and the Ombudsman shall obtain written approval from the Department for their internal ~~Complaint~~ Grievance and Appeals procedures.

D. MCOs, PIHPs, PAHPs, and the Ombudsman shall establish and maintain a timely and organized system(s) for recording, tracking, and resolving Medicaid ~~clients'~~ members' ~~complaints~~ Grievances and ~~appeal~~Appeals as specified in contract.

E. MCOs, PIHPs, PAHPS, and the Ombudsman shall confidentially maintain original records of all ~~Complaints~~ Grievances and Appeals from Medicaid ~~clients~~members, including the original ~~Complaint~~Grievance or Appeal, ~~action~~Adverse Benefit Determination, or resolution taken by the entity, and evidence of review activities. All such information shall be archived for ~~six~~ ten (~~6~~10) years from the date of the initial ~~Complaint~~Grievance or Appeal.

F. MCOs, PIHPs, and PAHPs shall ensure that neither cultural, expressive, or receptive communication differences negatively impact the ~~Complaint~~ Grievance and Appeals process. MCOs, PIHPs, and PAHPs shall provide services to facilitate ~~clients'~~ members' and ~~DCRs'~~

Designated Client Representatives' effective use of the ~~Complaint~~ Grievance and Appeals process, inclusive of qualified interpreters for (1) persons with communication disabilities or differences and (2) non-English-speaking ~~clients~~members. The MCO, PIHPs, or PAHP shall consult with the ~~client~~ member or the ~~DCR~~ Designated Client Representative about the individual or medium that will assist, and such assistance shall be at the cost of the MCO, PIHP, or PAHP.

G. MCOs, PIHPs, and PAHPs shall provide the ~~client~~member, ~~DCR~~Designated Client Representative, or any other person, upon written release from the ~~client~~ member or the ~~client's~~ member's legal guardian, access to or a copy of medical records, at no cost to the ~~client~~member, for dates of service occurring during enrollment in the MCO, PIHP, or PAHP. Such records shall be provided within a time frame that provides ~~clients~~ members copies of their records prior to any decision on a ~~Complaint~~ Grievance or ~~appeal~~Appeal, or in two weeks or less, if required by C.R.S. § § 25-1-801 and 25-1-802. The MCO, PIHP, or PAHP is only obligated to provide one copy of the ~~client's~~ member's medical records free of charge for each of the Medicaid ~~client's~~ member's ~~Complaints~~Grievances or Appeals.

H. MCOs, PIHPs, and PAHPs shall monitor participating network subcontractors or providers to ensure compliance with all ~~Complaint~~ Grievance and Appeals rules and contract requirements.

I. MCOs, PIHPs, PAHPs, and the Ombudsman shall handle specific Medicaid ~~client~~ member ~~Complaint~~ Grievance and Appeals information in the same way that medical record information is handled confidentially under State and Federal law and regulations.

J. Upon request by a ~~client~~member, the ~~client's~~ member's ~~DCR~~Designated Client Representative, or the ~~client's~~ member's provider, the MCO, PIHP, or PAHP shall disclose its standards for denial of treatments or other benefits on the grounds that such treatment or other covered benefit is not medically necessary, appropriate, effective, or efficient free of charge.

K. To assist ~~clients~~ members in making inquiries and filing ~~Complaints~~Grievances and Appeals, MCOs, PIHPs, PAHPs, and the Ombudsman shall ensure that ~~clients~~ members and ~~DCRs~~ Designated Client Representatives can contact them during routine business hours through a toll-free telephone number.~~.~~

DO NOT PUBLISH

Title of Rule:	Revision to Medical Assistance Community Living Office Rule concerning the Home and Community Based Services Supported Living Services Waiver (HCBS-SLS) , section 8.500.90.
Rule Number:	MSB 17-01-17-B
Division / Contact / Phone:	The Division for Intellectual and Developmental Disabilities (DIDD) / Adam Tucker / 303-866-5472

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 14-10-08-A, Revision to Medical Assistance Community Living Office Rule concerning the Home and Community Based Services Supported Living Services Waiver (HCBS-SLS) , section 8.500.90.
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.500.90, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.500.90 with the proposed text starting at 8.500.90 Definitions through the end of 8.500.90 Definitions. Replace the current text at 8.500.94 with the proposed text starting at 8.500.94.A through the end of 8.500.94.B.3. Replace the current text at 8.500.102 with the proposed text starting at 8.500.102.G through the end of 8.500.102.G. This rule is effective June 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule:	Revision to Medical Assistance Community Living Office Rule concerning the Home and Community Based Services Supported Living Services Waiver (HCBS-SLS) , section 8.500.90.
Rule Number:	MSB 17-01-17-B
Division / Contact / Phone:	The Division for Intellectual and Developmental Disabilities (DIDD) / Adam Tucker / 303-866-5472

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).

   To add Consumer Directed Attendant Support Service (CDASS) delivery option to the HCBS-SLS wavier. To add this services delivery option to allow individuals more access to managing their personal services, Health Maintenance has also been added and will only be available to those individuals utilizing CDASS.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C 1396n(c); 42 C.F.R. Section 441.300, et seq. (2014)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   25.5 - 6 -401, et seq., C.R.S. (2014); 25.5 - 6- 1102, C.R.S. (2014

Initial Review	**04/14/17**	Final Adoption	**05/12/17**
Proposed Effective Date	**06/30/17**	Emergency Adoption	

DOCUMENT #03

DO NOT PUBLISH

Title of Rule:	Revision to Medical Assistance Community Living Office Rule concerning the Home and Community Based Services Supported Living Services Waiver (HCBS-SLS) , section 8.500.90.
Rule Number:	MSB 17-01-17-B
Division / Contact / Phone:	The Division for Intellectual and Developmental Disabilities (DIDD) / Adam Tucker / 303-866-5472

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 implementation of this rule will effect individuals waiting for or receiving services through the Home and Community Based Services Supported Living Services (HCBS-SLS) waiver who choose to utilize the Consumer Directed Attendant Support Services (CDASS) delivery option, and receive Homemaker Services, Health Maintenance Activities and Personal Care Services through the HCBS-SLS waiver.

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

A recommendation in the Community Living Advisory Group report is to expand participant direction service delivery options in the waivers administered by the Office of Community Living. This rule will be the first step in the implementation of this recommendation by expanding a participant directed delivery option to the HCBS-SLS waiver. This rule will also improve the quality and adaptability of the HCBS-SLS waver by allowing individual participants to direct and structure their services to their individual needs, thus allowing individuals to live in the community they choose. By implementing CDASS into the HCBS-SLS waiver and giving employer and budget authority to individuals utilizing services to select their own staff and setting staff wages, an expansion of overall provider capacity will be realized.

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

The Department is anticipating that the cost of adding CDASS as a services delivery option to the HCBS-SLS waiver will result in an increase in overall costs. This increase would come from two sources. First, clients who select CDASS will shift their utilization from state plan Home Health Services to Health Maintenance Activities under the HCBS-SLS waiver. Second, based on the Department's experience with CDASS in the HCBS-Elderly Blind and Disabled waiver, the average utilization of Personal Care and Homemaker Services will increase for HCBS-SLS clients that enroll in CDASS, and this utilization would be higher than the average utilization of those authorized services for clients that do not enroll in CDASS. While the reasons for this increase needs to be studied further, it is likely due to individuals having greater flexibility in who provides services which allows their identified need for services to be more fully met.

The Department has also identified an ongoing cost of implementing CDASS will be related to administrating CDASS through a Financial Management Services (FMS) contractor. The FMS contractor makes financial transactions on behalf of the participant. The FMS handles the employment tax, workers' compensation, unemployment insurance, and other requirements associated with employing the attendant. This contractor is currently paid a capitated monthly rate based on enrolled CDASS clients as an administration fee for these services. The cost of monthly administration fees and client/AR training will be through the training and operations vendor incurring additional costs to the Department and would not replace or offset the cost of a similar service.

The Department assumes changes for modifying the existing Prior Authorization Request (PAR) in the Medicaid Management Information System related to implementing CDASS in HCBS-SLS waiver would cost $100,000 total funds. This estimate is preliminary and the Department is working with the contractor for a more detailed cost and time estimate.

The Department's budget request projects that implementing the CDASS service delivery option into HCBS-SLS will result in an increase of $1,282,006 in the fiscal year ending 2016 and $2,441,573 in the fiscal year ending 2017.

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

House Bill 05-1243 authorized the Department to expand participant direction options to all HCBS waivers participants. This is especially beneficial to clients in rural areas that may have access issues due to geographical barriers and provider capacity. Participant directed programs will also be beneficial by offering the flexibility to individuals, giving them the ability to set their own schedules for attendant services, so that their services remain individualized to better accommodate. The proposed rule will expand CDASS, a participant directed service delivery option, to the HCBS-SLS waiver. This expansion will not only give individuals receiving services in the HCBS-SLS waiver access to CDASS delivery option but will also allow the Department to study its implementation and help identify gaps in services as it works to expand these options in other waivers that support individuals diagnosed with an I/DD.

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

The Department has not identified less costly methods of expanding participant direction. The Department will work to find possible areas where more cost saving can be found and implemented, by studying data from this expansion of CDASS into the HCBS-SLS waiver.

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

The Department does not know of an alternative method at this time to expand participant directed service delivery options. This option has not been attempted in I/DD specific waiver before and the Department will use this expansion to learn and identify gaps as it works to expand participant direction into other HCBS waivers.

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, CO.0293. To the extent that the terms of the federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

HCBS-SLS services and supports which are available to assist persons with 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 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

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

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

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

~~AUTHORIZED REPRESENTATIVE (AR) means an individual designated by the client or the legal guardian, if appropriate, who has the judgment and ability to direct Consumer Directed Attendant Support Services on the client's behalf and meets the qualifications as defined at 10 CCR 2505-10, Sections 8.510.6 and 8.510.7.~~

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

CLIENT REPRESENTATIVE means a person who is designated by the 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.

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

CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service delivery option SET FORTH AT SECTION 8.510. ET. SEQ ~~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, homemaker activities.~~

COST CONTAINMENT means limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based

Services, and Medicaid State Plan Benefits including Long Term Home Health services, and targeted case management.

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

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

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

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

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

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

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

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

FAMILY means a relationship as it pertains to the client and includes the following:

A mother, father, brother, sister or,

Extended blood relatives such as grandparent, aunt or uncle

Cousins or,

An adoptive parent; or,

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

A spouse; or

The client's children.

~~FISCAL MANAGEMENT SERVICES ORGANIZATION (FMS) means the entity contracted with the Department as the employer of record for attendants to provide personnel management services, fiscal management services, and skills training to an authorized representative or a client receiving CDASS.~~

FUNCTIONAL ELIGIBLITY means that the applicant meets the criteria for Long Term Care services as determined by the Department' s prescribed instrument.

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the uniform long term care instrument and medical verification on the professional medical information page to determine if the applicant or client meets the institutional level of care (LOC).

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

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915(c) waiver of the 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 the mentally retarded (ICF-MR).

INSTITUTION means a hospital, nursing facility, or intermediate care facility for the mentally retarded (ICF-MR) for which the Department makes Medicaid payment under the State plan.

INTERMEDIATE CARE FACILITY FOR THE MENTALLY RETARDED (ICF-MR) means a public or private facility that provides health and habilitation services to a client with developmental disabilities or related conditions.

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

LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a client must require in order to receive services in an institutional setting under the state plan. LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or intermediate care facilities for the mentally retarded (ICF-MR), or home and community based services (HCBS), long term home health services, swing bed and hospital back up program (HBU).

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

MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the State covers, and how the State

addresses additional Federal Medicaid statutory requirements concerning the operation of its Medicaid program.

MEDICATION ADMINISTRATION means assisting a 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.

NATURAL SUPPORTS means 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.

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

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

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

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

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

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

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

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

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

RETROSPECTIVE REVIEW means the Department or the Operating Agency's review after services and supports are provided to ensure the client received services according to the service plan and standards of economy, efficiency and quality of service

SERVICE DELIVERY OPTION MEANS THE METHOD BY WHICH DIRECT SERVICES ARE PROVIDED FOR A PARTICIPANT. THOSE OPTIONS INCLUDE: A) BY AN AGENCY .~~-~~B) PARTICIPANT DIRECTED.

