THIS PAGE NOT FOR PUBLICATION

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 13-10-22-B, Revision to the Medical Assistance Rule Concerning Adults without Dependent Children Section 8.205.4.A
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) 8.205.4.A, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace current text at 8.205.4.A with the new text provided. Delete current text at §8.205.4.A.1. All text indicated in blue is for clarification only and should not be revised. These changes are effective March 30, 2014.

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Adults without Dependent Children Section 8.205.4.A
Rule Number:	MSB 13-10-22-B
Division / Contact / Phone:	Health Programs Office / Max Salazar / x3289

STATEMENT OF BASIS AND PURPOSE

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

The Department proposes to remove all references to AwDC in the MSB rules, effective January 1, 2014. All existing AwDC clients and waitlist clients will be converted to MAGI Adults and will be covered by MSB rules related to MAGI Adults. Approximately 20,000 AwDC clients and 9,000 AwDC waitlist clients will be affected by this change. The rules concerning the AwDC waiver program eligibility, enrollment, and benefits will be obsolete, since the waiver will no longer exist.

In May 2012, the Department began enrolling adults without dependent children (AwDC) into Medicaid through an 1115 Demonstration Waiver. The waiver allowed childless adults with incomes up to 10 percent of the federal poverty level to receive Medicaid coverage, but the program's enrollment was capped. Initially, the Department enrolled 10,000 clients, later raising the cap to 21,691. The Department maintained a waitlist of eligible clients and used a randomized selection process each month to enroll clients into available slots.

On January 1, 2014, AwDC with incomes up to 133 percent of the federal poverty level will be eligible to enroll in Medicaid through the Affordable Care Act. Beginning in January, the Department will receive 100 percent federal match on these clients rather than the 50 percent match available through the waiver. All waiver clients and waitlist clients will be able to enroll through this Medicaid expansion without caps or waitlists, so the waiver program will no longer be needed. The waiver will end on December 31, 2013.

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:

Initial Review	**01/10/2014**	Final Adoption	**02/14/2014**
Proposed Effective Date	**03/30/2014**	Emergency Adoption	

DOCUMENT #09

The federal authority to enroll AwDC was an 1115 Demonstration waiver, which ends December 31, 2013. Beginning January 1, 2014, AwDC will receive Medicaid through the authority of the Affordable Care Act. See, 42 U.S.C. § 1396a(a)(10)(i)(VIII).

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2012);
   25.5-5-201, C.R.S. (2013)

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Adults without Dependent Children Section 8.205.4.A
Rule Number:	MSB 13-10-22-B
Division / Contact / Phone:	Health Programs Office / Max Salazar / x3289

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.

   Adults without dependent children will be affected by this rule

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

   This rule change will have a positive impact on the affected class as more individuals have become eligible and enrolled in Medicaid.

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.

   As the Department will receive 100% federal matching funds for this population, this rule will have a positive effect on state revenues.

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

   Since the AwDC program is being phased out, inaction is not an option

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

   There are no less costly methods 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 achieving the purpose for the proposed rule.

8.205.4 CLIENT ENROLLMENT AND DISENROLLMENT

8.205.4.A. Enrollment in a PCCM, MCO, or PIHP is voluntary. ~~, except for the following:~~

~~1. Clients in the Adults without Dependent Children eligibility category are mandatorily enrolled into the Accountable Care Collaborative program.~~

8.205.4.B. Members who are disenrolled from a PCCM, MCO, or PIHP for a period of two (2) months or less due to loss of eligibility shall be reenrolled into the same program upon regaining eligibility within the two (2) month period.

8.205.4.C. A client who is enrolled with a PCCM, MCO, or PIHP remains assigned to that PCCM, MCO, or PIHP for a period of twelve (12) months except as otherwise provided in these rules.

8.205.4.D. A client who is not subject to mandatory enrollment may request disenrollment from their PCCM, MCO, or PIHP without cause during the ninety (90) days following the date of their initial enrollment or the date the Department or its designee sends the notice of enrollment, whichever is later.

8.205.4.E. A client who is not subject to mandatory enrollment may request disenrollment without cause at least every twelve (12) months after the date of initial enrollment with a PCCM, MCO, or PIHP.

1. A client who is not subject to mandatory enrollment may request disenrollment within 30 days of automatic enrollment into a PCC, MCO, or PIHP if the client was ineligible during the annual disenrollment opportunity and was automatically enrolled after becoming eligible for Medicaid again.

8.205.4.F. A client may request disenrollment when the Department imposes intermediate sanctions as set forth in the Department's contract with the PCCM, MCO, or PIHP.

8.205.4.G. A client who is not subject to mandatory enrollment may request disenrollment for cause at any time. Cause shall be defined as any of the following:

1. The client moves out of the PCCM, MCO, or PIHP service area.

2. The plan or program does not, because of moral or religious objections, cover the service the client needs.

3. The client needs related services to be performed at the same time and not all related services are available within the plan or program network, and the client's provider determines that receiving the services separately would subject the client to unnecessary risk.

4. The Department or its designee unintentionally enrolls a client into the wrong plan.

5. Poor quality of care, as documented by the Department.

6. Lack of access to covered services, as documented by the Department.

7. Lack of access to providers experienced in dealing with the client's health care needs, as documented by the Department.

8. The client's primary care provider leaves the PCCM, MCO, or PIHP.

9. Other reasons satisfactory to the Department.

8.205.4.H A client who is subject to mandatory enrollment may request to be exempt from enrollment, or request to be disenrolled from the program if:

1. The client does not have access to a primary care provider contracted with the program.

2. There is poor quality of care, as documented by the Department, and there is no access to another primary care provider contracted with the program.

3. The client and the program have been unable to develop a healthy working relationship and continued best clinical interest of the client.

4. The Department, at its discretion, decides that it would meet the considerations of equity to do so.

8.205.4.I. For clients who are unable to make decisions for themselves, a family member, legal guardian or designated advocate shall be included in all decision-making concerning enrollment and disenrollment of the client.

8.205.4.J. Primary care providers participating in a PCCM, MCO, or PIHP may dismiss an enrolled client from their practice for cause at any time. The primary care provider shall give no less than 45 days notice to both the Department and the client Cause shall be defined as any of the following:

1. The client misses multiple scheduled appointments.

2. The client fails to follow the recommended treatment plan or medical instructions.

3. The primary care provider cannot provide the level of care necessary to meet the client's needs.

4. The client and /or client's family is abusive to provider and/or staff in compliance with 42 CFR 438.56(a)(2).

5. The provider moves out of the service area.

6. Other reasons satisfactory to the Department.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201
Rule Number:	MSB 13-11-19-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

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 13-11-19-A, Revision to the Medical Assistance Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.201, 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 all text from §8.201 "TREATMENT OF ORAL MEDICAL CONDITIONS FOR ADULT CLIENTS" through the end of §8.201.4.A.2 with the new text provided. This revision is effective April 1, 2014

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201
Rule Number:	MSB 13-11-19-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

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).

   Colorado Senate Bill 13-242 requires that the Department create a limited adult dental benefit, available as of April 1, 2014. The Department is engaged in a Benefits Collaborative Process to create a defined benefit that details the full amount, scope and duration of this new benefit. Until such time that process concludes, the Department is amending Section 8.201 to: 1) remove language that prohibits services covered as of April 1 and 2, 2014) add preventive, diagnostic and restorative services (except for those restorative services expressly excluded) as a covered benefit for adults age 21 and older.

