THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Targeted Case Management Services, Section 8.760
Rule Number:	MSB 11-11-22-A
Division / Contact / Phone:	Long Term Care Benefits / John Barry / 3173

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 11-11-22-A, Revision to the Medical Assistance Rule Concerning Targeted Case Management Services, Section 8.760
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) 8.760, 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*

Please insert new text provided and delete current text as indicated from §8.760, TARGETED CASE MANAGEMENT SERVICES through the end of §8.761.51.e. This change is effective 04/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Targeted Case Management Services, Section 8.760
Rule Number:	MSB 11-11-22-A
Division / Contact / Phone:	Long Term Care Benefits / John Barry / 3173

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).

A change to this rule is to recommend an amendment to clarify the criteria for eligibility and requirements for reimbursement for Targeted Case Management (TCM) for persons with Development Disabilities.

This amendment also updates the rule to reflect the current practice of using a 15-minute unit of service for TCM, rather than one based on a full or partial month. It also adds the instructions for how to bill for travel time. Finally, it sets a limit of 60 units of TCM per client for State Fiscal Year 2011-12 (April-June 2012), and a limit of 240 units per client per state fiscal year for every state fiscal year thereafter.

The changes will make it easier for providers to understand the requirements. They will also make it easier for the Department to review and audit these services, and recover funds when necessary.

2. An emergency rule-making is imperatively necessary

   ☐ to comply with state or federal law or federal regulation and/or

   ☐ for the preservation of public health, safety and welfare.

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR § 441.18

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);
   25.5-5-202, C.R.S. (2011)

Initial Review	**01/13/2012**	Final Adoption	**02/10/2012**
Proposed Effective Date	**04/01/2012**	Emergency Adoption	

DOCUMENT # 04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Targeted Case Management Services, Section 8.760
Rule Number:	MSB 11-11-22-A
Division / Contact / Phone:	Long Term Care Benefits / John Barry / 3173

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 affects clients receiving services through Early Intervention Services, the Home and Community Based Services (HCBS) for Persons with Developmental Disability program, the HCBS Supported Living Services program, and the HCBS Children's Extensive Support program. This rule also affects Community Centered Boards, who are the providers of Targeted Case Management services to these populations.

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 unit limit for Targeted Case Management Services is expected to result in savings of approximately $1,622,028 per full fiscal year with incrementally lower savings in the 2011-12 fiscal year. The limits will affect about 10% of clients who receive these services. There were over 12,000 clients who used the service during FY 2010-11, and 1,327 used over 240 units during that time.

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

   There are nominal costs for placing a unit limit on these services in the MMIS. Overall, there will be a cost savings of $1,622,028 per full fiscal year to the Department as a result of this change. Savings in the 2011-12 fiscal year are expected to be less due to timing of implementation.

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

   Inaction will result in continued confusion about the reimbursement methodology for Targeted Case Management, and possible over-utilization of this service. The benefits of making this change outweigh the costs.

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 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.

   A unit limit is a key part of managing the utilization of this service so that it is used appropriately.

8.760 TARGETED CASE MANAGEMENT SERVICES

~~Targeted case management services are a Medicaid benefit when provided in accordance with the provisions of the following sections on TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES AND CASE MANAGEMENT-MENTAL-HEALTH.~~

~~**8.761 TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITITES**~~

8.~~761~~760.1 DEFINITIONS

.11 "Child with a developmental delay" means: a person less than five years of age with delayed development or who is at risk of having a developmental disability as set forth at 2 CCR 503-1 Section 16.120, or as amended.

.12 "Community ~~centered~~ Centered ~~board~~Board" means a private corporation, for profit or not for profit, which, when designated pursuant to C.R.S. 27-10.5-105, as amended, is authorized to determine eligibility of persons with developmental disabilities within a specific geographic catchment area for services authorized under C.R.S. 27-10.5, as amended, provide case management services to such persons, and provide authorized services to such persons either directly or by purchasing such services from local service agencies.

a.~~a.~~ Persons receiving targeted case management services may not be restricted from requesting, on a statewide basis, which community centered board will provide them with targeted case management services.

~~.11~~.13 "Developmental disability" means a disability that is manifested before the person reaches twenty-two ~~(22)~~ years of age; which constitutes a substantial ~~handicap~~ disability to the affected individual; and is attributable to mental retardation or related conditions which include~~d~~ 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~~ly~~ retardation~~.ed persons.~~ and ~~pursuant~~ as set forth in ~~to~~ 2 CCR 503-1 Section 16.120, or as amended. Unless otherwise specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec. 6000, et seq., shall not apply.