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

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

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

SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers information from a semi- structured interview of respondents who know the 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.

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

THIRD PARTY RESOURCES means services and supports that a 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.

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

8.500.94 HCBS-SLS WAIVER SERVICES

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

1. Assistive technology includes services, supports or devices that assist a client to increase, maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:

    a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,

    b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

    c. Training or technical assistance for the client, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives of the client,

    d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-SLS Waiver, and

    e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency procedure.

    f. Assistive technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan or third party resource.

    g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

    h. When the expected cost is to exceed $2,500 per device three estimates shall be obtained and maintained in the case record.

    i. Training and technical assistance shall be time limited, goal specific and outcome focused.

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

        i) Purchase, training or maintenance of service animals,

        ii) Computers,

        iii) Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of game,

iv) Training or adaptation directly related to a school or home educational goal or curriculum.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five year life of the waiver unless an exception is applied for and approved. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures within thirty (30) days of the request.

2. Behavioral services are services related to the client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral Services:

i) Behavioral consultation services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral ~~self-management~~self-management.

ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall be established.

iii). Behavioral consultation services are limited to eighty (80) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

v) Behavioral plan assessment services are limited to forty (40) units and one (1) assessment per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

vi) Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:

1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

3) Counseling services are limited to two hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and are:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a client at risk of institutional placement, and that places the client's health and safety or the safety of others at risk

4) Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. All behavioral line services shall be prior authorized in accordance with Operating Agency procedure

3. Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.

b. Day habilitation services and supports encompass three (3) types of habilitative environments; specialized habilitation services, supported community connections, and prevocational services.

c. Specialized habilitation (SH) services are provided to enable the client to attain the maximum functional level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services:

i) Are provided in a non-integrated setting where a majority of the clients have a disability,

ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported community connections services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan,

ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings,

iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan.

v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational services are provided to prepare a client for paid community employment. Services include teaching concepts including attendance, task completion, problem solving and safety and are associated with performing compensated work.

i) Prevocational services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for prevocational services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than 50 percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor regulations.

iv) Prevocational services are provided to support the client to obtain paid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving prevocational services shall occur at least once every five years to determine whether or not the person has developed the skills necessary for paid community employment.

vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under section 110 of the rehabilitation act of 1973 or the Individuals with Educational Disabilities Act (20 U.S.C. Section 1401 *et seq*).

f. Day habilitation services are limited to seven thousand one hundrend and twelve (7,112) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. The number of units available for day habilitation services in combination with prevocational services and supported employment shall not exceed seven thousand one hundred and twelve (7,112) units.

4. Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and co-payments

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

~~xi~~viii) Retention or recovery of space between teeth when indicated, and

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial,

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures

d. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at 10 CCR 2505-10, 8011.11 or available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client

e. Implants shall not be a benefit for clients who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users.

f. Subsequent implants are not a covered service when prior implants fail.

g. Full mouth implants or crowns are not covered.

h. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodotic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

i. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

j. Preventative and basic services are limited to two thousand ($2,000) per service plan year. Major services are limited to ten thousand ($10,000) for the five (5) year renewal period of the waiver.

5. Home Accessibility Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health, and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include:

a. The installation of ramps,

b. Widening or modification of doorways,

c. Modification of bathroom facilities to allow accessibility and assist with needs in activities of daily living,

d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment supplies that are necessary for the welfare of the client, and

e. Safety enhancing supports such as basic fences, door and window alarms.

f. The following items are specifically excluded from home accessibility adaptations and shall not be reimbursed:

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

ii) Carpeting,

iii) Roof repair,

iv). Central air conditioning,

v) Air duct cleaning,

vi) Whole house humidifiers,

vii) Whole house air purifiers,

viii) Installation or repair of driveways and sidewalks,

ix) Monthly or ongoing home security monitoring fees,

x) Home furnishings of any type, and

xi~~i~~) Luxury upgrades.

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

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

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

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

ii. configure a bathroom to accommodate a wheelchair.

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

j. All devices and adaptations shall be provided in accordance with applicable state or local building codes or applicable standards of manufacturing, design and installation. Medicaid state plan, EPSDT or third party resources shall be utilized prior to authorization of waiver services.

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

6. Homemaker services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of homemaker services:

a. Basic homemaker services include cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.

i) Assistance may take the form of hands-on assistance including actually performing a task for the client or cueing to prompt the client to perform a task.

ii) Lawn care, snow removal, air duct cleaning, and animal care are specifically excluded under the HCBS-SLS waiver and shall not be reimbursed.

b. Enhanced homemaker services includes basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning

i) Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.

ii) The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task:

1) When such support is incidental to the habilitative services being provided, and

2) To increase the independence of the client,

iii) Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the client.

iv) Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.

7. Mentorship services are provided to clients to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising and include:

   a. Assistance in interviewing potential providers,

   b. Assistance in understanding complicated health and safety issues,

   c. Assistance with participation on private and public boards, advisory groups and commissions, and

   d. Training in child and infant care for clients who are parenting children.

   e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.

   f. Mentorship services are limited to one hundred and ninety two (192) units (forty eight (48) hours) per service plan year. One (1) unit is equal to fifteen (15) minutes.

   g. Units to provide training to clients for child and infant care shall be prior authorized beyond the one hundred and ninety two (192) units per service plan year in accordance with Operating Agency procedures.

8. Non-medical transportation services enable clients to gain access to day habilitation, prevocational and supported employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

   a. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the service plan.

   b. Non-medical transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-medical transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip charge assessed each way to and from day habilitation and supported employment services.

   c. Transportation provided to destinations other than to day program or supported employment is limited to four (4) trips per week reimbursed at mileage band one

   d. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. the applicable mileage band. Non-medical traMedicaid State Plan, defined at 42 C.F.R. §440.170(A).

9. Personal Emergency Response System (PERS) is an electronic device that enables clients to secure help in an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to a signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

a. The client and the client's case manager shall develop a protocol for identifying who should to be contacted if the system is activated.

10. Personal Care is assistance to enable a client to accomplish tasks that the client would complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task. Personal care services include:

a. PERSONAL CARE SERVICES INCLUDE: ~~Assistance with basic self-care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.~~

i) ~~–~~Assistance with basic self-care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.

ii) ~~–~~Assistance with money management,

iii) ~~–~~Assistance with menu planning and grocery shopping, and

iv) ~~-~~Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments, support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.

b. ~~-~~Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.

c. If the annual functional needs assessment identifies a possible need for skilled care: then the client shall obtain a home health assessment.

I. THE CLIENT SHALL OBTAIN A HOME HEALTH ASSESSMENT, OR

II. THE CLIENT SHALL BE INFORMED OF THE OPTION TO DIRECT HIS/HER HEALTH MAINTENANCE ACTIVITIES PURSUANT TO SECTION 8.510.12, ET SEQ.

~~b. Assistance with money management,~~
~~c. Assistance with menu planning and grocery shopping, and~~
~~d. Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine oras needed medical, dental and therapy appointments, support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.~~
~~e. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be~~

~~covered to the extent the Medicaid state plan or third party resource does not cover the service.~~

~~f. If the annual functional needs assessment identifies a possible need for skilled care then the client shall obtain a home health assessment.~~

11. Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or behavioral need. Professional services include:

a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.

b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.

c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes watsu.

d. Professional services can be reimbursed only when:

i) The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,

ii) The intervention is related to an identified medical or behavioral need, and

iii) The Medicaid State plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

e. A pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes.

f. The following services are excluded under the HCBS Waiver from reimbursement;

i) Acupuncture,

ii) Chiropractic care,

iii) Fitness trainer

~~=~~

iv) Equine therapy,

v) Art therapy,

vi) Warm water therapy,

vii) Experimental treatments or therapies, and.

viii~~ix~~) Yoga.

12. Respite service is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.

a. Respite may be provided:

i) In the client's home and private place of residence,

ii) The private residence of a respite care provider, or

iii) In the community.

b. Respite shall be provided according to individual or group rates as defined below:

i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.

ii) Individual Day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period.

iii) Overnight Group: the client receives respite in a setting which is defined as a facility that offers 24 hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.

iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.

c. The following limitations to respite services shall apply:

i) Federal financial participation shall not be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility approved pursuant to 2 CCR 503-1, Section 16.221. by the state that is not a private residence.

ii) Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.

iii) Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight group respite rate shall not exceed the respite daily rate.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

h. Documentation of the client's application for services through the Colorado Department of Human Services Division for Vocational Rehabilitation shall be

maintained in the file of each client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. § 1401et seq).

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

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

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

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

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

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

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

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

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

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

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

ii) Purchase or lease of a vehicle, and

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

c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of

the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.

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

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

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

c. Prior authorized in accordance with Operating Agency procedures.

17. HEALTH MAINTENANCE ACTIVITIES ARE AVAILABLE ONLY AS A PARTICIPANT DIRECTED SUPPORTED LIVING SERVICE IN ACCORDANCE WITH 8.500.94.B. HEALTH MAINTENANCE ACTIVITIES MEANS ROUTINE AND REPETITIVE HEALTH RELATED TASKS FURNISHED TO AN ELIGIBLE CLIENT IN THE COMMUNITY OR IN THE CLIENT'S HOME, WHICH ARE NECESSARY FOR HEALTH AND NORMAL BODILY FUNCTIONING THAT A PERSON WITH A DISABILITY IS UNABLE TO PHYSICALLY CARRY OUT. SERVICES MAY INCLUDE:

a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection. Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional

b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation

c. Mouth care performed when:

i) there is injury or disease of the face, mouth, head or neck

ii) in the presence of communicable disease

iii) the client is unconscious, OR

iv) oral suctioning is required

d. Dressing, including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary

e. Feeding

i) when suctioning is needed on a stand-by or other basis

ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study

iii) Syringe feeding, OR

iv) Feeding using apparatus

f. Exercise prescribed by a licensed medical professional including passive rangE of motion

g. Transferring a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed

h. Bowel care provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist

i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters

j. Medical management required by a medical professional to monitor blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections

k. Respiratory care:

i. Postural drainage

ii) Cupping

iii) Adjusting oxygen flow within established ~~PARAMETERS~~parameters

iv) Suctioning of mouth and nose

v) Nebulizers

vi) Ventilator and tracheostomy care

vii) Prescribed respiratory equipment

8.500.94.B PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES

Participant direction of HCBS-SLS waiver services is authorized pursuant to the provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293 and C.R.S. 25.5-6-1101, et seq. (2014).

1. Participants may choose to direct their own services through the Consumer Directed Attendant Support Services delivery OPTION SET FORTH at Section 8.510, et seq.

2. Services that may be participant-directed UNDER THIS OPTION are as follows:

   i) Personal Care as defined at Section 10 CCR 2505-10 §8.500.94.A.10

   ii) Homemaker as defined at Section 10 CCR 2505-10 §8.500.94.A.6

   iii) Health Maintenance ActivitIES as defined at Section 10 CCR 2505-10 §8.500.94.A.17

3. The case manager shall conduct the case management functions SET FORTH at section 8.510.14 et. seq.

8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

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

8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations and vehicle modifications.

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

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

8.500.102.E Each SPAL is associated with six support levels determined by an algorithm which analyzes a client's level of service need as determined by the SIS assessment and additional factors including exceptional medical and behavioral support needs and identification as a community safety risk.