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:

   §1905(a)(10) of the Social Security Act.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   25.5-5-207 C.R.S. (2013)

Initial Review	**01/10/2014**	Final Adoption	**02/14/2014**
Proposed Effective Date	**04/01/2014**	Emergency Adoption	

DOCUMENT #02

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Treatment of Oral Medical Conditions for Adult Clients, Section 8.201
Rule Number:	MSB 13-11-19-A
Division / Contact / Phone:	Medicaid Programs & Services / Max Salazar / 3289

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 currently provides a dental benefit to children 21 years of age and younger in the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program. For most adults, reimbursement is provided for emergency oral health services only. Clients with certain concurrentmedical conditions are also allowed access to dental services for conditions related to oral cavities, but not preventative or restorative services.

This rule will enable the Department to provide adult Medicaid clients 21 and older basic diagnostic, preventative and restorative dental services (such as x-rays, cleanings and fillings) and will enable the Department to enroll and reimburse providers for the provision of those services.

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

Research has shown that untreated oral health conditions negatively affect a person's overall health and that gum disease has been linked to diabetes, heart disease, strokes, kidney disease, Alzheimer's disease, and even mental illness.

Regular dental care and prevention are the most cost-effective methods available to prevent minor oral conditions from developing into more complex oral and physical health conditions that would eventually require emergency and palliative care.

A 2012 report from the Pew Center on the States found that preventable dental conditions were the primary diagnosis in 830,590 visits to emergency departments nationwide in 2009.

For FY 2013-14, the Department anticipates emergency dental services costs will be $12.7 million. The introduction of a limited adult dental benefit should reduce emergency dental service costs by 15 percent, or $1.9 million, in FY 2013-14 and 30 percent, or $4.0 million, in FY 2014-15. Additional medical savings can be expected.

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.

SB 13-242 created the Adult Dental Fund. The transfer of funds from the Unclaimed Property Trust Fund to the Adult Dental Fund is authorized to pay state costs associated with the provision and administration of the adult dental benefit. The Adult Dental Fund may retain interest

earnings and unexpended moneys at the end of each fiscal year. This amounts to approximately X per year.

Dental benefits will be capped at $1,000 per client. The fiscal note that accompanied SB 13-242 assumes that clients will use an average of $627 in dental benefits per year. Of the eligible population, The Department estimates approximately 27 percent of eligible clients will use dental benefits, which is prorated in the first year. As a result, caseload is estimated at 43,043 in FY 2013-14 and 82,072 in FY 2014-15.

Total adult dental benefit costs are $28.8 million in FY 2013-14 and $58.8 million in FY 2014-15. However, a portion of the adult dental benefit costs are assumed to be offset by reduced emergency dental services. The fiscal note assumes savings of 15 percent, or $1.9 million, in FY 2013-14 and 30 percent, or $4.0 million, in FY 2014-15.

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

See items #2 and #3.

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

This rule is legislatively mandated and the state share is fully funded by monies collected as part of the Unclaimed Property Tax Fund - now the Adult Dental Fund.

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

   Because this new benefit is mandated pursuant to SB 13-242 and must be implemented April 1, 2014, there are no alternative methods for achieving the purpose of the proposed rule.

8.201 DENTAL SERVICES~~TREATMENT OF ORAL MEDICAL CONDITIONS FOR ADULT CLIENTS~~

8.201.1 DEFINITIONS

Adult Client means an individual who is 21 years or older and eligible for medical assistance benefits.~~Condition of the Oral Cavity means a problem in the oral cavity requiring treatment.~~

~~Concurrent Medical Condition means a pre-existing medically-diagnosed state that can be exacerbated by a condition present in the oral cavity.~~

Concurrent Medical Condition means a pre-existing medically-diagnosed state that can be exacerbated by a condition present in the oral cavity.

Diagnostic Imaging means a visual display of structural or functional patterns for the purpose of diagnostic evaluation, as defined by the Current Dental Terminology (CDT) (2014).

Emergency ~~Treatment~~ Services means the need for immediate intervention by a physician, osteopath or dentist to stabilize an oral cavity condition. Immediate Intervention or Treatment means services rendered within twelve (12) hours.

Evaluation means a patient assessment that may include gathering of information through interview, observation, examination, and use of specific tests that allows a dentist to diagnose existing conditions, as defined by the CDT (2014).

Oral Cavity means the jaw, mouth or any structure contiguous to the jaw.

Preventive services means services concerned with promoting good oral health and function by preventing or reducing the onset and/or development of oral diseases or deformities and the occurrence of oro-facial injuries, as defined by the CDT (2014).

Restorative means services rendered for the purpose of rehabilitation of dentition to functional or aesthetic requirements of the client, as defined by the CDT (2014).

8.201.2 BENEFITS

8.201.2.A. Treatment of a Condition of the Oral Cavity for Adult Clients with a Concurrent Medical Condition is a benefit.

1. Allowable Concurrent Medical Conditions include:

a. Neoplastic disease requiring chemotherapy and/or radiation.

b. Pre and post organ transplant.

c. Pregnancy.

d. Chronic medical condition in which there is documentation that the medical condition is exacerbated by a Condition of the Oral Cavity.

~~8.201.2.A. Treatment of a Condition of the Oral Cavity for Adult Clients with a Concurrent Medical Condition is a benefit.~~

~~1. Allowable Concurrent Medical Conditions include:~~

~~a. Neoplastic disease requiring chemotherapy and/or radiation.~~

~~b. Pre and post organ transplant.~~

~~c. Pregnancy.~~

~~d. Chronic medical condition in which there is documentation that the medical condition is exacerbated by a Condition of the Oral Cavity.~~

8.201.2.~~A~~B. Covered Services

Subject to 8.201.2.B, evaluations, diagnostic imaging, preventive, and restorative services shall be available for all adult clients. Emergency Treatment as defined in 8.201.1 is a covered service. The dental benefit for children age 20 and under are defined at 8.280 (EPSDT).

8.201.2.~~B~~C.. Exclusions.

1. The following services/treatments are not a benefit for Adult Clients under any circumstances:

~~a. Preventive services to include prophylaxis, fluoride treatment and oral hygiene instruction.~~

~~b. Treatment for dental caries, gingivitis and tooth fractures.~~

~~c~~a. Cosmetic Procedures.

~~d~~b. Inlay and onlay restorations.

~~e~~c. Crowns.

~~f~~d. Treatment of the Oral Cavity in preparation for partial or full mouth dentures.

~~g~~e. Assessment for, delivery of dentures or subsequent adjustments to dentures and bridges.

~~h~~f. Implants

~~8.201.2.C. Emergency Treatment.~~

~~1. Emergency Treatment can be provided to an Adult Client who:~~

~~a. Presents with an acute Condition of the Oral Cavity that requires hospitalization and or immediate surgical care.~~

~~b. Presents with a Condition of the Oral Cavity that would result in acute hospital medical care and or subsequent hospitalization if no Immediate Treatment is rendered.~~

~~2. Emergency Treatment provided to an Adult Client includes, but is not limited to:~~

a. Immediate Treatment or surgery to repair trauma to the jaw.

b. Reduction of any fracture of the jaw or any facial bone, including splints or other appliances used for this purpose.

c. Extraction of tooth or tooth structures associated with the Emergency Treatment of a Condition of the Oral Cavity.

d. Repair of traumatic Oral Cavity wounds.

e. Anesthesia services ancillary to the provision of emergency treatment.

8.201.3 PRIOR AUTHORIZATION REQUEST

8.201.3.A. Prior authorization is required for treatment rendered for an Adult Client with a Concurrent Medical Condition.

1. Emergency Services do not require a prior authorization before services can be rendered.

2. All prior authorization requests shall include:

a. Statement identifying the chronic medical condition.

b. Description of Condition of the Oral Cavity that is exacerbating the chronic medical condition.

c. Narrative describing why the recommended treatment is necessary to prevent exacerbation of the Adult Client's chronic medical condition.