~~.12 "Person with developmental disabilities" means a person with a developmental disability and may included a person less than five years of age who is at risk, of having a developmental disability and requires treatment or services similar to those required by persons who are mentally retarded.~~

~~.13 "Community centered board" means a private corporation, for profit or not for profit, which, when designated pursuant to C.R.S. 27-10.5-105, as amended, is authorized to determine eligibility of persons with developmental disabilities within a specific geographic catchment area for services authorized under C.R.S. 27-10.5, as amended, provide case management services to such persons, and provide authorized services to such persons either directly or by purchasing such services from local service agencies.~~

~~a.a. Persons receiving targeted case management services may not be restricted from requesting, on a statewide basis, which community centered board will provide them with targeted case management services.~~

8.761 TARGETED CASE MANAGEMENT SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITITES

.14 "Targeted Case Management services for persons with developmental disabilities" consists of facilitating enrollment; locating, coordinating, and monitoring needed developmental disabilities services; and coordinating with other non-developmental disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources. Targeted case management services includes the following activities: at least one activity every other month, by the community centered board which is providing targeted case management services to the individual, for one or more of the following purposes:

a. a. Comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the client experiences significant change in need or in level of support. These assessment activities include:coordinating the completion of assessments for the determination of the need for services;

1. taking client history;

2. identifying the client's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers, and educators as necessary, to form a complete assessment of the client.

b. b. Development and periodic revision of a specific care plan that:facilitating the development of the Individual Habilitation Plan (IMP) and ensuring the development of related Individual Program Plans (IPP);

1. is based on the information collected through the assessment;

2. specifies the goals and actions to address the medical, social, educational, and other services needed by the client;

3. includes activities such as ensuring the active participation of the client, and working with the client (or the client representative as defined in 10 CCR 2505-10 Section 8.500.1) and others to develop those goals; and

4. identifies a course of action to respond to the assessed needs of the client.

c. c. Referral and related activities to help a client obtain needed services including activities that help link a client with: monitoring and reviewing the goals and services identified in the Individual Habilitation Plan and individual program plans developed in response to the IHP;

1. medical, social, educational providers; or

2. other programs and services including, making referrals to providers for needed services and scheduling appointments, as needed.

d. d. Monitoring and follow-up includes activities that are necessary to ensure the care plan is implemented and adequately addresses the eligible individual's needs. Monitoring and

follow up actions shall: ~~coordination of the services being provided as identified in the IHP to ensure continuity of service provision~~

1. be performed when necessary to address health and safety and services in the care plan.

2. include activities to ensure:

A. services are being furnished in accordance with the client's care plan;

B. services in the care plan are adequate; and

C. necessary adjustments in the care plan and service arrangements with providers are made if the needs of the client have changed.

3. include direct contact and observation with the client in a place where services are delivered to a client in accordance with the following frequency:

A. Face to face monitoring shall be completed for a client enrolled in HCBS-DD at least once per quarter,

B. Face to face monitoring shall be completed for a client enrolled in HCBS-SLS at least once per quarter,

C. Face to face monitoring shall be completed for a client in HCBS-CES at least once per quarter, or

D. Face to face monitoring shall be completed at least once per six month period for children in Early Intervention Services.

~~e. advocate for the entry of persons receiving services into the services and/or programs identified in the IHP;~~

~~f. provide counsel and support to the person receiving services and other appropriate parties as necessary to prepare them for entry, transfer or termination from a program;~~

~~g. providing notification and documentation of intended actions, transfers or terminations; or,~~

~~h. for persons who no longer require services from the developmental disabilites system or whose needs would be better served in alternative services options, termination from services or transfer to other necessary services.~~

8.761.2 DETERMINATION OF CLIENT ELIGIBLITY

.21 To receive targeted case management services individuals must meet the following criteria:

a. be determined to be eligible for Medicaid by the Department of Social Services in the county in which the person resides;

b. be determined by the designated ~~community~~ Community ~~centered~~ Centered ~~board~~ Board to have a developmental disability or developmental delay; and~~.~~

c. be actively enrolled in one of the following programs ~~under contract with the Division for Developmental Disabilities, hereafter referred to as the Division~~:

1. Home and Community Based Services for Persons with Developmental Disabilities waiver;~~adult residential services~~

2. Home and Community Based Services – Supported Living Services waiver;~~adult day services~~

3. Home and Community Based Services – Children's Extensive Support waiver; or

~~early childhood services~~

4. Early Intervention Services.~~family resource services.~~

.22 The specific programs listed in 8.761.21 (C)(1) through (4) are the only programs which are eligible for targeted case management services.