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

8.500.102 G HEALTH MAINTENANCE ACTIVITIES AVAILABLE UNDER CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) IS NOT SUBJECT TO THE SERVICE PLAN AUTHORIZATION LIMIT

DO NOT PUBLISH

Title of Rule: Revision to the Colorado Indigent Care Program Rule Concerning Modernizing the CICP, Section 8.900
Rule Number: MSB 16-11-22-A
Division / Contact / Phone: Special Financing / Taryn Graf / 303-866-5634

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 16-11-22-A, Revision to the Colorado Indigent Care Program Rule Concerning Modernizing the CICP, Section 8.900
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) 8.900, 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 8.900 with the proposed text beginning at 8.900 through the end of Appendix A. This rule is effective June 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Colorado Indigent Care Program Rule Concerning Modernizing the CICP, Section 8.900
Rule Number: MSB 16-11-22-A
Division / Contact / Phone: Special Financing / Taryn Graf / 303-866-5634

STATEMENT OF BASIS AND PURPOSE

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

   The proposed changes to this rule are intended to modernize the CICP to remain an effective safety net for qualified low-income Coloradans to receive discounted health care services while decreasing the administrative burden for Colorado Indigent Care Program providers and simplifying the financial determination process for applicants and providers. The proposed rule also creates a formal advisory council for the CICP and promotes payment reform for CICP clinics.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2016);
   25.5-3-101 through 25.5-3-111, C.R.S. (2016)

Initial Review	**04/14/17**	Final Adoption	**05/12/17**
Proposed Effective Date	**06/30/17**	Emergency Adoption	

DOCUMENT #04

DO NOT PUBLISH

Title of Rule: Revision to the Colorado Indigent Care Program Rule Concerning Modernizing the CICP, Section 8.900
Rule Number: MSB 16-11-22-A
Division / Contact / Phone: Special Financing / Taryn Graf / 303-866-5634

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.

   Existing program policies currently are strictly prescriptive about how providers are to determine income for applicants and what sliding fee scale they must adhere to. This rule update allows more flexibility for hospital providers to decide what liquid assets they want to include and which deductions from applicant income they want to allow when determining client financial eligibility for the CICP. The proposed rule also permits clinics to align their income determination processes and sliding fee scale for CICP with their income determination processes and sliding fee scale for their federal grants. This rule effects CICP hospitals, clinics, clients, and applicants. The program covers Coloradoans up to 250% of the Federal Poverty Level who are not eligible for Medicaid or CHP+.

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

   This rule change will make the income determination process easier for both applicants and providers. Applicants will have less documentation to provide about their financial status, and providers will be able to align their income determination processes with their own internal charity care programs if they so choose. Since the definition of income is changing, it is possible that the number of people eligible for the program may also change. It is not possible to estimate if the number of people eligible will be higher or lower due to these changes. The general guiding principle adhered to when developing these proposed changes was to hold clients harmless.

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

   The Department of Health Care Policy and Financing sees no fiscal impact of this rule change for the Department. The funds for the Colorado Indigent Care Program are appropriated, and this rule update will have no effect on the appropriation. The clinic appropriation is $6,119,760. Funding for hospitals will continue in accordance with rule 8.2000.

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

   Updating this rule to decrease the administrative burden may incentivize providers to continue to remain providers of the program, even with the decreased client population. The update also makes changes to the payment methodology for the clinics by adding quality metrics to the formula. The addition of these quality metrics incentivizes clinic providers towards improved health outcomes for clients in order to increase their payments. The update also creates a formal stakeholder forum which ensures there will always be stakeholder input, and creates a group that is representative of the providers as a whole and includes consumer advocate input. The stakeholder forum will ensure the program is well run and meets the needs of low-income, uninsured clients. The update also simplifies the client copayment table, helping to ensure that clients are charged the intended amount for the services they receive. Providers will also be able to use a modified sliding fee scale, provided that the scale meets Department standards outlined in the proposed rule. The Department will also take the opportunity with this update to simplify the administrative policy (not specifically prescribed in detail in the new proposed rule) around data reporting requirements for providers by both collapsing breakouts of information fields, and reducing the number of times throughout the year that providers need to submit data. Language in the existing rule that was identified as confusing or unclear in a regulatory review conducted in the summer of 2015 has been either deleted or clarified.

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

   Since the Department of Health Care Policy and Financing does not foresee any fiscal impact of this rule change, there are not any less costly methods that were considered.

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

   The Department and the workgroup considered other possible changes to the program that would require legislative changes or budget actions, including changing the program's name and the addition of a Department controlled audit of providers. The Department is not pursuing legislative changes at this time given potential political changes for lower-income Americans receiving health insurance through the health exchange. Providers will continue to conduct self-audits under the proposed new rule. The Department may pursue a state-administered audit through the Budget process. The feedback the Department has received through our various forums has been positive and favorable to the proposed changes.

8.900 COLORADO INDIGENT CARE PROGRAM (CICP)

PROGRAM OVERVIEW

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate qualified health care providers for uncompensated costs associated with services rendered to the indigent population. Qualified health care providers who receive this funding render discounted health care services to Colorado residents, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to qualified health care providers who serve eligible persons who are indigent. The CICP issues procedures to ensure the funding is used to serve the indigent population in a uniform method. Any significant departure from these procedures will result in termination of the contract with, and the funding to, a health care provider. The legislative authority for this program was enacted in 1983 and is at 26-15-101, et seq., C.R.S., the "Reform Act for the Provision of Health Care for the Medically Indigent."

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in Section 10-16-102 (22.5), C.R.S. Medically indigent persons receiving discounted health care services from qualified health care providers are subject to the limitations and requirements imposed by article 15, title 26, C.R.S.

8.901 DEFINITIONS

A. "Applicant" means an individual who has applied at a qualified health care provider to receive discounted health care services.

B. "Client" means an individual whose application to receive discounted health care services has been approved by a qualified health care provider.

C. "Emergency care" is treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus, Section 25.5-3-103, C.R.S.

D. "Urgent care" is treatment needed because of an injury or serious illness that requires immediate treatment because the client's life or health may be in danger.

E. "General provider" means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. 1395x (aa)(4), a rural health clinic, as defined in 42 U.S.C. 1395x (aa)(2), a health maintenance organization issued a certificate authority pursuant to section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to section 25.5-3-108 (5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the program, "general provider" includes associated physicians.

42 U.S.C. 1395x is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of

the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203. Additionally, any incorporated material in these rules may be examined at any State publications depository library.

F. "Qualified health care provider" means any general provider who is contracted with the Department to provide, and receive funding for, discounted health care services under the Colorado Indigent Care Program.

G. "Hospital provider" means any "qualified health care provider" that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to C.R.S. §25-1.5-103 and which operates inpatient facilities.

H. "State-owned hospital provider" is any "hospital provider" that is either owned or operated by the State.

I. "Local-owned hospital provider" is any "hospital provider" that is either owned or operated by a government entity other than the State.

J. "Private-owned hospital provider" is any "hospital provider" that is privately owned and operated.

8.902 DISCOUNTED HEALTH CARE SERVICES

A. Funding provided under the CICP shall be used to provide clients with discounted health care services determined to be medically necessary by the qualified health care provider.

B. All health care services normally provided at the qualified health care provider should be available at a discount to clients. If health care services normally provided at the qualified health care provider are not available to clients at a discount, clients must be informed that the services can be offered without a discount prior to the rendering of such services.

C. Qualified health care providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:

1. Emergency care;

2. Urgent care; and

3. Any other medical care.

D. Additional discounted health care services may include:

1. Emergency mental health services if the qualified health care provider renders these services to a client at the same time that the client receives other medically necessary services.

2. Qualified health care providers may provide discounted pharmaceutical services. The qualified health care provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the qualified health care provider. Qualified health care providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible clients who are also eligible for Medicare.

3. Qualified health care providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for indigent women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The qualified health care provider is responsible for providing a description of the services included in the prenatal benefit to the client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.

2. Nursing home care.

3. Chiropractic services.

4. Sex change surgical procedures.

5. Cosmetic surgery.

6. Experimental and non-FDA approved treatments.

7. Elective surgeries that are not medically necessary.

8. Court ordered procedures, such as drug testing.

9. Abortions - Except as specified in Section 26-15-104.5, C.R.S.

10. Mental health services in clinic settings pursuant to 26-15-111, C.R.S., part 2 of article 1 of title 27, C.R.S., any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.903 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Contract Requirements for Qualified Health Care Providers

1. A contract will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by 25.5-3-108 (5)(a)(I), C.R.S.

2. A contract will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver metropolitan area and complex care that is not contracted for in the remaining areas of the state, as required by 25.5-3-108 (5)(a)(II), C.R.S.

3. Contracts may be executed with general providers throughout Colorado that can meet the following minimum criteria:

a. Licensed or certified as a general hospital, community health clinic, or maternity hospital (birth center) by the Department of Public Health and Environment, or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.

b. Hospital providers shall assure that emergency care is available to all clients throughout the contract year.

c. Hospital providers shall have at least two obstetricians with staff privileges at the hospital provider who agree to provide obstetric services to individuals under Medicaid. In the case where a hospital provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital provider to perform non-emergency obstetric procedures. The rule does not apply to a hospital provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

d. If the general provider is located within the City and County of Denver, the general provider must offer discounted specialty health care services to a specific population, of which more than 50% must reside outside the City and County of Denver (does not apply to University Hospital or Denver Health).

B. Determination of Client Eligibility to Receive Discounted Health Care Services Under Available CICP Funds

1. Using the information submitted in connection with an application to receive discounted health care services under available CICP funds, the provider shall determine whether the applicant meets all requirements to receive discounted health care services under available CICP funds. If the applicant is eligible to receive discounted health care services under available CICP funds, the qualified health care provider shall determine an appropriate rating and copayment for the client, using the current federal poverty levels published in The Federal Register (referred to as the ability to pay scale) and copayment table, under section 8.907 in these regulations.

2. The qualified health care provider should determine if the applicant is eligible to receive discounted services under available CICP funds at the time of application, unless required documentation is not available. The qualified health care provider shall determine whether the applicant is eligible to receive discounted health care services within 15 days from the date that the applicant submits a signed application and such other information, written or otherwise, as is necessary to process the application.

3. The qualified health care provider shall provide the applicant and/or representative a written notice of the provider's determination as to the applicant's eligibility to receive discounted services under available CICP funds. If eligibility to receive discounted health care services is granted by the qualified health care provider, the notice shall include the date when eligibility began. If eligibility to receive discounted health care services is denied, the notice shall include a brief, understandable explanation of the reason(s) for the denial. Every notice of the qualified health care provider's decision, whether an approval or a denial, shall include an explanation of the applicant's appeal rights found at Section 8.908 in these regulations.

C. Distribution of Available Funds to Providers

1. Distribution of available funds to qualified hospitals is found in 10 CCR 2505-10 section 8.2000.

2. Distribution of available funds for indigent care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate medically indigent charges. Available medically indigent charges are converted to medically indigent costs using the most recent provider specific audited cost-to-charge ratio available as of March 1 of each fiscal year. Medically indigent costs are inflated forward to the budget year using the United States Department of Labor Bureau of Labor Statistics Consumer Price Index - Urban Wage Earners, Medical Care Index - U.S. City Average for the second half of the previous calendar year. Providers will be notified of the distribution amounts for each State fiscal year no later than thirty (30) days prior to July 1 of each State fiscal year. The Department will notify the provider, without prior notice, of any changes in the distribution amounts applicable to the provider for a current State fiscal year that occur after July 1 of that State fiscal year.

3. Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department concerning the use of CICP funding.

4. Providers shall deduct the full patient liability amount from total charges, which is the amount due from the client as identified in the CICP Copayment Table, as defined under Section 8.907 in these regulations. The summary information submitted to the Department concerning the use of CICP funding by the provider shall include the full patient liability amount even if the provider receives the full payment at a later date or through several smaller installments or no payment from the client.

5. Beyond the distribution of available funds made by the CICP, allowable client copayments, and other third-party sources, a provider shall not seek payment from a client for the provider's CICP discounted health care services to the client.

6. Pediatric Major Teaching Hospital Payment. Hospital providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

   a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s;

   b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed;

   c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

   d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

   e. Participates in the Colorado Indigent Care Program

   The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

7. Colorado Health Care Services Payment. This payment is repealed effective September 1, 2009.

8. Rural Hospital Payment. This payment is repealed effective September 1, 2009.

9. Public Hospital Payment. This payment is repealed effective September 1, 2009.

D. Audit Requirements

The qualified health care provider shall provide the Department with an annual audit compliance statement as specified in the CICP Manual. The purpose of the audit requirement is to furnish the Department with a separate audit report, which attests to the qualified health care provider's compliance with the use of CICP funding and other requirements for participation. In addition, the audit report will furnish verification that the qualified health care provider accurately reported to the Department Medicaid-eligible inpatient days and total inpatient days used to calculate the distribution of available funds to providers defined under 8.903(C).