8.201.4. PROVIDER REQUIREMENTS/REIMBURSEMENT

8.201.4.A. To submit claims for treatment of oral medical conditions for Adult Clients, the provider shall meet one of the following requirements:

1. Enroll as a physician and bill according to all medical billing requirements including using Current Procedural Terminology (CPT) codes.

2. Enroll as a ~~dentist~~ dental provider and bill according to all dental billing requirements including using Current Dental Terminology (CDT) codes.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Early and Periodic Screening Diagnosis and Treatment (EPSDT) Personal Care Section 8.280
Rule Number:	MSB 13-10-22-A
Division / Contact / Phone:	Health Programs Office / Max Salazar / x3289

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 13-10-22-A, Revision to the Medical Assistance Rule Concerning Early and Periodic Screening Diagnosis and Treatment (EPSDT) Personal Care Section 8.280
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) 8.280, 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 all current text from §8.280 "EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT" through the end of §8.280.8 with the new text provided. This revision is effective March 30, 2014

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Early and Periodic Screening Diagnosis and Treatment (EPSDT) Personal Care Section 8.280
Rule Number:	MSB 13-10-22-A
Division / Contact / Phone:	Health Programs Office / Max Salazar / x3289

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 targets four categories. First, it revises the existing wording of the rule to achieve more clarity. Second, there are certain policies which the Department no longer has in place or have otherwise changed and therefore need to be updated. Third, new federal regulations for EPSDT have been promulgated and therefore those changed need to be reflected in the rule. Fourth, the Department will implement a personal care benefit in 2014 which is a component of EPSDT. This rule change therefore defines the purpose of that program.

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:

   §1905 of the Social Security Act,
   42 U.S.C. §§1396a(a)(42), 1396a(4)(B) and 1396d(r) and 1396d(a).

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review	**01/10/2014**	Final Adoption	**02/14/2014**
Proposed Effective Date	**03/30/2014**	Emergency Adoption	

DOCUMENT #03

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Early and Periodic Screening Diagnosis and Treatment (EPSDT) Personal Care Section 8.280
Rule Number:	MSB 13-10-22-A
Division / Contact / Phone:	Health Programs Office / Max Salazar / x3289

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.

   Recipients and providers of EPSDT services will be among the affected classes of persons for this proposed rule. Clients whose hours are reduced as a result of the Department's revised Pediatric Assessment Tool will benefit from this rule change as the addition of personal care services will offer another opportunity to obtain such services

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 will have a positive quantitative impact on those receiving personal care services as the proposed rule will allow for greater access to personal care services. Furthermore, the rule change will provide greater clarity for every class of person affected by this rule and therefore will have a quantitative impact of ensuring greater predictability in the EPSDT 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.

   This proposed rule will likely have a neutral impact on state revenues as any savings gained from reducing hours in Home Health Personal services will be offset by the increased costs of adding the personal care benefit to EPSDT.

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

   Inaction is not an option as the rule changes reflects changes in federal guidance, changes in department policies and the addition of a program which the Department has committed to implementing.

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

   There are no less costly methods.

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

   There are no alternative methods for achieving the purpose of the proposed rule.

8.280 EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT [Eff. 10/01/2007]

8.280.1 DEFINITIONS

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) means the child health component of Medicaid. The EPSDT program ~~is the pediatric component of Medicaid and~~ requires coverage of periodic and interperiodic screens, vision, dental and hearing care, diagnostic services needed to confirm the existence of a physical or mental illness or condition, and all medical assistance services that are recognized under Section 1905 of the Social Security Act, even if not offered under the state plan pursuant to federal laws applicable to the program (including 1905(a), 42 U.S.C. §§1396a(a)(42), 1396d(a)(4)(B) and ~~-~~1396d(r)).

EPSDT ~~Early and Periodic Screening, Diagnosis and Treatment~~ Case Management means an activity that assists Medicaid clients in getting and/or coordinating services based on individual need.

EPSDT Outreach means methods to inform recipients or potential recipients, such as those found to be presumptively eligible, to enter into care.

EPSDT Outreach and Case Management Entity means an entity that has contracted with the Department to provide the activities specified in 8.280.3 below.

Medical N~~n~~ecessity means that a covered service shall be deemed a medical necessity or medically necessary if, in a manner consistent with accepted standards of medical practice, it:

1. Is found to be an equally effective treatment among other less conservative or more costly treatment options, and

2. Meets at least one of the following criteria:

    a. The service will, or is reasonably expected to prevent or diagnose the onset of an illness, condition, primary disability, or secondary disability.

    b. The service will, or is reasonably expected to cure, correct, reduce or ameliorate the physical, mental cognitive or developmental effects of an illness, injury or disability.

    c. The service will, or is reasonably expected to reduce or ameliorate the pain or suffering caused by an illness, injury or disability.

    d. The service will, or is reasonably expected to assist the individual to achieve or maintain maximum functional capacity in performing Activities of Daily Living.

Medical necessity may also be a course of treatment that includes mere observation or no treatment at all.

Personal Care Services means assistance with non-skilled activities of daily living in order to meet the client's physical, maintenance and supportive needs. This assistance may take the form of hands-on assistance (actually performing a task for the person), or prompting or cueing the client to complete the task.

8.280.2 EPSDT ELIGIBILITY

A child or youth age 20 and under ~~and pregnant women of any age who are~~ enrolled in Medicaid are~~is~~ eligible for EPSDT services.

8.280.3 EPSDT OUTREACH AND CASE MANAGEMENT

8.280.3.A. EPSDT Outreach and Case Management entities shall provide pregnant women, children, their parents or legal guardians (based on the current eligibility information received from the Department) the following within 60 days of eligibility through oral communication including face to face meetings, discussions or telephone conversations, as well as written materials: ~~upon request from the individual client and/or family:~~

1. Information about EPSDT services and how to access them.

2. Education on the importance of preventive health care with an emphasis on well child exams, developmental and depression screenings, dental examinations~~screenings~~, immunizations, and prenatal care.

3. Assistance in selecting a Primary Care Physician (PCP) or Managed Care Organization (MCO), and to supply a list of available options if requested. Children without a PCP shall be informed of the choices of PCPs and/or MCOs. Families/children shall notify the enrollment broker of their choice as described in 10 C.C.R. 2505-10, Section 8.205.

4. Assist clients in choosing an Accountable Care Organization if appropriate.

5~~4~~. Assistance with coordinating primary health coverage with Medicaid benefits.

6~~5~~. Assistance with coordinating ~~in arranging~~ appointments with providers, including assistance with missed appointments.

~~6. Follow-up when an appointment is not kept including efforts to assist with rescheduling the missed appointment.~~

7. Assistance with reporting the birth of newborns to the local department of human/social services.

8. A current list of covered and uncovered services available in the community.

9. Information regarding the availability of non-emergency medical transportation. ~~if such assistance is required and approved.~~

8.280.4 EPSDT SERVICES

8.280.4.A. Periodic screening is a procedure used to determine a child's mental and physical growth progress, and to identify a disease or abnormality. Screening identifies additional diagnosis and treatments of physical or emotional problems.

1. Screening shall include a comprehensive health assessment performed soon after birth or as early as possible in a child's life and repeated at periodic intervals of time as recommended by the Colorado periodicity schedules.

2. The periodicity schedules describe the intervals at which preventive physical, sensory, developmental and behavioral screening, including vision; hearing and dental services shall be performed for enrolled children and youth age 20 and under. The periodicity schedules also include the recommended frequency of follow-up examinations.