8.761.3 PROVIDER ELIGIBILITY

.31 Only designated Community Centered Boards may be reimbursed for targeted case management services for persons with developmental disabilities.

8.761.4 REIMBURSEMENT

.41 Claims are reimbursable only when supported by the following documentation:

a. the name of the client;

b. the date of the activity;

c. the nature of the activity including whether it is direct or indirect contact;

d. the content of the activity including the relevant observations, assessments, findings;

e. outcomes achieved, and as appropriate, follow up action; and

f. the total number of units associated with the activity.

.42 TCM providers shall put documentation in log notes and enter it into the state data system as required by the Department.

.43 Claims for travel time to and from a Targeted Case Management activity are reimbursable at the same unit rate as targeted case management services. The time claimed for travel shall be documented separately from the time claimed for the targeted case management activity.

.44 Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at 42 C.F.R. 447.205, and shall be based upon a market-based rate with a unit of service equal to fifteen (15) minutes according to the State's approved fee schedule.~~on the following:~~

~~a. Full month . Services provided to individuals who are eligible for targeted case management services for sixteen (16) days or more within any calendar month shall be reimbursed for two (2) units of service.~~

~~b. Partial month . Services provided to individuals who are eligible for targeted case management services for fifteen (15) days or less within any calendar month shall be reimbursed for one (1) unit of service.~~

.~~4~~5 Targeted case management services may not be claimed prior to the first day of enrollment into an eligible~~division~~ program nor prior to the actual date of eligibility for Medicaid benefits.

.~~4~~6 Targeted Case Management is limited to 60 units per client for State Fiscal Year 2011-12 (April 1 to June 30, 2012). Thereafter, Targeted Case Management is limited to 240 units per client per state fiscal year. This limitation is in effect upon approval from the Centers for Medicare and Medicaid Services (CMS).

~~.43 Targeted case management services will become reimbursable as of July 1, 1989.~~

8.761.5 EXCLUSIONS

.51 Case management services provided to any individuals enrolled in the following programs are not billable as targeted case management services for persons with developmental disabilities as specified in section 8.760:

~~a. Persons enrolled in the Home and Community Based services for the Developmentally Disabled (HCB-DD) program as described in section 8.500 herein.~~

a~~b~~. Persons enrolled in ~~the~~ a Home and Community Based ~~s~~Services ~~for the Elderly, Blind and Disabled (HCBS-EBD) program as described in section 8.484 herein~~ waiver not included as an eligible HCBS service as described in 10 CCR 2505-10 Section 8.761.21c.

b~~c~~. Persons residing in a Class I nursing facility.

c~~d~~. Persons residing in an Intermediate Care Facility for ~~the Mentally Retarded~~ the Intellectually Disabled (ICF-~~MR~~ID).

d~~e~~. ~~Persons receiving services from the community centered board which are not under the state contract with that community Centered board for division programs.~~

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Interfaces for Citizenship and/or Identity for Medicaid eligibility. Section 8.100.3.H.
Rule Number:	MSB 11-12-09-C
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 11-12-09-C, Revision to the Medical Assistance Rule Concerning Interfaces for Citizenship and/or Identity for Medicaid eligibility. Section 8.100.3.H.
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) 8.100.3.H.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)? Yes
   If yes, state effective date: 04/01/2012
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Please insert new text provided at §8.100.3.H.1.a.ii. All other text is for clarification purposes only. This change is effective 04/01/2012.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Interfaces for Citizenship and/or Identity for Medicaid eligibility. Section 8.100.3.H.
Rule Number:	MSB 11-12-09-C
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).

   Interfaces are needed to ease the administrative burden of the paper verification process for citizenship and identity for eligibility sites and clients. The Department of Motor Vehicles (DMV) interface will enable eligibility sites to accept the interface results as identity verification and process cases without further documentation of identity.

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:

   Title XIX Section 1903(x) of the Social Security Act, 42 U.S.C. §1396b(x)(3)(D)(ii) and 42 CFR 435.407(e)(1) and (2) (2010 version)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2011);

Initial Review		Final Adoption	**02/10/2012**
Proposed Effective Date	**04/01/2012**	Emergency Adoption	

DOCUMENT # 05

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Interfaces for Citizenship and/or Identity for Medicaid eligibility. Section 8.100.3.H.
Rule Number:	MSB 11-12-09-C
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.