E. HIPAA

The Department has determined that the Colorado Indigent Care Program (CICP) is NOT a "covered entity" under the Health Insurance Portability and Accountability Act of 1996 privacy regulations (45 C.F.R. Parts 160 and 164). Because the Colorado Indigent Care Program (CICP) is not a part of Medicaid, and its principal activity is the making of grants to providers who serve eligible persons who are medically indigent, CICP is not considered a covered entity under HIPAA. The state personnel administering the CICP will provide oversight in the form of procedures and conditions, to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a qualified health care provider or client.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an applicant shall satisfy the following requirements:

1. Execute an affidavit regarding citizenship status;

2. Be lawfully present in the United States;

3. Be a resident of Colorado;

4. Meet all CICP eligibility requirements as defined by state law and procedures; and

5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, where required by 10 C.C.R. 2505-10, Section 8.904.E (2007.)

B. Affidavit

1. Each first-time applicant, or applicant seeking to reapply, eighteen (18) years of age or older shall execute an affidavit stating:

a. That he or she is a United States citizen, or

b. That he or she is a legal permanent resident, or is otherwise lawfully present in the United States pursuant to federal law.

2. For an applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall, within 30 days of the application date, verify lawful presence through the Federal Systematic Alien Verification of Entitlement Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security. Until verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.

C. Establishing Lawful Presence

1. Each first-time applicant, or applicant seeking to reapply, eighteen (18) years of age or older shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective August 30, 2016), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

2. Submission, Receipt and Retention of Documentation

a. Lawful presence documentation may be accepted from the applicant, the applicant's spouse, parent, guardian, or authorized representative in person, by mail, or facsimile.

b. Providers shall develop procedures for handling original documents to ensure that the documents are not lost, damaged or destroyed. Providers shall develop and follow procedures for returning or mailing original documents to applicants within five business days of receipt.

c. Providers shall accept copies of an applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter, provided that the verification identifies that the copy is from an original and that the individual who reviewed the document(s) signifies such by including their name, organization, address, telephone number and signature on the copy.

d. The qualified health care provider shall retain photocopies of the affidavit and lawful presence documentation with the application.

3. Expired or absent documentation for non-U.S. citizens

a. If an applicant presents expired documents or is unable to present any documentation evidencing his or her immigration status, refer the applicant to the local Department of Homeland Security office to obtain documentation of status.

b. In unusual circumstances involving applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the applicant can provide an alien registration number, the provider may file U.S.C.I.S. Form G-845 and Supplement, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status.

c. If an applicant presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.

4. The provider shall not discriminate against applicants on the basis of race, national origin, gender, religion, age or disability. If an applicant has a disability that limits the applicant's ability to provide the required evidence of citizenship or lawful presence, the provider shall assist the individual to obtain the required evidence.

a. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the applicant may provide the required documentation; or referring the client to other agencies or organizations which may be able to provide assistance.

b. Examples of additional assistance that shall be provided to applicants who are unable to comply with the documentation requirements due to physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the applicant.

c. The provider shall not be required to pay for the cost of obtaining required documentation.

d. The provider shall document its efforts of providing additional assistance to the client. Documentation of such shall be retained in the applicant's application file.

D. Residence in Colorado

An applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons;

2. Meet the lawful presence criteria, as defined in paragraph B of this section; and

3. Employed in Colorado.

E. Social security number(s) shall be required for all clients receiving discounted health care services under available CICP funding. If an applicant does not have a social security number, documentation that the applicant has applied for a social security number must be provided to complete the application to receive discounted health care services under available CICP funding. This section shall not apply to unborn children or homeless individuals who are unable to provide a social security number.

F. Applicants Not Eligible

1. The following individuals are not eligible to receive discounted services under available CICP funds:

   a. Individuals for whom lawful presence cannot be verified.

   b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

   c. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

   d. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

2. Persons who qualify for Medicaid. However, applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:

   a. QMB benefits described at section 10 C.C.R. 2505-10, Section 8.111.1 (2007) of these regulations;

   b. SLMB benefits described at section 10 C.C.R. 2505-10, Section 8.122 (2007), or

   c. The QI1 benefits described at section 10 C.C.R. 2505-10, Section 8.123 (2007).

3. Individuals who are eligible for the Children's Basic Health Plan. However, individuals who are waiting to become an enrollee in the Children's Basic Health Plan and/or have incurred charges at a participating qualified health care provider in the 90 days prior to the application date shall not be excluded from consideration for eligibility on a temporary basis. Once the applicant becomes enrolled in the Children's Basic Health Plan, the applicant is no longer eligible to receive discounted health care services under available CICP funding.

G. Application

1. Regular Application Process

   The applicant or an authorized representative of that applicant must sign the application to receive discounted health care services submitted to the qualified health care provider within 90 calendar days of the date of health care services. If an applicant is unable to sign the application or has died, a spouse, relative, or guardian may sign the application. Until it is signed, the application is not complete, the applicant cannot receive discounted health care services under available CICP funding and the applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

2. Emergency Application

a. In emergency circumstances, an applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the qualified health care provider shall follow these steps in processing the application:

I. Use the regular application to receive discounted health care services under available CICP funding, but check emergency application on the application.

II. Ask the applicant to give spoken answers to all questions and to sign the application to receive discounted health care services under available CICP funding.

III. Assign a discount rating based on the spoken information provided.

b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the client receives any care other than the emergency room visit, the qualified health care provider must request the client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the client does not support the earlier, spoken information, the qualified health care provider must obtain a new application from the client. If the client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.

c. In emergency circumstances, an applicant is not required to provide identification or execute an affidavit as specified at 10 C.C.R. 2505-10, Section 8.904.B.

H. Applicants

1. Any adult, over the age of 18, may apply to receive discounted health care services under available CICP funding on behalf of themselves and members of the applicant's family household.

2. If an applicant is deceased, the executor of the estate or a family member may complete the application on behalf of the applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.

3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the applicant's family household. In determining household size, a family member of any age may be included as long as s/he receives at least 50% of his/her support from the household.

4. A minor shall not be rated separately from his/her parents or guardians unless s/he is emancipated or there exists a special circumstance as outlined in the CICP Manual. A minor is an individual under the age of 18.

I. Health Insurance Information

The applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

J. Subsequent Insurance Payments

If a client receives discounted health care services under available CICP funding, and their insurance subsequently pays for services, or if the patient is awarded a settlement, the insurance company or patient shall reimburse the qualified health care provider for discounted health care services rendered to the patient.

8.905 FINANCIAL ELIGIBILITY

General Rule: An applicant shall be financially eligible for discounted health care services under available CICP funding if the client's household income and resources (minus allowable deductions and adjustments) are no more than 250% of the most recently published federal poverty level (FPL) for a household of that size.

1. The determination of financial eligibility for applicants, also known as "the rating process," is intended to be uniform throughout Colorado. The application must be completed with the eligibility technician at the qualified health care provider's site.

2. All qualified health care providers must accept each other's CICP Ratings, unless the provider believes that the rating was determined incorrectly or that the rating was a result of a provider management exception.

3. The rating process looks at the financial circumstances of a household as of the date that a signed application is completed.

4. CICP Ratings are retroactive for services received from a qualified health care provider up to 90 days prior to application.

5. Every effort must be made by the qualified health care provider to obtain the necessary documentation needed concerning the applicant's financial status.

8.906 CICP RATING

The federal poverty levels or the ability-to-pay scale is divided into eleven ratings. The result of the calculated income and resources and the family household size are used to determine what percentage of the federal poverty level the family meets.

Ability-to-Pay Scale Percentage of Federal poverty levels		
CICP Rating	**Percent of Federal Poverty Levels**	**Further Descriptions**
N	40%	
A	62%	
B	81%	
C	100%	
D	117%	
E	133%	
F	159%	
G	185%	
H	200%	
I	250%	

Z	40%	Homeless Clients Only

A qualified health care provider shall assign a CICP Rating or denial, and notify the applicant of his status within five working days of the applicant completing the application to receive discounted health care services. Members of applicant's family household receiving discounted health care services under the same application shall all have the same CICP Rating.

The rating letter or letter denying the application to receive discounted health care services shall include a statement informing the applicant that s/he has 15 days to appeal the denial or CICP Rating.

The CICP Rating determines a family's copayment and client copayment annual cap. CICP Ratings are effective for a maximum of one year from the date of the rating, unless the client's financial or family situation changes or the rating is a result of a qualified health care provider management exception, according to Section 8.908 (E) of these regulations.

Any family member eligible for the Children's Basic Health Plan may only receive a CICP Rating on a temporary basis. The CICP Rating is retroactive for services received 90 days prior to the application to receive discounted health care services and valid for a temporary basis from the application date.

A. Determining the CICP Rating

The CICP Rating of an eligible client shall be determined by matching the family's net CICP income and resources to the appropriate bracket on the ability-to-pay scale, taking into account the current federal poverty level for a household of the same size.

B. CICP Re-rating

A client is required to receive a re-rating because his/her financial or family situation has changed since the initial rating. To re-rate a client, the qualified health care provider must complete a new application. Client re-ratings affect only future charges. Therefore, bills incurred after the initial rating but prior to the re-rating shall be discounted based on the client's initial rating.

If the client requests a re-rating and can document that relevant circumstances have changed since the initial rating, the qualified health care provider must re-rate the client. Reasons that justify the client to request or require the client to receive a re-rating include but are not limited to:

1. Family income has changed significantly;

2. Number of dependents has changed;

3. An error in the calculation; or

4. The eligibility year has expired.

8.907 CLIENT COPAYMENT

A. Client Copayments - General Policies

A client is responsible for paying a portion of his/her medical bills. The client's portion is called the "client copayment". Qualified health care providers are responsible for charging the client a copayment. The maximum allowable client copayments by service are shown below in the Client Copayment Table. Qualified health care providers may require clients to pay their copayment prior to receiving care (except for emergency care).

Client Copayment Table					
CICP Rating	Inpatient Hospital, Ambulatory Surgery Copayment	Inpatient & Emergency Room – Physician Copayment	Outpatient Clinic Copayment	Hospital Emergency Room, Specialty Outpatient Clinic & Emergency Transportation Copayment	Prescription and Laboratory, Radiology, Imaging Copayment
N	$15	$7	$7	$15	$5
A	$65	$35	$15	$25	$10
B	$105	$55	$15	$25	$10
C	$155	$80	$20	$30	$15
D	$220	$110	$20	$30	$15
E	$300	$150	$25	$35	$20
F	$390	$195	$25	$35	$20
G	$535	$270	$35	$45	$30
H	$600	$300	$35	$45	$30
I	$630	$315	$40	$50	$35
Z	$0	$0	$0	$0	$0

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related client copayments.

1. Hospital inpatient facility charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay of 24 hours or longer. The client is responsible for the corresponding Hospital Inpatient Copayment.

2. Ambulatory Surgery charges are for all operative procedures received by a client who is admitted to and discharged from the hospital setting on the same day. The client is responsible for the corresponding Inpatient Hospital Copayment for the non-physician (facility) services and the corresponding Physician Copayment for the physician services.

3. The Inpatient and Emergency Room Physician charges are for services provided to a client by a physician in the hospital setting, including inpatient and emergency room care. The client is responsible for the corresponding Physician Copayment.

4. Outpatient Clinic charges are for all non-physician (facility) and physician services received by a client while receiving care in the outpatient clinic setting, but does not include charges from outpatient services provided in the hospital setting (i.e. emergency room care, ambulatory surgery, radiology). Outpatient charges include primary and preventive medical care. The client is responsible for the corresponding Outpatient Clinic Copayment.

5. Hospital Emergency Room, charges are for all non-physician (facility) services received by a client while receiving care in the hospital setting for a continuous stay less than 24

hours (i.e., emergency room care). The client is responsible for the corresponding Hospital Emergency Room Copayment.

6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a client while receiving care in the specialty outpatient clinic setting, but do not include charges from outpatient services provided in the hospital setting (i.e., emergency room care, ambulatory surgery). Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. The client is responsible for the corresponding Specialty Outpatient Clinic Copayment. A qualified health care provider must receive written approval from the Department to charge the Specialty Outpatient Clinic Copayment.