3. The components of a screen shall include:

   a. A comprehensive unclothed physical exam.

b. A detailed health and development history.

c. An assessment of vision, hearing, mouth, oral cavity and teeth, including referral to a dentist beginning at age 1, and other systems including but not limited to: Respiratory, Cardiovascular, Gastrointestinal, Genitourinary, Musculoskeletal, Skin, Neurologic, Psychiatric/Emotional/Education, and Nutrition~~mental/behavioral health, nutritional status, cardiovascular and respiratory function, genital/urinary and gastrointestinal systems~~.

d. A developmental screening~~assessment~~ including a range of activities to determine whether a child's emotional and developmental processes fall within a benchmarked range of achievement schedule according to the child's age group and cultural background. This screening~~assessment~~ shall include self-help and self-care skills, gross and fine motor development, communication skills or language development, social-emotional development, cognitive skills and appropriate mental/behavioral health screening.

e. Appropriate immunizations according to the schedule established by the Advisory Committee on Immunization Practices (ACIP) for pediatric vaccines.

f. Lead Toxicity Screening - All children are considered at risk and should be screened for lead poisoning via blood testing. Children between the ages of 36 months and 72 months of age should receive a ~~screening~~ blood lead test if they have not been previously ~~screened~~ tested for lead poisoning.

g. Any appropriate age-specific screening or laboratory tests at intervals recommended by the Colorado Periodicity Schedule.

h. Health education and anticipatory guidance.

4. Screenings shall be age appropriate and performed in a culturally and linguistically sensitive manner by a provider qualified to furnish primary medical and/or mental health care services.

5. Results of screenings and examinations shall be recorded in the child's medical record. Documentation shall include at a minimum identified problems and negative findings and further diagnostic studies and/or treatments needed and date ordered.

8.280.4.B. Inter-Periodic exam

Inter-periodic exam shall be any health care that occurs outside the periodic preventive care screening such as a further diagnosis, evaluation, acute or sick care.

8.280.4.C. Diagnosis and treatment

1. When a screening examination indicates the need for further evaluation of the individual's health, diagnostic services are provided.

2. If the screening provider is not licensed or equipped to render the necessary treatment or further diagnosis, the screening provider shall refer the individual to an appropriate enrolled practitioner or facility, or to the EPSDT Outreach and Case Management ~~Healthy Communities~~ Office for supportive help in locating an appropriate provider.

3~~2~~. Treatment to correct or ameliorate defects, physical and mental illnesses or conditions discovered by the screening and diagnostic services shall be available.

8.280.4.D. Personal Care Services

Personal Care Services as defined in 8.280.1, are a benefit for clients age 20 and unders ~~0 to 20 years of age~~ who meet the criteria for EPSDT.

8.280.4.E ~~Other health care services~~ ~~OTHER EPSDT~~ ~~BENEFITS~~Other EPSDT Benefits

Other health care services may include ~~expanded~~ other EPSDT benefits if the need for such services is identified ~~during a periodic screening or inter-periodic exam~~. The services are a benefit when they meet the following requirements:

1. The service is in accordance with generally accepted standards of medical practice.
2. The service is clinically appropriate in terms of type, frequency, extent, and duration.
3. The service provides a safe environment or situation for the child.
4. The service is not for the convenience of the caregiver.
5. The service is medically necessary.
6. The service is not experimental or investigational and is generally accepted by the medical community for the purpose stated.
7. The service is the least costly. ~~, effective means.~~

~~a. Early language intervention for children ages birth through three with a hearing loss may be provided by audiologists, speech therapists, speech pathologists and Colorado Home Intervention Program (CHIP) providers.~~

~~b. Family Planning Services shall be provided in accordance with 10 C.C.R. 2505-10, Sections 8.730 et seq.~~

~~c. Obstetrical services shall include prenatal care services and physician or certified nurse-midwife services in pregnancy, labor, delivery and 60 days postpartum.~~

~~d. Mental and behavioral health care and treatment shall be provided in accordance with the State Plan, Sections 3.1and 4.39.~~

~~e. Wrap-around services~~

~~i) Wrap-around services include those services not included in the client's MCO benefit package, or services that exceed coverage limitations under the contract between the MCO and the Department.~~

~~f. EPSDT extraordinary home health services shall be provided in accordance with 10 C.C.R. 2505-10, Sections 8.257 et seq.~~

8.280.5 LIMITATIONS/SPECIAL CONSIDERATIONS

8.280.5.A. Experimental services or procedures are excluded.

8.280.5.B. Services or items not generally accepted as effective by the medical community are excluded.

8.280.5.C. Pharmaceutical items not requiring a prescription are excluded unless prior authorized and medically necessary.

~~8.280.5.D. Determination of the refractive state only is allowable as a partial vision screening. The code shall not be billed with general ophthalmologic examinations or other evaluation and management codes. Separate or "stand-alone" charges for refractions are not billable to clients as non-benefit services.~~

8.280.5.D~~E~~. Eyeglasses are a benefit only when ordered by an ophthalmologist or an optometrist. Vision benefits are limited to single or multi-focal clear plastic lenses and one standard frame. ~~Repair of eyeglasses is covered only when due to broken frames or lenses. Replacement glasses shall be provided when medically necessary or when the glasses are damaged to the extent that repairs are not cost effective.~~

~~1. If a child, parent or legal guardian desires options that have additional costs, the amount reimbursed for standard frames and clear lenses shall be applied to the total cost of these services. This shall also apply to repair or replacement of broken eyeglasses. The EPSDT provider shall be permitted to charge the child for the difference between the retail price of the service and the amount paid by the Department. Providers shall notify the child and the child's parent or legal guardian or the child's designated client representative in writing of the difference and obtain the signature of the child's parent or guardian or designated client representative indicating agreement to pay the additional costs.~~

8.280.5.E~~2~~. ~~–~~Contact lenses or orthoptic vision treatment services shall be a benefit when medically necessary and shall require prior authorization submitted by an Ophthalmologist, Optometrist, or Optician.

8.280.5.F. ~~3.~~ Orthodontic services are available for children with congenital, severe developmental or acquired handicapping malocclusions when the orthodontist documents Medical Necessity that is confirmed by pre-treatment case review. Orthodontists shall submit requests for prior authorization of covered orthodontic services.

8.280.5.G~~H~~. ~~–~~Early language intervention for children age birth through three with a hearing loss may be provided by audiologists, speech therapists, speech pathologists and Colorado Home Intervention Program (CHIP) providers

8.280.6 REFERRALS

When a client is enrolled a managed care plan, a referral from his/her primary care physician may be required for care provided by anyone other than the primary care physician. Any client may self-refer for routine vision, dental, hearing, mental health services or family planning services.

8.280.7 PRIOR AUTHORIZATIONS

Providers shall be responsible for obtaining prior authorization when required for identified services such as home health, orthodontia, private duty nursing and pharmaceuticals. Prior authorization of services is not a guarantee of payment.

8.280.8 MANAGED CARE AND CONTRACTED HEALTH CARE SERVICES

8.280.8.A The Contractor must ensure the delivery of EPSDT services for Contractor Covered Services. The Contractor~~Plan~~ must have written policies and procedures for providing EPSDT services including lead testing~~screenings~~ and immunizations to the eligible population. ~~Memberschildren and youth ages 20 and under under twenty-one (21) years of age and~~under and ~~all pregnant women.~~

8.280.8..B. The ContractorPlan must comply with all EPSDT regulations set forth in 1905(a), 42 USC 1396d(r)(5) and 42 USC 1396d(a), and performance will be verified by paid claims.

8.280.8.C. The ContractorPlan must assure the provision of all required components of periodic health screens., including lead screenings at twelve (12) and twenty four (24) months of age, children between thirty six (36) seventy two (72) months if not previously screened for leadtesting.