   Medicaid clients that have their data matched through the DMV interface will benefit from this proposed rule because they will have their identity verified without having to provide documents. The interface will also ease administrative burdens for eligibility workers at counties and eligibility sites.

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

   Interfaces are needed to ease the administrative burden of the paper verification process for citizenship and identity for eligibility sites and clients. DMV interface will enable eligibility sites to accept the interface results as identity verification and process cases without further documentation of identity.

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 cost of the DMV electronic interface implementation into the Colorado Benefits Management System is $357,480. These costs are being funded through the State Health Access Program grant to support Colorado's health care expansion efforts.

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

   Without the proposed rule, Medicaid clients would have to continue to provide paper documentation to prove identity, which is a barrier to enrollment for individuals that do not have immediate access to a driver's license or a state issued identification card. In addition, eligibility workers at counties and eligibility sites would have to continue the paper verification process for identity, which currently causes an administrative burden and delays in application processing for clients that do not have immediate access to the required documentation.

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

There are no less costly or less intrusive methods for achieving the purpose of this 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 to the interface in this proposed rule.

8.100.3.H. Citizenship and Identity Documentation Requirements

1. ____For determinations of initial eligibility and redeterminations of eligibility for Medical Assistance made on or after July 1, 2006, citizenship or nationality and identity status must be verified unless such satisfactory documentary evidence has already been provided, as described in 8.100.3.H.4.b. This requirement applies to an individual who declares or who has previously declared that he or she is a citizen or national of the United States.

   a. ____The following electronic interfaces shall be accepted as proof of citizenship and/or identity as listed and should be used prior to requesting documentary evidence from applicants/clients:

      i) _____SSA Interface is an acceptable interface to verify citizenship and identity. An automated response from SSA that confirms that the data submitted is consistent with SSA data, including citizenship or nationality, meets citizenship and identity verification requirements. No further action is required for the individual and no additional documentation of either citizenship or identity is required.

      ii) _____Department of Motor Vehicles (DMV) Interface is an acceptable interface to verify identity. An automated response from DMV confirms that the data submitted is consistent with DMV data for identity verification requirements. No further action is required for the individual and no additional documentation of identity is required.

   b. ____This requirement does not apply to the following groups:

      i). ____Individuals who are entitled to or who are enrolled in any part of Medicare.

      ii). ____Individuals who receive Supplemental Security Income (SSI).

      iii). ____Individuals who receive child welfare services under Title IV-B of the Social Security Act on the basis of being a child in foster care.

      iv). ____Individuals who receive adoption or foster care assistance under Title IV-E of the Social Security Act.

      v). ____Individuals who receive Social Security Disability Insurance (SSDI).

      vi). ____Children born to a woman who has applied for, has been determined eligible, and is receiving Medical Assistance on the date of the child's birth, as described in 8.100.4.G.5. This includes instances where the labor and delivery services were provided before the date of application and were covered by the Medical Assistance Program as an emergency service based on retroactive eligibility.

         1) ____A child meeting the criteria described in 8.100.3.H.1.f. shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence at any time in the future, regardless of any subsequent changes in the child's eligibility for Medical Assistance.

         2) ____Special Provisions for Retroactive Reversal of a Previous Denial

            a) ____If a child described at 8.100.3.H.1.f. was previously determined to be ineligible for Medical Assistance solely for failure to meet

the citizenship and identity documentation requirements, the denial shall be reversed. Eligibility shall be effective retroactively to the date of the child's birth provided all of the following criteria are met:

(1) ____The child was determined to be ineligible for Medical Assistance during the period between July 1, 2006 and October 1, 2009 solely for failure to meet the citizenship and identity documentation requirements as they existed during that period;

(2) ____The child would have been determined to be eligible for Medical Assistance had 8.100.3.H.1.f. and/or 8.100.3.H.1.f.ii.1) been in effect during the period from July 1, 2006 through October 1, 2009; and

(3) ____The child's parent, caretaker relative, or legally appointed guardian or conservator requests that the denial of eligibility for Medical Assistance be reversed. The request may be verbal or in writing.

b) ____A child for whom denial of eligibility for Medical Assistance has been retroactively reversed shall be subject to the eligibility redetermination provisions described at 8.100.3.Q.1. Such redetermination shall occur twelve months from the retroactive eligibility date determined when the denial was reversed pursuant to this subsection 1.

(c) ____A child granted retroactive eligibility for Medical Assistance shall be subject to the requirements described at 8.100.4.G.5. for continued eligibility.

vii). ___Individuals receiving Medical Assistance during a period of presumptive eligibility.