7. Emergency Transportation charges are for transportation provided by an ambulance. The client is responsible for the corresponding Emergency Transportation Copayment.

8. Laboratory Service charges are for all laboratory tests received by a client not associated with an inpatient facility or hospital outpatient charge during the same period. The client is responsible for the corresponding Laboratory Services Copayment.

9. Radiology and Imaging Service charges are for all radiology and imaging services received by a client while receiving care in the outpatient clinic setting, but does not include charges from outpatient or inpatient services provided in the hospital setting. The client is responsible for the corresponding Radiology and Imaging Copayment.

10. Prescription charges are for prescription drugs received by a client at a qualified health care provider's pharmacy as an outpatient service. The client is responsible for the corresponding Prescription Copayment. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.

11. Clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in an Outpatient setting are responsible for the Hospital Inpatient Facility copayment in addition to the Outpatient Specialty Clinic copayment.

B. Z-Rating. These are homeless clients, clients living in transitional housing, clients residing with others, or recipients of Colorado's Aid to the Needy Disabled financial assistance program, who are at or below 40% of the Federal Poverty Level (qualify for an N-Rating). These clients are exempt from client copayments and are rated with the Z-rating.

a. Homeless. A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

In addition, homeless clients are exempt from client copayments, the income verification requirement, and providing proof of residency when completing the CICP application.

b. Transitional Housing. Transitional housing is designed to assist individuals in becoming self-supporting, but not referenced in 8.904.E.2. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program.

In addition, transitional housing clients are exempt from the income verification requirement when completing the CICP application.

c. Residing with Others. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the client are considered residing with others. The individual allowing the client to reside with him or her may be asked to provide a written statement confirming that the client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.

d. Recipient of Colorado's Aid to the Needy Disabled financial assistance program. A client who is eligible and enrolled to receive the monthly grant award from Colorado's Aid to the Needy Disabled financial assistance program.

In addition, recipients of Colorado's Aid to the Needy Disabled financial assistance program are exempt from client copayments, and the income verification requirement when completing the CICP application.

C. Client Annual Copayment Cap

1. For all CICP Ratings annual copayments for clients shall not exceed 10% of the family's net income and resources.

2. The client annual copayment cap (annual cap) is based on the client's date of eligibility. Clients are responsible for any charges incurred prior to receiving their CICP Rating. Clients shall track their CICP copayments and inform the provider in writing (including documentation) within 90 days after meeting their annual cap. However, if a client overpays the annual cap and informs the qualified health care provider of that fact in writing, the qualified health care provider shall reimburse the client for the overpayment.

3. A CICP client is eligible to receive a re-rating if his/her financial or family situation has changed since the initial rating. CICP copayments made under the prior rating will not count toward a new CICP rating cap and the client's annual copayment cap is resets when the client completes a new application.

4. An annual cap applies only to charges incurred after a client is eligible to receive discounted health care services, and applies only to discounted services incurred at a qualified CICP health care provider.

D. Determining Client Copayments

The client's copayment shall be determined by matching the client's CICP rating with the corresponding rate on the CICP copayment table.

E. The patient must pay the lower of the copayment listed or actual charges.

F. Clients shall be notified at or before time of services rendered of their copayment responsibility.

G. Grants for Client Copayments

Grants from foundations to clients from non-profit, tax exempt, charitable foundations specifically for client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

8.908 APPEAL PROCESS

A. If an applicant or client feels that a rating or denial is in error, the applicant/client shall only challenge the rating or denial by filing an appeal with the qualified health care provider who completed the application to receive discounted health care services under available CICP funding pursuant to this section 8.908. There is no appeal process available through the Office of Administrative Courts.

B. Instructions for Filing an Appeal

The qualified health care provider shall inform the applicant or client that s/he has the right to appeal the rating or denial if s/he is not satisfied with the qualified health care provider's decision.

If the applicant or client wishes to appeal the rating or denial of the application, the applicant or client shall submit a written request for appeal, which includes any documentation supporting the reasons for the request.

C. Appeals

An applicant or client may file an appeal if the applicant or client wishes to challenge the accuracy of his or her initial rating.

A client or applicant shall have 15 calendar days from the date of the qualified health care provider's decision to request an appeal.

If the qualified health care provider does not receive the applicant's or client's appeal within the 15 days, the qualified health care provider shall notify the applicant or client in writing that the appeal was denied because it was not submitted timely. At the discretion of the qualified health care provider and for good cause shown, including a death in the applicant's or client's immediate family, the qualified health care provider may review an appeal received after 15 days.

An applicant or client can request an appeal for the following reasons:

1. The initial rating or denial was based on inaccurate information because the family member or representative was uninformed;

2. The applicant or client believes that the calculation is inaccurate for some other reason; or

3. Miscommunication between the applicant or client and the rating technician, cause incomplete or inaccurate data to be recorded on the application.

Each qualified health care provider shall designate a manager to review appeals and grant management exceptions. An appeal involves receiving a written request from the applicant or client, and reviewing the application completed by the rating technician, including all back-up documentation, to determine if the application to receive discounted health care services under available CICP funding is accurate.

~~If the manager finds that the initial rating or denial is not accurate, the designated manager shall correct the application to receive discounted health care services under available CICP funding and assign the correct rating to the applicant or client. The correct rating is effective retroactive to the initial date of application, and charges incurred 90 days prior to the initial date of application must be discounted. The qualified health care provider shall notify the applicant or client in writing of the results of an appeal within 15 working days following receipt of the appeal request from the client.~~

~~D. Provider Management Exception~~

~~At the discretion of the qualified health care provider and for good cause shown, the designated manager may grant the applicant or client a provider management exception.~~

~~A client may request and a qualified health care provider may grant a provider management exception if the client can demonstrate that there are unusual circumstances that may have affected his or her initial rating. Provider Management Exceptions shall always result in a lower client rating. Provider Management Exceptions shall not be used for applicants who do not qualify to receive discounted health care services under available CICP funding due to being over-resourced.~~

~~A client may request a provider management exception within 15 calendar days of the qualified health care provider's decision regarding an appeal, or simultaneously with an appeal.~~

~~The facility shall notify the client in writing of the qualified health care provider's findings within 15 working days of receipt of the written request.~~

~~Designated managers may authorize a three-month exception to a client's rating based on unusual circumstances. After the 90-day period ends, the client shall be re-rated. The qualified health care provider must note provider management exceptions on the application. Qualified health care providers shall treat clients equitably in the provider management exception process.~~

~~**A rating from a provider management exception is effective as of the initial date of application. Charges incurred 90 days prior to the initial date of application must be discounted. Qualified health care providers are not required to honor provider management exceptions granted by other qualified health care providers.**~~

8.900 COLORADO INDIGENT CARE PROGRAM (CICP)

PROGRAM OVERVIEW AND LEGAL BASIS

The Colorado Indigent Care Program (CICP) is a program that distributes federal and State funds to partially compensate Qualified Health Care Providers for uncompensated costs associated with services rendered to the indigent population. Qualified Health Care Providers who receive this funding render discounted health care services to Colorado residents, migrant workers and legal immigrants with limited financial resources who are uninsured or underinsured and not eligible for benefits under the Medicaid Program or the Children's Basic Health Plan.

The Colorado Department of Health Care Policy and Financing (Department) administers the CICP by distributing funding to Qualified Health Care Providers who serve eligible persons who are indigent. The CICP issues procedures to ensure the funding is used to serve the indigent population in a uniform method. Any significant departure from these procedures will result in termination of the approval of, and the funding to, a health care provider. The CICP is authorized by state law at part 1 of article 3 of title 25.5, C.R.S. (2016).

The CICP does not offer a specified discounted medical benefit package or an entitlement to medical benefits or funding to individuals or medical providers. The CICP does not offer a health coverage plan as defined in Section 10-16-102 (34), C.R.S. Medically indigent persons receiving discounted health care services from Qualified Health Care Providers are subject to the limitations and requirements imposed by part 1 of article 3 of title 25.5, C.R.S.

8.901 DEFINITIONS

A. Applicant means an individual who has applied at a Qualified Health Care Provider to receive discounted health care services.

B. Children's Basic Health Plan or the Child Health Plan Plus (CHP+) means the Children's Basic Health Plan as defined in article 8 of title 25.5, C.R.S. (2016).

C. Client means an individual whose application to receive discounted health care services has been approved by a Qualified Health Care Provider.

D. Clinic Provider means any Qualified Health Care Provider that is a community health clinic licensed or certified by the Department of Public Health and Environment pursuant to C.R.S §25-1.5-103, a federally qualified health center as defined in 42 U.S.C. 1395x (aa)(4), or a rural health clinic, as defined in 42 U.S.C. 1395x (aa)(2).

E. Colorado Indigent Care Program or CICP or Program means the Colorado Indigent Care Program as authorized by state law at part 1 of article 3 of title 25.5, C.R.S. (2016).

F. Denver Metropolitan Area means the Denver-Aurora-Lakewood, CO metropolitan area as defined by the Bureau of Labor Statistics.

G. Department means the Department of Health Care Policy and Financing established pursuant to title 25.5, C.R.S. (2016).

H. Emergency Care means treatment for conditions of an acute, severe nature which are life, limb, or disability threats requiring immediate attention, where any delay in treatment would, in the judgment of the responsible physician, threaten life or loss of function of a patient or viable fetus.

I. General Provider means a general hospital, birth center, or community health clinic licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103(1)(a)(I) or (1)(a)(II), C.R.S., a federally qualified health center, as defined in 42 U.S.C. 1395x (aa)(4), a rural health clinic, as defined in 42 U.S.C. 1395x (aa)(2), a health maintenance organization issued a certificate authority pursuant to Section 10-16-402, C.R.S., and the University of Colorado Health Sciences Center when acting pursuant to Section 25.5-3-108 (5)(a)(I) or (5)(a)(II)(A), C.R.S. For the purposes of the Program, General Provider includes associated physicians.

42 U.S.C. 1395x is incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. Pursuant to Section 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains either electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, Colorado 80203. Additionally, any incorporated material in these rules may be examined at any State publications depository library.

J. Hospital Provider means any Qualified Health Care Provider that is a general hospital licensed or certified by the Department of Public Health and Environment pursuant to Section 25-1.5-103, C.R.S. and which operates inpatient facilities.

K. Liquid Resources means resources that can be readily converted to cash, including but not limited to checking and savings accounts, health savings accounts, prepaid bank cards, certificates of deposit less the penalty for early withdrawal.

L. Medicaid means the Colorado medical assistance program as defined in article 4 of title 25.5, C.R.S.

M. Qualified Health Care Provider means any General Provider who is approved by the Department to provide, and receive funding for, discounted health care services under the Colorado Indigent Care Program.

N. Spend Down means when an Applicant uses his or her available Liquid Resources to pay off part or all of a medical bill to lower his or her financial determination to a level that will allow him or her to qualify for the Program.

O. Urgent Care means treatment needed because of an injury or serious illness that requires immediate treatment.

8.902 PROVISIONS APPLICABLE TO QUALIFIED HEALTH CARE PROVIDERS

A. Requirements for Qualified Health Care Providers

1. Agreements will be made annually between the Department and Qualified Health Care Providers through an application process.

2. Agreements may be executed with Hospital Providers throughout Colorado that meet the following requirements:

a. Licensed or certified as a general hospital or birth center by the Department of Public Health and Environment.

b. Hospital Providers shall assure that Emergency Care is available to all Clients throughout the Program year.

c. Hospital Providers shall have at least two obstetricians with staff privileges at the Hospital Provider who agree to provide obstetric services to individuals under Medicaid. In the case where a Hospital Provider is located in a rural area (that is, an area outside of a metropolitan statistical area, as defined by the Executive Office of Management and Budget), the term “obstetrician” includes any physician with staff privileges at the Hospital Provider to perform non-emergency obstetric procedures.