8.280.8.D. At a minimum, such efforts shall include:

1. education and outreach to eligiblesEnrollees of the importance of EPSDT services;

2. a proactive approach to ensure eligibles obtain EPSDT services;

3. systematic communication process with network providers regarding the Department'sivision's EPSDT requirements;

4. process to measure and assure compliance with the EPSDT schedule; and,

5. a process to assure that the medically necessary services not covered by the PlanContractor are referred to the Office of MedicalClinical Services for action; and,

6. comply with all reporting requirements and data needs for federal reporting.

8.280.98 REIMBURSEMENT

Reimbursement shall be in accordance with the regulations for pricing health services as reflected at 10 C.C.R. 2505-10, Section 8.200 for all EPSDT medical screening, diagnostic and treatment services.

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Merging of Clients in the Persons Living With AIDS (PLWA) Waiver to the Elderly, Blind, and Disabled (EBD) Waiver, Section 8.485.
Rule Number:	MSB 13-10-03-A
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin/(303) 866-2549

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 13-10-03-A, Revision to the Medical Assistance Rule Concerning the Merging of Clients in the Persons Living With AIDS (PLWA) Waiver to the Elderly, Blind, and Disabled (EBD) Waiver, Section 8.485.
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) 8.485, 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*

Revise all current text beginning at §8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED (HCBS-EBD) GENERAL PROVISIONS through the end of §8.486.300.301 with new text provided. The change is effective March 30, 2014

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Merging of Clients in the Persons Living With AIDS (PLWA) Waiver to the Elderly, Blind, and Disabled (EBD) Waiver, Section 8.485.
Rule Number:	MSB 13-10-03-A
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin/(303) 866-2549

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 Rule changes the EBD waiver to allow for clients receiving services on the PLWA waiver to now receive services on the EBD 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 U.S.C. Section 1915 (c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);
   25.5-6-301 et seq., C.R.S. (2013)

Initial Review	**01/10/2014**	Final Adoption	**02/14/2014**
Proposed Effective Date	**03/30/2014**	Emergency Adoption	

DOCUMENT #04

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning Merging of Clients in the Persons Living With AIDS (PLWA) Waiver to the Elderly, Blind, and Disabled (EBD) Waiver, Section 8.485.
Rule Number:	MSB 13-10-03-A
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin/(303) 866-2549

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.

   Clients in the PLWA waiver will benefit from the proposed rule by allowing access to the services under the EBD waiver. The cost of the proposed rule change is not projected to have any impact and will be covered by the current appropriation for HCBS-EBD waiver services.

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

   There is not a quantitative nor a qualitative impact on clients.

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 additional cost to the Department outside of current appropriation of waivered services.

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

   The Department is actively working to simplify the delivery of services under its 1915(c) waivers to ensure all clients have access to necessary and consistent services without regard to their disability diagnosis. Merging PLWA into EBD is one step in ensuring continuity of services and service delivery options across Colorado's waivers.

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 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 achieving the purpose of the proposed rule and of simplifying waivered services.

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

8.485.10 LEGAL BASIS

The Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-EBD program is also authorized under state law at ~~26-4-601 et seq., C.R.S. (1991 Supplement), and 25.5-6-301 et seq. as amended~~C.R.S. § 25.5-6-301 et seq. – as amended.

8.485.20 KEYS AMENDMENT COMPLIANCE

~~All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the Social Security Act of 1935 and 45 CFR Part 1397 (October 1,1991), by possession of a valid Assisted Living Residence license Personal Care Boarding Home license issued under C.R.S. 25-27-105, and regulations of the Colorado Department of Public Health and Environment, at 6 CCR 1011-1, Chapters 2 and Chapters 7. Pursuant to 24-4-103(12.5) C.R.S., the Department maintains with 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, CO 80203. Additionally, any incorporated material in these rules may be examined at any State depository library.~~ All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616€ of the Social Security Act of 1935 and 45 C.F.R. Part 1397 (October 1, 1991), by possession of a valid Assisted Living Residence license issued under C.R.S. § 25-27-105, and regulations of the Colorado Department of Public Health and Environment at 6 C.C.R. 1011-1, Chapters 2 and 7. C.R.S. § 25-27-105 and 6 C.C.R. 1011-1 are hereby incorporated by reference. The incorporation of C.R.S. § 25-27-105 and 6 C.C.R. 1011-1 excludes later amendments to, or editions of, the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), 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.~~No amendments or later editions are incorporated. The program assistant of the Community Based Long Term Care Section of the Colorado Department of Health Care Policy and Financing may be contacted at 1575 Sherman, Denver, CO 80203, for a copy of 45 CFR Part 1397; or the material may be examined at any State Publications Depository Library.~~

8.485.30 SERVICES PROVIDED [Eff. 12/30/2007]

.31 HCBS EBD services provided as an alternative to nursing facility or hospital care ~~placement~~ include:

A. Adult day services; and

B. Alternative care facility services, including homemaker and personal care services in a residential setting; and

C. Electronic monitoring; and

D. Home modification; and

E. Homemaker services; and

F. Non-medical transportation; and

G. Personal care; and

H. Respite care; and

I. In-Home Support Services; and

J. Community Transition Services; and

K. Consumer Directed Attendant Support Services.

.32 Case management is not a service of the HCBS-EBD waiver program, but shall be provided as an administrative activity through Single Entry Point Agencies.

.33 HCBS-EBD clients are eligible for all other Medicaid state plan benefits, including the Home Health program.

8.485.40 DEFINITIONS OF SERVICES [Eff. 12/30/2007]

A. Adult day services shall be as defined at Section 8.491.

B. Alternative Ceare Facility services shall be as defined at Section 8.495.

C. Electronic monitoring services shall be as defined at Section 8.488.

D. Home modification shall be as defined at Section 8.493.

E. Homemaker services shall be as defined at Section 8.490.

F. Non-medical transportation services shall be as defined at Section 8.494.

G. Personal care services shall be as defined at Section 8.489.

H. Respite care shall be as defined at Section 8.492.

I. In-Home Support Services shall be as defined at Section 8.552.

J. Community Transition Services (CTS) shall be as defined at Section 8.553.

K. Consumer Directed Attendant Support Services (CDASS) shall be defined at Section 8.510.

8.485.50 GENERAL DEFINITIONS

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

B. Assessment shall be as defined at 8.390.1(B).

C. Case management -shall be as defined at 8.390.1(D), including the calculation of client payment and the determination of individual cost-effectiveness.

~~D. Case~~ Services plan ~~shall be as defined 8.390.1 C, including the funding source, frequency, amount and provider of each service. This case plan shall be written on a State-prescribed Long Term Care Plan form.~~

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

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

~~G~~F. Uncertified Congregate Facility -shall be a facility as defined at 8.485.50(F) that is not certified as an Alternative Care Facility. See 8.495.1~~1~~.

~~H~~G. Continued stay review- shall be a re-assessment as defined at section 8.402.60 ~~through 8.402.65~~ and 8.390.1(C).

~~I~~H. Corrective action plan -shall be as defined at 8.390.1(E).

~~J~~I. Cost containment -shall be defined as the determination that, on an individual client basis, the cost of providing care in the community is less than the cost of providing care in an institutional setting. The cost of providing care in the community shall include the cost of providing HCBS-EBD services and~~,~~ long term home health services. ~~and care provided under the Home Care Allowance Program.~~

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

~~L~~K. Diverted- shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized, as defined at 8.485.50(K).

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

~~N~~M. Intake/screening/referral -shall be as defined 8.390.1(J).

~~O~~N. Level of care screen ~~-~~shall be as defined at 8.401.

~~P. Non-diversion shall be defined as a client who was certified by the Utilization Review Contractor as meeting the level of care screen and target group for the HCBS-EBD program, but who did not receive HCBS-EBD services for some other reason.~~

~~Q~~O. Provider agency~~-~~ shall be defined as an agency, certified by the Department and which has a contract with the Department to provide one of the services listed at 8.485.40. A single entry point agency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria at 8.393.61 are met.

~~R~~P. Reassessment ~~-~~shall be as defined at 8.390.1(~~L~~)N).

~~D~~Q. Service plan shall be as defined 8.390.1 C, including the funding source, frequency, amount and provider of each service. This case plan shall be written on a State-prescribed Long Term Care Plan form.

~~S~~R. Single entry point agency ~~-~~shall be defined as an organization as described at 8.390.1(R)~~90.(1)(P)~~.

~~T~~S. Department ~~-~~shall be defined as the state agency designated as the single state Medicaid agency for Colorado, or any divisions or sub-units within that agency.

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

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

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

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

~~V~~U. Transition Coordination Agency (TCA) ~~means~~ shall be defined as an agency certified by the Department to provide CTS. ~~-~~To be a certified TCA, the agency shall provide at least two independent living core services. Independent living core services means information and referral services, independent living skills training, peer counseling, including cross-disability peer counseling and individual and systems advocacy.

8.485.60 ELIGIBLE PERSONS

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

A. Financial Eligibility

~~Clients shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual of the Colorado Department of Human Services at 9 CCR 2503-1 and the Colorado Department of Health Care Policy and Financing regulations at 10 CCR 2505-10 Section 8.100, Medical Assistance Eligibility., at 8.100.~~Clients shall meet the eligibility criteria as specified in the Income Maintenance Staff Manual of the Colorado

Department of Human Services at 9 C.C.R. 2503-1 and the Colorado Department of Health Care Policy and Financing regulations at 10 C.C.R. 2505-10 Section 9.100, Medical Assistance Eligibility, which are hereby incorporated by reference. The incorporation of 9 C.C.R. 2503-1 and 10 C.C.R. 2505-10 Section 8.100 exclude later amendments to, or editions of, the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), 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.

B. Level of Care and Target Group

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

1. Determined by the ~~Utilization Review Contractor~~Single Entry Point agency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult, or persons living with AIDS as defined at Section 8.400.16; and

2. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to Section 8.401.11 through 8.401.15; ~~and~~or

3. Determined by a formal level of care assessment to require the level of care available in a hospital ~~utilizing the Adult and Pediatric Severity of Illness/Intensity of Service Criteria (APSI/ISC).~~; ~~and.~~

~~4~~3. A length of stay shall be assigned by the ~~Utilization Review Contractor~~Single Entry Point agency for approved admissions, according to guidelines at Section 8.402.60.

C. Receiving HCBS-EBD Services

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

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

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

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

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD services while residing in such institutions unless the ~~SEP~~ single entry point agency determines the client is eligible for EBD as described in 10 C.C.R. 2505-10 §8.486.33.

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

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

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

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

E. Cost-effectiveness

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

F. Waiting List

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

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

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

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

   a. Clients being deinstitutionalized from nursing facilities.

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

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

d. Clients with high ULTC 100.2 scores who are at risk of imminent nursing facility placement.

8.485.70 START DATE

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

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

B. Level of Care : This date is determined by the official Utilization Review Contractor's stamp and the Utilization Review Contractor -assigned start date on the ULTC 100.2 form.

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

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

.72 The start date for CTS may precede HCBS-EBD enrollment when a client meets the conditions set forth at 10 C.C.R. 2505-10 8.486.33. The start date for CTS shall be no more than 180 calendar days before a client's discharge from a nursing facility.

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

.81 When a client has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, the Department may reduce Medicaid payment for Alternative Care Facility services according to the procedures at Section 8.486.60.

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

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

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

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

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

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

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

.95 Every PAR shall be supported by information on the ~~Long Term Care Plan form~~Service Plan, the ULTC-100.2 and written documentation from the income maintenance technician of the client's current monthly income. All units of service requested on the PAR shall be listed on the ~~Long Term Care Plan form.~~Service Plan. ~~If a range of units is estimated on the care plan, the number of units at the higher end of the range may be requested on the PAR. As needed or PRN services must be given a numerical estimate on the care~~ Service Plan~~plan.~~

~~.96 If a PAR includes a request for home modification services above the Department prescribed amount, the PAR shall also include all documentation listed at Section 8.493.~~

~~.97~~ 96 If a PAR is for an Alternative Care Facility client who is 300% eligible, all medical and remedial care requested as deductions shall be listed on the Client Payment form.

.~~98~~ 97 The start date on the Prior Authorization Request form shall not precede the start date of eligibility for HCBS-EBD services, according to Section 8.485.70, except for CTS. A TCA may provide CTS up to 180 days prior to nursing facility discharge when authorized by the ~~SEP~~single entry point agency. The TCA is eligible for reimbursement beginning on the first day of the client's HCBS-EBD enrollment.

.~~99~~ 98 The PAR shall not cover a period of time longer than the length of stay assigned by the Utilization Review Contractor.

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

8.485.200 LIMITATIONS ON PAYMENT TO FAMILY

.201 In no case shall any person be reimbursed to provide HCBS EBD services to his or her spouse.

.202 Family members other than spouses may be employed by certified personal care agencies to provide personal care services to relatives under the HCBS EBD program subject to the conditions below. For purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption or common law.

.203 The family member shall meet all requirements for employment by a certified personal care agency, and shall be employed and supervised by the personal care agency.

.204 The family member providing personal care shall be reimbursed, using an hourly rate, by the personal care agency which employs the family member, with the following restrictions:

A. The total number of Medicaid personal care units for a member of the client's family shall not exceed the equivalent of 444 ~~personal care units~~hours per annual certification for HCBS-EBD ~~and HCBS-PLWA~~.

1. The maximum number of Medicaid personal care units per annual certification for HCBS-EBD ~~and HCBS-PLWA~~ shall include any portions of the Medicaid reimbursement which are kept by the personal care agency for unemployment insurance, worker's compensation, FICA, cost of training and supervision, and all other administrative costs.

2. The maximum number of hours for personal care units ~~per annual certification for~~ HCBS-EBD ~~and HCBS-PLWA~~ shall be 444. Family members must average at least 1.2164 hours of care per day (as indicated on the client's ~~care plan~~Service Plan) in order to receive the maximum reimbursement.

a. If the certification period for HCBS-EBD ~~and HCBS-PLWA~~ is less than one year, the maximum reimbursement for relative personal care shall be calculated by multiplying the number of days the client is receiving care by the average ~~units~~ hours per day of personal care for a full year (444/365=1.2164).

B. If two or more HCBS EBD clients reside in the same household, family members may be reimbursed up to the maximum for each client if the services are not duplicative and are appropriate to meet the client's needs.

C. When HCBS EBD funds are utilized for reimbursement of personal care services provided by the client's family, the home care allowance cannot be used to reimburse the family.

D. Restrictions on allowable personal care units shall not apply to parents who provide Attendant services to their eligible children under In-Home Support Services (- §8.552).

E. Services other than personal care shall not be reimbursed with HCBS EBD funds when provided by the client's family, with the exception of Attendant services provided under In-Home Support Services (§8.552).

8.485.300 CLIENT RIGHTS

.301 The case manager shall inform persons eligible for HCBS-EBD, in writing, of their right to choose between HCBS-EBD services and nursing facility or hospital care. In addition, the case manager shall discuss the option and potential benefits of in-home support services with all eligible HCBS-EBD clients.