This requirement does not apply to a Hospital Provider in which the inpatients are predominantly under 18 years of age or which does not offer non-emergency obstetric services as of December 21, 1987.

d. Using the information submitted by an Applicant, the Qualified Health Care Provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. If the Applicant is eligible to receive discounted health care services under the Program, the Qualified Health Care Provider shall determine an appropriate copayment for the Client. Hospital Providers shall determine if the Applicant is eligible to receive discounted services under the Program at the time of application, unless required documentation is not available, in which case a determination should be made within 15 working days of the date the Applicant provides a signed application

and such other information, written or otherwise, as is necessary to process the application. Hospital Providers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age eighteen (18) and older;

II. Household size, where all non-spouse or civil union partner, non-student adults ages eighteen (18) to sixty-four (64) included on the application must have financial support demonstrated or attested to; and

III. Liquid Resources. Including Liquid Resources in the financial eligibility determination is optional for Hospital Providers. If a Hospital Provider chooses to include Liquid Resources in the financial eligibility determination, at least $2,500 must be protected for each family member counted in household size, and the Hospital Provider must include a Spend Down opportunity.

e. Hospital Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories divided into at least three income tiers covering 0 to 250% of the federal poverty level. Copayments shall be expressed in dollar amounts and shall not exceed the copayments in the Standard Client Copayment Table found in Appendix A.

f. Hospital Providers shall submit Program utilization and charge data in a format and timeline determined by the Department.

3. Agreements may be executed with Clinic Providers throughout Colorado that meet the following minimum criteria:

a. Licensed or certified as a community health clinic by the Department of Public Health and Environment, or certified by the U.S. Department of Health and Human Services as a federally qualified health center or rural health clinic.

b. Using the information submitted by an Applicant, the provider shall determine whether the Applicant meets all requirements to receive discounted health care services under the Program. If the Applicant is eligible to receive discounted health care services under the Program, the Qualified Health Care Provider shall determine an appropriate copayment for the Client. Clinic Providers should determine if the Applicant is eligible to receive discounted services under the Program at the time of application, unless required documentation is not available, in which case a determination should be made within 15 days of the date the Applicant provides a signed application and such other information, written or otherwise, as is necessary to process the application. Clinic Providers who are federally qualified health centers shall determine Client financial eligibility as required under federal regulations and guidelines. Clinic Providers who are not federally qualified health centers shall determine Client financial eligibility using the following information:

I. Income from each Applicant age eighteen (18) and older, and

II. Household size.

c. Clinic Providers shall submit a Sliding Fee Scale for Department approval with their annual application that shows copayments for different service categories. Copayments for Clients between 0 and 100% of the federal poverty level shall be

nominal or $0. Sliding Fee Scales shall have at least three tiers between 101 and 250% of the federal poverty level.

I. Sliding fee scales used by federally qualified health centers approved by the federal government meet all requirements of the Program.

II. Copayments for Clients between 101 and 250% of the federal poverty level may not be less than the copayments for Clients between 0 and 100% of the federal poverty level.

III. The same sliding fee scale shall be used for all Clients eligible for the Program.

IV. Sliding fee scales shall be reviewed by the Qualified Health Care Provider on a regular basis to ensure there are no barriers to care.

d. Clinic Providers shall submit Program data and quality metrics with their annual application. Specific quality metrics are listed in Section 8.905.B. The data and quality metrics shall be submitted in a format determined by the Department and provided as part of the annual application.

4. Determination of Lawful Presence

a. Qualified Health Care Providers shall develop procedures for handling original lawful presence documents to ensure that the documents are not lost, damaged or destroyed. Qualified Health Care Providers shall develop and follow procedures for returning or mailing original documents to Applicants within five business days of receipt.

b. Qualified Health Care Providers shall accept copies of an Applicant's lawful presence documentation that have been verified by other CICP providers, Medical Assistance sites, county departments of social services, or any other entity designated by the Department of Health Care Policy and Financing through an agency letter, provided that the verification identifies that the copy is from an original and that the individual who reviewed the document(s) signifies such by including their name, organization, address, telephone number and signature on the copy.

c. Qualified Health Care Providers shall retain photocopies of the Applicant's affidavit and lawful presence documentation.

d. Qualified Health Care Providers shall not discriminate against Applicants on the basis of race, national origin, gender, religion, age or disability. If an Applicant has a disability that limits the Applicant's ability to provide the required evidence of citizenship or lawful presence, the provider shall assist the individual to obtain the required evidence.

I. Examples of reasonable assistance that may be expected include, but are not limited to, providing contact information for the appropriate agencies that issue required documents; explaining the documentation requirements and how the Applicant may provide the required documentation; or referring the Applicant to other agencies or organizations which may be able to provide assistance.

II. Examples of additional assistance that shall be provided to Applicants who are unable to comply with the documentation requirements due to

physical or mental impairments or homelessness and who do not have a guardian or representative who can provide assistance include, but are not limited to, contacting any known family members who may have the required documentation; contacting any known health care providers who may have the required documentation; or contacting other social services agencies or organizations that are known to have provided assistance to the Applicant.

III. The Qualified Health Care Provider shall not be required to pay for the cost of obtaining required documentation.

IV. The Qualified Health Care Provider shall document its efforts of providing additional assistance to the Applicant and retain such documentation.

5. Qualified Health Care Providers shall provide the Applicant and/or representative a written notice of the provider's determination as to the Applicant's eligibility to receive discounted services under the Program. If eligibility to receive discounted health care services is granted by the Qualified Health Care Provider, the notice shall include the date when eligibility began. If eligibility to receive discounted health care services is denied, the notice shall include a brief, understandable explanation of the reason(s) for the denial. Every notice of the Qualified Health Care Provider's decision, whether an approval or a denial, shall include an explanation of the Applicant's appeal rights found at Section 8.902.B in these regulations.

6. Qualified Health Care Providers shall screen all Applicants for eligibility for Medicaid and the Children's Basic Health Plan and refer Applicants to those programs if they appear eligible. The Qualified Health Care Provider shall refer Applicants to Colorado's health insurance marketplace for information about private health insurance.

B. Client Appeals

1. If an Applicant or Client feels that a financial determination or denial is in error, he or she shall only challenge the financial determination or denial by filing an appeal with the Qualified Health Care Provider who determined eligibility to receive discounted health care services under the CICP pursuant to this Section 8.902. There is no appeal process available through the Office of Administrative Courts.

2. Instructions for Filing an Appeal

The Qualified Health Care Provider shall inform the Applicant or Client that he or she has the right to appeal the financial determination or denial if he or she is not satisfied with the Qualified Health Care Provider's decision.

If the Applicant or Client wishes to appeal the financial determination or denial of the application, the Applicant or Client shall submit a written request for appeal to the Qualified Health Care Provider, which includes any documentation supporting the reasons for the request.

3. Appeals

An Applicant or Client may file an appeal if he or she wishes to challenge the accuracy of his or her initial financial determination.

A Client or Applicant shall have 15 calendar -days to request an appeal from the date of the Qualified Health Care Provider's decision.

If the Qualified Health Care Provider receives the Applicant's or Client's appeal after the 15 working day deadline, the Qualified Health Care Provider shall notify the Applicant or Client in writing that the appeal was denied because it was not submitted timely. At the discretion of the Qualified Health Care Provider and for good cause shown, including a death in the Applicant's or Client's immediate family member, the Qualified Health Care Provider may review an appeal received after 15 working days.

An Applicant or Client can request an appeal for the following reasons:

a. The initial financial determination or denial was based on inaccurate information because the family member or representative was uninformed;

b. The Applicant or Client believes that the calculation is inaccurate for some other reason; or

c. Miscommunication between the Applicant or Client and the financial determination technician cause incomplete or inaccurate data to be recorded on the application.

Each Qualified Health Care Provider shall designate a manager to review appeals. An appeal involves receiving a written request from the Applicant or Client, and reviewing the application completed by the financial determination technician, including all back-up documentation, to determine if the application to receive discounted health care services under the CICP is accurate.

If the manager finds that the initial financial determination or denial is not accurate, the designated manager shall correct the financial determination to receive discounted health care services under the CICP and assign the correct financial determination to the Applicant or Client. The correct financial determination is effective retroactive to the initial date of application, and charges incurred 90 days prior to the initial date of application must be discounted. The Qualified Health Care Provider shall notify the Applicant or Client in writing of the results of an appeal within 15 working days following receipt of the appeal request from the Applicant or Client.

4. Provider Management Exception

Each Qualified Health Care Provider shall designate a manager to review provider management exceptions. At the discretion of the Qualified Health Care Provider and for good cause shown, the designated manager may grant the Applicant or Client a provider management exception to the Client's financial determination. This process can be used during the initial financial determination, simultaneously with an appeal, or within 15 working days of the Qualified Health Care Provider's decision regarding an appeal.

A Client may request and a Qualified Health Care Provider may grant a provider management exception if the Client can demonstrate that there are circumstances that should be taken into consideration when establishing his or her initial financial determination. Provider Management Exceptions shall always result in a lower Client financial determination.

A Client may request a provider management exception simultaneously with an appeal, or within 15 working days of the Qualified Health Care Provider's decision regarding an appeal.

The facility shall notify the Client in writing of the Qualified Health Care Provider's findings within 15 working days of receipt of the written request.

The Qualified Health Care Provider must note provider management exceptions on the application. Qualified Health Care Providers shall treat Clients equitably in the provider management exception process.

A financial determination from a provider management exception is effective as of the initial date of application. Charges incurred 90 days prior to the initial date of application must be discounted. Qualified Health Care Providers are not required to honor provider management exceptions granted by other Qualified Health Care Providers.

C. Financial Eligibility

General Rule: An Applicant shall be financially eligible for discounted health care services under the CICP if his or her household income is no more than 250% of the most recently published federal poverty level (FPL) for a household of that size.

1. Qualified Health Care Providers determine eligibility for the CICP and shall maintain auditable files of applications for discounted health care services under the CICP.

2. The determination of financial eligibility process looks at the financial circumstances of a household as of the date that a signed application is completed.

3. All Qualified Health Care Providers must accept each other's CICP financial determinations unless the Qualified Health Care Provider believes that the financial determination was determined incorrectly, the Qualified Health Care Provider's financial determination process is materially different from the process used by the issuing Qualified Health Care Provider, or that the financial determination was a result of a provider management exception.

4. CICP eligibility is retroactive for services received from a Qualified Health Care Provider up to 90 days prior to application.

5. Documentation concerning the Applicant's financial status shall be maintained by the provider.

6. Beyond the distribution of available funds made by the CICP, allowable Client copayments, and other third-party sources, a provider shall not seek payment from a Client for the provider's CICP discounted health care services to the Client.

7. Emergency Application for Providers

   a. In emergency circumstances, an Applicant may be unable to provide all of the information or documentation required by the usual application process. For emergency situations, the Qualified Health Care Provider shall follow these steps in processing the application:

      I. Use the regular application to receive discounted health care services under the CICP, but indicate emergency application on the application.

      II. Ask the Applicant to give spoken answers to all questions and to sign the application to receive discounted health care services under the CICP.

      III. Determine a federal poverty level based on the spoken information provided.

b. An emergency application is good for only one episode of service in an emergency room and any subsequent service related to the emergency room episode. If the Client receives any care other than the emergency room visit, the Hospital Provider must request the Client to submit documentation to support all figures on the emergency application or complete a new application. If the documentation submitted by the Client does not support the earlier, spoken information, the Hospital Provider must obtain a new application from the Client. If the Client does not submit any supporting documentation or complete a new application upon the request of the provider, the provider shall use the information contained in the emergency application.

c. In emergency circumstances, an Applicant is not required to provide identification or execute an affidavit as specified at 10 C.C.R. 2505-10, Section 8.904.D.

D. Audit Requirements

The Qualified Health Care Provider shall provide the Department with an annual audit compliance statement in a format as specified by the Department. The purpose of the audit requirement is to furnish the Department with a separate audit report, which attests to the Qualified Health Care Provider's compliance with the use of CICP funding and other requirements for participation.

E. HIPAA

The CICP does not meet the definition of a covered entity or business associate under the Health Insurance Portability and Accountability Act of 1996 at 45 CFR 160.103. The CICP is not a part of the Colorado Medical Assistance Program, nor of Health First Colorado, Colorado's Medicaid program. CICP's principal activity is the making of grants to providers who serve eligible persons who are medically indigent. The state personnel administering the CICP will provide oversight in the form of procedures and conditions to ensure funds provided are being used to serve the target population, but they will not be significantly involved in any health care decisions or disputes involving a Qualified Health Care Provider or Client.