THIS PAGE NOT FOR PUBLICATION

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 13-10-03-B, Revision to the Medical Assistance Rule Concerning the Repeal of the Persons Living with AIDS Waiver (PLWA), Section 8.496.
3. This action is an adoption of: a repeal of existing rules
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.496, 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*

Delete (repeal) all current text from § 8.496 HOME AND COMMUNITY BASED SERVICES FOR PERSONS LIVING WITH AIDS (HCBS-PLWA) GENERAL PROVISIONS through the end of §8.496.960 and replace with new text provided. This change is effective March 30, 2014

*to be completed by MSB Board Coordinator

THIS PAGE NOT FOR PUBLICATION

Title of Rule:	Revision to the Medical Assistance Rule Concerning the Repeal of the Persons Living with AIDS Waiver (PLWA), Section 8.496.
Rule Number:	MSB 13-10-03-B
Division / Contact / Phone:	Long Term Services & Supports/Colin Laughlin/(303)866-2549

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 rule repeals the PLWA waiver to allow for clients receiving services on the PLWA waiver to now receive services on the EBD 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 U.S.C. Section 1915(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2013);

Initial Review	**01/10/2014**	Final Adoption	**02/14/2014**
Proposed Effective Date	**03/30/2014**	Emergency Adoption	

DOCUMENT #05

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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.

   Clients in the PLWA waiver will benefit from the proposed rule by allowing access to the services under the EBD waiver. The cost of the proposed rule change is not projected to have any impact and will be covered by the current appropriation for HCBS-EBD waiver services.

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

   There is not a quantitative nor a qualitative impact on clients.

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 additional cost to the Department outside of current appropriation of waivered services.

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

   The Department is actively working to simplify the delivery of services under its 1915(c) waivers to ensure all clients have access to necessary and consistent services without regard to their disability diagnosis. Merging PLWA into EBD is one step in ensuring continuity of services and service delivery options across Colorado's waivers.

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 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 achieving the purpose of the proposed rule and of simplifying waivered services.

(Repealed effective March 30, 2014)

8.496 HOME AND COMMUNITY BASED SERVICES FOR PERSONS LIVING WITH AIDS (HCBS-PLWA) GENERAL PROVISIONS

8.496.10 LEGAL BASIS

The Home and Community Based Services for Persons Living with AIDS (HCBS-PLWA) program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-PLWA program is also authorized under state law at 26-4-641 et. seq., C.R.S. (1991 Supplement), as amended.

8.496.20 KEYS AMENDMENT COMPLIANCE

All congregate facilities where any HCBS client resides must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the Social Security Act of 1935 and 45 CFR Part 1397. (October 1, 1991), by possession of a valid Assisted Living Residence license issued under C.R.S. 25-27-105, and regulations of the Colorado Department of Public Health and Environment at 6.CCR 1011-1, Chapters 2 and Chapters 7. No amendments or later editions are incorporated. The program assistant of the Community Based Long Term Care Section of the Colorado Department of Health Care Policy and Financing may be contacted at 1575 Sherman, Denver, CO 80203, for a copy of 45 CFR Part 1397; or the material may be examined any State Publications Depository Library.

8.496.30 SERVICES PROVIDED

.31 HCBS-PLWA services provided as an alternative to nursing facility or hospital care include:

A. Adult day services; and

B. Homemaker services; and

C. Electronic, monitoring; and

D. Personal care; and

E. Private duty nursing and

F. Non-medical transportation

.32 Case management shall not be a service of the HCBS-PLWA waiver program, but shall be provided as administrative activity through single entry point agencies.

.33 HCBS-PLWA clients are eligible for including the Home Health program all other Medicaid state plan benefits,

8.496.40 DEFINITIONS OF SERVICES

A. Adult Day Services shall be services as defined at §8.491.

B. Homemaker Services shall be services as defined at §8.490.

C. Electronic Monitoring Services shall be services as defined at §8.488.

D. Personal Care shall be services as defined at §8.489.

E. Private Duty Nursing shall be services as defined at §8.496.950.

F. Non-Medical Transportation Services shall be services as defined at §8.494.

8.496.50 GENERAL DEFINITIONS

A. Agency shall be as defined at §8.485.50(A).

B. Assessment shall be an assessment as defined at §8.485.50(B).

C. Case Management shall be case management as defined at 58.

D. Case Plan shall be a case Plan as defined at §8.485.50(D)

E. Categorically Eligible , as the term is used in relation to the program, shall be as defined at §8.485.50(E).

F. Congregate Facility shall be as defined at §8.485.50(F)

G. Continued Stay Review shall be a reassessment as define through §8.402.65.

H. Corrective Action Plan shall be a corrective action plan §8.390.1(E).

I. Cost Containment shall be defined as the determination individual client basis, the average daily cost of providing HCBS-PLWA services, plus care provided under the Home Care Allowance program, does not exceed the equivalent daily cost of nursing facility care, or of hospital care, according to the assigned level of care.

J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type services reimbursed by Medicaid, within fourteen calendar days of admission to HCBS-PLWA at the nursing facility level of care; or who were hospitalized on the day of admission to HCBS-PLWA at the hospital level of care.

K. Diverted shall be defined as HCBS-PLWA waiver clients who were not deinstitutionalized, as defined at §8.496.50(J).

L. Home and Community Based Services for Persons Living with AIDS shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing facility care or hospital care without the provision of HCBS-PLWA; and for whom HCBS-PLWA service's can be provided at no more than the cost of nursing facility care for persons needing nursing facility level of care, or no more than the cost of hospital care for persons needing hospital level of care.

M. Intake/Screening/Referral shall be intake/screening/referral as defined at §8.485.50(N).

N. Level Of Care Screen shall be level of care screen as defined at 58.401.

O. Non-Diversion shall be defined as a client who was certified by the Utilization Review Contractor as meeting the level of care screen and target group for the HCBS-PLWA program, but who did not receive HCBS-PLWA services for some other reason.

P. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department to provide one of the services listed at §8.496.40. A single entry point agency is not a provider agency. Case management is not a service, but is administrative activity.

Q. Reassessment shall be reassessment as defined at §8.390.1 (L).

R. Single Entry Point Agency shall be an organization as described at §8.390(1)(P).

S. Department shall be defined at §8.485.50(T).

T. Three Hundred Percent (300%) Eligible shall be three hundred percent (300%) eligible as defined at §8.485.50(U).

8.496.60 ELIGIBLE PERSONS

.61 HCBS-PLWA services shall be offered to persons who meet all of the eligibility requirements below:

A. Financial Eligibility

Clients shall meet the eligibility criteria as specified in Staff Manual Volume 3, and §8.100.

B. Level of Care and Target Group

Clients who have been determined to meet the level of care and target group criteria shall be certified by the Utilization Review Contractor as medically eligible for HCBS-PLWA. The Utilization Review Contractor shall only certify HCBS-PLWA eligibility for those clients:

1. Determined by a Utilization Review Contractor to meet the target group definition for persons living with AIDS, as defined at §8.400.16; and
2. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to §8.401.11 through §8.401.17;or
3. Determined by a formal level of care assessment to require the level of care available in a hospital, utilizing the Adult and Pediatric Severity of Illness/Intensity of Service Criteria (APSI/ISC).
4. The Utilization Review Contractor shall not assign a length of stay longer than one (1) year, for persons at the nursing facility level of care; or for longer than one (1) month, for persons at the hospital level of care.

C. Receiving HCBS-PLWA Services

Only clients who receive, or who have agreed to accept HCBS-PLWA services as soon as all other eligibility criteria have been met, are eligible for the HCBS-PLWA program. Case management shall not be a service and cannot be used to satisfy this requirement. Desire or need for home health services or other Medicaid services that are not HCBS-PLWA services, as listed at §8.496.30, shall not satisfy this eligibility requirement. HCBS-PLWA clients who have received no HCBS-PLWA services for one month shall be discontinued from the program.