8.903 DISCOUNTED HEALTH CARE SERVICES

A. Funding provided under the CICP shall be used to provide Clients with discounted health care services determined to be medically necessary by the Qualified Health Care Provider.

B. All health care services normally provided at the Qualified Health Care Provider should be available at a discount to Clients. If health care services normally provided at the Qualified Health Care Provider are not available to Clients at a discount, Clients must be informed that the services can be offered without a discount prior to the rendering of such services.

C. Qualified Health Care Providers receiving funding under the CICP shall prioritize the use of funding such that discounted health care services are available in the following order:

1. Emergency Care;

2. Urgent Care; and

3. Any other medical care.

D. Additional discounted health care services may include:

1. Emergency mental health services if the Qualified Health Care Provider renders these services to a Client at the same time that the Client receives other medically necessary services.

2. Qualified Health Care Providers may provide discounted pharmaceutical services. The Qualified Health Care Provider should only provide discounted prescriptions that are written by doctors on its staff, or by a doctor that is under contract with the Qualified Health Care Provider. Qualified Health Care Providers shall exclude prescription drugs included in the definition of Medicare Part-D from eligible Clients who are also eligible for Medicare.

3. Qualified Health Care Providers may provide packages of services to patients with modified copayment requirements.

    a. Packages of services benefit Clients who need to utilize services more often than average Clients. Things that would be beneficial to the client include but are not limited to charging a lower copay, charging the copay on an alternative schedule (i.e. once a week, or ever other time), or setting a cap on the amount or number of copayments made towards the packaged services. Examples of packages may include but are not limited to oncology treatments, physical therapy, and dialysis.

    b. Qualified Health Care Providers may provide a prenatal benefit with a predetermined copayment designed to encourage access to prenatal care for indigent women. This prenatal benefit shall not cover the delivery or the hospital stay, or visits that are not related to the pregnancy. The Qualified Health Care Provider is responsible for providing a description of the services included in the prenatal benefit to the Client prior to services rendered. Services and copayments may vary among sites.

E. Excluded Discounted Health Care Services

Funding provided under the CICP shall not be used for providing discounted health care services for the following:

1. Non-urgent dental services.

2. Nursing home care.

3. Chiropractic services.

4. Sex change surgical procedures.

5. Cosmetic surgery.

6. Experimental and non-United States Federal Drug Administration approved treatments.

7. Elective surgeries that are not medically necessary.

8. Court ordered procedures, such as drug testing.

9. Abortions - Except as specified in Section 25.5-3-106, C.R.S.

10. Mental health services in clinic settings pursuant to Section 25.5-3-110, C.R.S., part 2 of article 66 of title 27, C.R.S., any provisions of article 22 of title 23, C.R.S., or any other provisions of law relating to the University of Colorado Psychiatric Hospital.

8.904 PROVISIONS APPLICABLE TO CLIENTS

A. Overview of Requirements

In order to qualify to receive discounted health care services under available CICP funds, an Applicant shall satisfy the following requirements:

1. Execute an affidavit regarding citizenship status;

2. Be lawfully present in the United States;

3. Be a resident of Colorado;

4. Meet all CICP eligibility requirements as defined by state law and procedures; and

5. Furnish a social security number (SSN) or evidence that an application for a SSN has been submitted, where required by 10 C.C.R. 2505-10, Section 8.904.G (2016).

B. Applicants

1. Any adult age 18 and older may apply to receive discounted health care services on behalf of themselves and members of the Applicant's family household.

2. If an Applicant is deceased, the executor of the estate or a family member may complete the application on behalf of the Applicant. The family member completing the application will not be responsible for any copayments incurred on behalf of the deceased member.

3. The application to receive discounted health care services under available CICP funding shall include the names of all members of the Applicant's family household. All non-spouse or civil union partner, non-student adults ages 18-64 must have financial support demonstrated or attested to in order to be included in household size. All minors and those 65 or older do not need documentation of financial support to be counted in household size. Income from spouses or civil union partners and all non-student adults must be included in the application.

4. A minor shall not be rated separately from his or her parents or guardians unless he or she is emancipated or there exists a special circumstance. A minor is an individual under the age of 18.

C. Signing the Application

The Applicant or an authorized representative of the Applicant must sign the application to receive discounted health care services submitted to the Qualified Health Care Provider within 90 calendar days of the date of health care services. If an Applicant is unable to sign the application or has died, a spouse, civil union partner, relative, or guardian may sign the application. Until it is signed, the application is not complete, the Applicant cannot receive discounted health care services under the CICP and the Applicant has no appeal rights. All information needed by the provider to process the application must be submitted before the application is signed.

D. Affidavit

1. Each first-time Applicant, or Applicant seeking to reapply, eighteen (18) years of age or older shall execute an affidavit stating:

   a. That he or she is a United States citizen, or

   b. That he or she is a legal permanent resident, or is otherwise lawfully present in the United States pursuant to federal law.

2. For an Applicant who has executed an affidavit stating that he or she is lawfully present in the United States but is not a United States citizen, the provider shall, within 30 days of the application date, verify lawful presence through the Federal Systematic Alien Verification of Entitlement Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security. Until verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.

E. Establishing Lawful Presence

1. Each first-time Applicant, or Applicant seeking to reapply, eighteen (18) years of age or older shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective August 30, 2016), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.

2. Submission of Documentation

   Lawful presence documentation may be accepted from the Applicant, the Applicant's spouse, civil union partner, parent, guardian, or authorized representative in person, by mail, or facsimile.

3. Expired or absent documentation for non-U.S. citizens

   a. If an Applicant presents expired documents or is unable to present any documentation evidencing his or her immigration status, refer the Applicant to the local Department of Homeland Security office to obtain documentation of status.

   b. In unusual circumstances involving Applicants who are hospitalized or medically disabled or who can otherwise show good cause for their inability to present documentation and for whom securing such documentation would constitute undue hardship, if the Applicant can provide an alien registration number, the provider may file U.S.C.I.S. Form G-845 and Supplement, along with the alien registration and a copy of any expired Department of Homeland Security document, with the local Department of Homeland Security office to verify status.

   c. If an Applicant presents a receipt indicating that he or she has applied to the Department of Homeland Security for a replacement document, file U.S.C.I.S. Form G-845 and Supplement with a copy of the receipt with the local Department of Homeland Security office to verify status.

F. Residence in Colorado

An Applicant must be a resident of Colorado. A Colorado resident is a person who currently lives in Colorado and intends to remain in the state.

Migrant workers and all dependent family members must meet all of the following criteria to comply with residency requirements:

1. Maintains a temporary home in Colorado for employment reasons;

2. Meet the lawful presence criteria, as defined in paragraph E of this Section; and

3. Employed in Colorado.

G. Social security number(s) shall be required for all Clients receiving discounted health care services under the Program. If an Applicant does not have a social security number, documentation that the Applicant has applied for a social security number must be provided to complete the application to receive discounted health care services under the Program. This section shall not apply to unborn children or homeless individuals who are unable to provide a social security number.

H. Applicants Not Eligible

1. The following individuals are not eligible to receive discounted services under the CICP:

a. Individuals for whom lawful presence cannot be verified.

b. Individuals who are being held or confined involuntarily under governmental control in State or federal prisons, jails, detention facilities or other penal facilities. This includes those individuals residing in detention centers awaiting trial, at a wilderness camp, residing in half-way houses who do not have freedom of movement and association, and those persons in the custody of a law enforcement agency temporarily released for the sole purpose of receiving health care.

c. College students whose residence is from outside Colorado or the United States that are in Colorado for the purpose of higher education. These students are not Colorado residents and cannot receive services under the CICP.

d. Visitors from other states or countries temporarily visiting Colorado and have primary residences outside of Colorado.

e. Persons who qualify for Medicaid. However, Applicants whose only Medicaid benefits are the following shall not be excluded from consideration for CICP eligibility:

I. QMB benefits described at Section 10 C.C.R. 2505-10, Section 8.100.6.L (2016) of these regulations;

II. SLMB benefits described at Section 10 C.C.R. 2505-10, Section 8.1006.M (2016), or

III. The QI1 benefits described at Section 10 C.C.R. 2505-10, Section 8.100.6.N (2016).

f. Individuals who are eligible for the Children's Basic Health Plan.

I. Health Insurance Information

The Applicant shall submit all necessary information related to health insurance, including a copy of the insurance policy or insurance card, the address where the medical claim forms must be submitted, policy number, and any other information determined necessary.

J. Subsequent Insurance Payments

If a Client receives discounted health care services under the CICP, and their insurance subsequently pays for services, or if the Client is awarded a settlement, the insurance company or patient shall reimburse the Qualified Health Care Provider for discounted health care services rendered to the Client.

8.905 DEPARTMENT RESPONSIBILITIES

A. Provider Application

1. The Department shall produce and publish a provider application annually.

a. The application will be updated annually to incorporate any necessary changes and update any Program information.

b. The application will include data and quality metric submission templates.

2. The Department shall determine Qualified Health Care Providers annually through the application process.

3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108 (5)(a)(I), C.R.S.

4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108 (5)(a)(II), C.R.S.

5. The Department shall produce and publish a provider directory annually.

B. Payments to Providers

1. Funding for hospitals shall be distributed in accordance with 10 CCR 2505-10 Section 8.2000 and 8.905 B.5.

2. Clinics

a. Funding for Clinic Providers is appropriated through the Colorado General Assembly under the Children's Hospital, Clinic Based Indigent Care line item. Effective July 1, 2018, funding for clinics shall be separated into two different groups, as follows:

I. Seventy-five (75) percent of the funding will be distributed based on Clinic Providers' write off costs relative to the total write off costs for all Clinic Providers.

II. Twenty-five (25) percent of the funding will be distributed based on a points system granted to Clinic Providers based on their quality metric scores multiplied by the Clinic Provider's total visits from their submitted Program data.

b. The quality metric scores will be calculated based on the following four metrics. The metrics are defined by the Health Resources & Services Administration (HRSA):

I. Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up

II. Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan

III. Diabetes: Hemoglobin A1c Poor Control

IV. Controlling High Blood Pressure

c. Write off costs will be calculated as follows:

I. Distribution of available funds for indigent care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate medically indigent charges.

II. Clinic Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department.

III. Clinic Providers shall deduct the full patient liability amount from total charges, which is the amount due from the Client as identified in the CICP Standard Client Copayment Table, as defined under Appendix A in these rules, or an alternative sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department. The summary information submitted to the Department by the provider shall include the full CICP patient liability amount even if the Clinic Provider receives the full payment at a later date or through several smaller installments or no payment from the Client.

IV. Medically indigent charges will be converted to medically indigent costs using the most recently available cost-to-charge ratio from the Clinic Provider's cost report or other financial documentation accepted by the Department.

d. The Department shall notify Clinic Providers of their expected payment no later than July 31 of each year. The notification shall include the total expected payment and a description of the methodology used to calculate the payment.

e. For the 2017-18 Program year, Clinic Provider payments will be based solely on calendar year 2016 write-off costs relative to the total write off costs for all Clinic Providers. Write off charges shall be calculated as described in part c of this section.

3. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s;

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed;

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

e. Participates in the Colorado Indigent Care Program

The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

C. Provider Appeals

1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.

2. The provider's first level appeal must be filed within five (5) business days of the receipt of the denial letter. The Department's Special Financing Division Director will respond to any first level appeals within ten (10) business days of receipt of the appeal.

3. If a provider disagrees with the Department's Special Financing Division Director's first level appeal determination, they may file a second level appeal within five (5) business days of the receipt of the first level appeal determination. The Department's Executive Director will respond to the second level appeal within ten (10) business days of the receipt of the second level appeal.

D. Advisory Council

The Department shall create a CICP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICP Stakeholder Advisory Council. Members shall include:

1. A member representing the Department;

2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;

3. A representative from a federally qualified health center as defined at 42 U.S.C. 1395x (aa)(4);

4. A representative from a rural health clinic as defined at 42 U.S.C. 1395x (aa)(2), or a representative from a clinic licensed or certified as a community health clinic by the

Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;

5. A representative from either Denver Health or University Hospital;

6. A representative from an urban hospital;

7. A representative from a rural or critical access hospital;

8. A representative of an organization of Colorado community health centers, as defined in the federal "Public Health Service Act", 42 U.S.C. sec. 254b;

9. A representative from an organization of Colorado hospitals.

Members shall serve without compensation or reimbursement of expenses. The Executive Director shall at least annually select a chair for the council to serve for a maximum period of twelve months. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. Of the members initially appointed to the advisory council, the executive director shall appoint six for two-year terms and five for three-year terms. In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

The council shall

1. Advise the Department of operation and policies for the Program

2. Make recommendations to the Medical Services Board regarding rules for the Program

E. Annual Report

1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.

2. The report shall at minimum include charges for each Qualified Health Care Provider, numbers of Clients served, and total payments made to each Qualified Health Care Provider.

10 CCR 2505-10 § 8.900 APPENDIX A: STANDARD CICP CLIENT COPAYMENT

A. Client Copayments - General Policies

A Client is responsible for paying a portion of his or her medical bills. The Client's portion is called the Client Copayment. Qualified Health Care Providers are responsible for charging the Client a copayment. Qualified Health Care Providers may require Clients to pay their copayment prior to receiving care (except for Emergency Care). Qualified Health Care Providers may charge copayments in accordance with the Standard Client Copayment Table or an alternate sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department.

Percent of FPL	0 - 40% and Homeless	0 - 40%	41 - 62%	63 - 81%	82 - 100%	101 - 117%	118 - 133%	134 - 159%	160 - 185%	186 - 200%	201 - 250%
Ambulatory Surgery	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Inpatient Facility	$0	$15	$65	$105	$155	$220	$300	$390	$535	$600	$630
Hospital Physician	$0	$7	$35	$55	$80	$110	$150	$195	$270	$300	$315
Emergency Room	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Emergency Transportation	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Outpatient Hospital Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Clinic Services	$0	$7	$15	$15	$20	$20	$25	$25	$35	$35	$40
Specialty Outpatient	$0	$15	$25	$25	$30	$30	$35	$35	$45	$45	$50
Prescription	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Laboratory	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
Basic Radiology & Imaging	$0	$5	$10	$10	$15	$15	$20	$20	$30	$30	$35
High-Level Radiology & Imaging	$0	$30	$90	$130	$185	$250	$335	$425	$580	$645	$680

There are different copayments for different service charges. The following information explains the different types of medical care charges and the related Client Copayments under the Standard Client Copayment Table.

1. Inpatient facility charges are for all non-physician (facility) services received by a Client while receiving care in the hospital setting for a continuous stay of 24 hours or longer.

2. Ambulatory Surgery charges are for all non-physician (facility) Ambulatory Surgery operative procedures received by a Client who is admitted to and discharged from the hospital setting on the same day. The Client is also responsible for the corresponding Hospital Physician charges.

3. The Hospital Physician charges are for services provided directly by a physician in the hospital setting, including inpatient, ambulatory surgery, and emergency room care.

4. Clinic Services charges are for all non-physician (facility) and physician services received by a Client while receiving care in the outpatient clinic setting. Outpatient charges include primary and preventive medical care. This charge does not include radiology or laboratory services performed at the clinic.

5. Emergency Room charges are for all non-physician (facility) services received by a Client while receiving Emergency Care or Urgent Care in the hospital setting for a continuous stay less than 24 hours (i.e., emergency room care).

6. Specialty Outpatient charges are for all non-physician (facility) and physician services received by a Client while receiving care in the specialty outpatient setting. These services can be provided in standalone clinics and outpatient hospital settings. Specialty Outpatient charges include distinctive medical care (i.e., oncology, orthopedics, hematology, pulmonary) that is not normally available as primary and preventive medical care. Specialty Outpatient charges do not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

7. Emergency Transportation charges are for transportation provided by an ambulance.

8. Laboratory Service charges are for all laboratory tests received by a Client while receiving care in the outpatient hospital or clinic setting. Laboratory Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

9. Basic Radiology and Imaging Service charges are for all radiology and imaging services received by a Client while receiving care in the outpatient hospital or clinic setting. Basic Radiology and Imaging Service charges may not be charged in addition to charges for emergency room or inpatient services provided in the hospital setting.

10. Prescription charges are for prescription drugs received by a Client at a Qualified Health Care Provider's pharmacy as an outpatient service. To encourage the availability of discounted prescription drugs, providers are allowed to modify (increase or decrease) the Prescription Copayment with the written approval of the Department.

11. High-Level Radiology and Imaging Service charges are for Clients receiving a Magnetic Resonance Imaging (MRI), Computed Tomography (CT), Positron Emission Tomography (PET) or other Nuclear Medicine services, Sleep Studies, or Catheterization Laboratory (cath lab) in the outpatient hospital, emergency room, or clinic setting.

12. Outpatient Hospital Service charges are for all non-physician (facility) and physician services received by a Client while receiving non-Emergency Care or non-Urgent Care in the outpatient clinic setting. Outpatient Hospital Services charges include primary and preventive medical care. This charge does not include radiology, laboratory, emergency room, or ambulatory surgery services provided in a hospital setting.

13. Clients who are seen in the hospital setting in an observation bed should be charged the emergency room copay if their stay is less than 24 hours and the inpatient facility copay if their stay is 24 hours or longer.

B. Homeless Clients, Clients living in transitional housing, Clients residing with others, or recipients of Colorado's Aid to the Needy Disabled financial assistance program, who are at or below 40% of the Federal Poverty Level are exempt from Client Copayments.

1. Homeless. A person is considered homeless who lacks a fixed, regular, and adequate night-time residence or has a primary night time residency that is: (A) a supervised publicly or privately operated shelter designed to provide temporary living accommodations, (B) an institution that provides a temporary residence for individuals intended to be institutionalized, or (C) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings. This does not include an individual imprisoned or otherwise detained pursuant to federal or state law.

   In addition, homeless Clients are exempt from Client Copayments, the income verification requirement, and providing proof of residency when completing the CICP application.

2. Transitional Housing. Transitional housing is designed to assist individuals in becoming self-supporting, but not referenced in 8.904.E.2. Clients living in transitional housing must provide a written statement from their counselor or program director asserting that they are participating in a transitional housing program.

   In addition, transitional housing Clients are exempt from the income verification requirement when completing the CICP application.

3. Residing with Others. Clients who have no permanent housing of their own and who are temporarily living with a person who has no legal obligation to financially support the Client are considered residing with others. The individual allowing the Client to reside with him or her may be asked to provide a written statement confirming that the Client is not providing financial assistance to the household and that the living arrangement is not intended to be permanent.

4. Recipient of Colorado's Aid to the Needy Disabled financial assistance program. A Client who is eligible and enrolled to receive the monthly grant award from Colorado's Aid to the Needy Disabled financial assistance program.

   In addition, recipients of Colorado's Aid to the Needy Disabled financial assistance program are exempt from Client Copayments, and the income verification requirement when completing the CICP application.

C. Client Annual Copayment Cap

1. Homeless Clients whose financial determination is between 0 and 40% of the federal poverty level are exempt from copayments, so their copayment cap is $0. Clients whose financial determination is between 0 and 40% of the federal poverty level who are not homeless have a copayment cap that is the lesser of 10% of the family's net income or $120. Clients who are also Old Age Pension Health and Medical Care Program clients

have a copayment cap of $300 as mandated by 10 CCR 2505-10 8.941.10. For all other CICP Clients, annual copayments shall not exceed 10% of the family's financial determination.

2. Clients who are also Old Age Pension Health and Medical Care Program clients have annual copayment caps based on a calendar year. All other Client annual copayment caps (annual caps) are based on the Client's date of eligibility.

3. Clients are responsible for any charges incurred prior to the determination of the Client's financial eligibility.

4. Clients are responsible for tracking their CICP copayments and informing the provider in writing, including documentation, within 90 days after meeting or exceeding their annual cap. If a Client overpays the annual cap and informs the Qualified Health Care Provider of that fact in writing, the Qualified Health Care Provider shall reimburse the Client for the overpayment.

5. A CICP Client is eligible to receive a new determination if his or her financial or family situation has changed since the initial financial determination. CICP copayments made under the prior financial determination will not count toward a new CICP copayment cap and the Client's annual copayment cap resets when the Client completes a new application.

6. An annual cap applies only to charges incurred after a Client is eligible to receive discounted health care services, and applies only to discounted services incurred at a CICP Qualified Health Care Provider.

D. The Client must pay the lower of the copayment listed, the patient responsibility portion if the Client is insured, or actual charges.

E. Clients shall be notified at or before time of services rendered of their copayment responsibility.

F. Grants for Client Copayments

Grants from foundations to Clients from non-profit, tax exempt, charitable foundations specifically for Client copayments are not considered other medical insurance or income. The provider shall honor these grants and may not count the grant as a resource or income.

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Community Mental Health Services Program Capitation Rate Setting
Rule Number: MSB 16-08-01-A
Division / Contact / Phone: Payment Reform / Adam Schafer / 3038665450

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 16-08-01-A, Revision to the Medical Assistance Rule Concerning Community Mental Health Services Program Capitation Rate Setting

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) 8.215.6.C.3, 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 8.215.6.C.3 with the proposed text beginning at 8.215.6.C.3 through the end of 8.215.6.C.3. The rule is effective June 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Community Mental Health Services Program Capitation Rate Setting
Rule Number: MSB 16-08-01-A
Division / Contact / Phone: Payment Reform / Adam Schafer / 3038665450

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 currently states that behavioral health organizations (BHO) must maintain a medical loss ratio (MLR) of 77%. New federal guidelines require that these organizations maintain a MLR of 85%. This proposed rule change will require BHOs to maintain a MLR of 85%.

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. 438.(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-5-411, C.R.S. (2009).

Initial Review	**04/14/17**	Final Adoption	**05/12/17**
Proposed Effective Date	**06/30/17**	Emergency Adoption	

DOCUMENT #03

DO NOT PUBLISH

Title of Rule: Revision to the Medical Assistance Rule Concerning Community Mental Health Services Program Capitation Rate Setting
Rule Number: MSB 16-08-01-A
Division / Contact / Phone: Payment Reform / Adam Schafer / 3038665450

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 rule change has the unlikely potential to have a very small fiscal impact on behavioral health organizations. There is a small potential that taxpayers could benefit slightly due to behavioral health organizations running more efficiently.

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

   This rule has the unlikely potential to have a very small fiscal impact on behavioral health organizations. It is possible that the behavioral health organizations will be run more efficiently if these entities were performing at an MLR below 85% previously.

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 no costs to the Department or any other agency due to this proposed rule.

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

   The benefits of this rule change will be that state rule will be in alignment with federal regulations. There are no probable costs. Probable costs of inaction is that the state rule would not be in agreement with federal regulations.

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.

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

   There no other methods that would achieve this purpose.

8.215 COMMUNITY MENTAL HEALTH SERVICES PROGRAM CAPITATION RATE SETTING

8.215.6 COST CONTAINMENT MECHANISMS

8.215.6.A. The Department shall establish cost-effective, capitated rates for community mental health services in a manner that includes cost containment mechanisms.

8.215.6.B. The cost containment mechanisms shall be consistent with the principles of actuarial soundness, as determined by the independent actuary.

8.215.6.C. These cost containment mechanisms shall include:

1. Limiting costs and data considered in rate setting to that reasonable based upon enrollees' need for services within the scope of services in the behavioral health organizations' contracts.

2. Establishing health status based risk adjusted case rates for a negotiated portion of the actuarially sound capitation rate. Case rates shall be calculated based upon a statewide average cost, providing BHOs an incentive for efficiency relative to peers.

3. Requiring that behavioral health organizations maintain medical loss ratios in excess of ~~77~~85% of total Medicaid capitations. Medical loss ratios of less than ~~77~~85% shall result in a refund due the Department in the amount the medical loss is less than that threshold.

8.215.6.D. The Department may, upon consultation and feedback from the behavioral health organizations and the stakeholder community, implement other cost containment mechanisms that it finds necessary to constrain rate growth to a level that is sustainable and appropriate.