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals shall not be eligible for HCBS-PLWA services while residing in such institutions.
2. A client who is already an HCBS-PLWA recipient and who enters a hospital for treatment may not receive HCBS-PLWA services while in the hospital. If the hospitalization continues for thirty (30) days or longer, the case manager shall terminate the client from the HCBS-PLWA program.
3. A client who is already an HCBS-PLWA recipient and who enters a nursing facility may not receive HCBS-PLWA services while in the nursing facility. The case manager must terminate the client from the HCBS-PLWA program if Medicaid pays for all or part of the nursing facility care, or if there is a Utilization Review Contractor-certified ULTC-100 for the nursing facility placement, as verified by telephoning the Utilization Review Contractor.

E. Cost-effectiveness

Only persons who can be safely served within cost containment, as defined at §8.496.50, shall be eligible for the HCBS-PLWA program. The

equivalent cost of nursing facility care or hospital care is calculated by the State according to §8.496.100.

8.496.70 START DATE

.71 The start date of eligibility for HCBS-PLWA services shall not precede the date that all of the requirements at §8.496.60, have been met The first date for which HCBS-PLWA services can be reimbursed shall be the LATER of any of the following:

A. Financial eligibility start date, as defined at 58.485.71 (A).

B. Level of Care start date as defined at §8.485.71 (B).

C. Receiving Services start date as defined at §8.485.71(C).

D. Institutional Status start date as defined at §8.485.71(D).

8.496.80 CLIENT PAYMENT OBLIGATION – POST ELIGIBILITY TREATMENT OF INCOME (PETI)

(PETI) The client payment obligation shall be in accordance with Section §8.485.80, CLIENT PAYMENT OBLIGATION – POST ELIGIBILITY TREATMENT.OF INCOME (PETI).

8.496.90 STATE PRIOR AUTHORIZATION OF SERVICES shall be in accordance with §8.485.90.

8.496.100 STATE CALCULATION OF COST-CONTAINMENT AMOUNTS

.101 The State shall compute the equivalent daily cost of nursing facility care according to §8.485.100.

.102 The State shall calculate the equivalent daily cost of hospital care by determining the total annual costs of hospital care for all Medicaid clients with HIWAIDS who received hospital care, and dividing by the total number of hospital days for this client group.

8.496.200 LIMITATIONS ON PAYMENT TO FAMILY shall be in accordance with §8.485.200.

8.496.300 CLIENT RIGHTS provisions shall be in accordance with §8.485.300.

8.496.400 SINGLE ENTRY POINT AGENCIES PERFORMING HCBS – PLWA CASE MANAGEMENT ACTIVITIES must comply with single entry point rules 2/01/96 at §8.390 through §8.394 and shall comply with all HCBS PLWA specific case management requirements below.

8.496.500 HCBS-PLWA CASE MANAGEMENT FUNCTIONS shall be performed in accordance with §8.486, with the following additional requirements:

8.496.600 ASSESSMENT OF PERSONS IN NEED OF HOSPITAL LEVEL OF CARE

Case managers shall complete the assessment and submit the ULTC-100 to the Utilization Review Contractor, within twenty-four (24) hours after the original referral, whenever a hospital level of care screen is required.

8.496.610 REASSESSMENT OF PERSONS IN NEED OF HOSPITAL LEVEL OF CARE

A. For any client being served in HCBS-PLWA at the hospital level of care, the case manager shall complete the reassessment and submit the ULTC-100 to the Utilization Review Contractor for continued stay review, one (1) calendar week prior to the end of the length of stay.

B. For any client being served in HCBS-PLWA at the nursing facility level of care, whose needs change to require hospital level of care, the case manager shall

complete an assessment and submit the ULTC-100 to the Utilization Review Contractor within twenty-four (24) hours.

C. For any client being served in HCBS-PLWA at the hospital level of care, whose needs change to nursing facility level of care, the case manager shall notify the Utilization Review Contractor by telephone, electronic transmission or fax within one (1) working day; the Utilization Review Contractor shall then assign a new length of stay to the existing ULTC-100 assessment form, provided that all other requirements are met.

8.496.620 COST CONTAINMENT AT HOSPITAL LEVEL OF CARE

.621 To determine cost containment for clients at the hospital level of care, the case manager shall:

A. Determine the maximum authorized costs for all HCBS-PLWA services needed for the period of time covered by the care plan and compute the average cost per day by dividing by the number of days in the care plan period; and

B. Determine that this average cost per day is less than or equivalent to the equivalent daily cost of hospital care, as calculated by the Department according to §8.496.100.

8.496.700 DOCUMENTATION OF CLIENT CHOICE

The case manager shall document the client's choice of HCBS-PLWA services or hospital placement, for persons at the hospital level of care.

8.496.800 HCBS-PLWA PROVIDER AGENCIES shall be subject to all the procedures at §8.487.

8.496.900 HCBS-PLWA SERVICES

8.496.910 ADULT DAY SERVICES shall be provided according to §8.491.

8.496.920 HOMEMAKER SERVICES shall be provided according to §8.490.

8.496.930 ELECTRONIC MONITORING shall be provided in accordance with §8.488.

8.496.940 PERSONAL CARE shall be provided in accordance with §8.489

8.496.950 PRIVATE DUTY NURSING SERVICES (HCBS-PLWA) are hourly, skilled nursing services provided for up to twenty-four hours per day in a home setting to an eligible HCBS-PLWA program client as a cost-effective alternative to hospitalization or nursing facility placement when care cannot be safely managed within the scope and standards of intermittent nursing care.

.951 DEFINITIONS

Private Duty Nursing, for the purposes of this waiver, shall be defined as intensive and continuous, hourly nursing care as different from part-time or intermittent care for persons living with HIV/AIDS.

Eligible HCBS-PLWA Program Recipient shall be defined as a client who requires intensive and prolonged, hourly skilled nursing care on more than an intermittent basis. Criteria which would qualify for skilled nursing services on a continuous basis are:

A. Intravenous, intramuscular, or subcutaneous injections; or

B. Requiring prolonged intravenous administration of nutritional substances, hydration or drugs; or

C. Dependence daily on other respiratory or nutritional support, including tracheostomy tube care, suctioning, oxygen support, or tube feeding; or

D. Insertion, irrigation and replacement of catheters; or

E. Application of dressings involving prescription medications and aseptic techniques; or
F. Treatment of extensive decubitus ulcers or other widespread skin disorder

These criteria are useful as a guide in evaluating whether a client's needs fall within the designation of skilled level of care. Hourly private duty nursing care can only be provided when care is required continuously and when a combination of the above criteria is indicated. Periodic, episodic, or infrequent need for skilled nursing services does not indicate the need for the level of care designation of private duty nursing.

Skilled Nursing shall be defined as services provided under the licensure scope and standards of the Colorado Nurse Practice Act, by a registered nurse under the direction of a physician, or a licensed practical nurse under the supervision of a registered nurse and the direction of a physician.

Hospital shall be defined as an institution primarily engaged in providing to inpatients by or under the supervision of physicians, diagnostic and therapeutic services for the purpose of medical diagnosis, treatment and care of an injured, disabled or sick person.

.952 GENERAL ELIGIBILITY REQUIREMENTS

An HCBS-PLWA program client shall be determined to be eligible for private duty nursing services when the following requirements are met:

A. The client shall be an eligible HCBS-PLWA program client as defined above; and
B. The client shall be medically stable and appropriate for home care, as documented by the physician; and
C. The client's physician shall certify on a Department prescribed form, at least every sixty (60) days, that without these services, the person would require care in a hospital; and
D. The client shall require intensive and prolonged, hourly skilled nursing care on more than an intermittent basis; and
E. All costs to Medicaid in the home shall be less than all costs to Medicaid in the hospital as calculated on a Department prescribed form; and
F. All other available, appropriate, and less expensive non-hospital settings shall first be explored and utilized.

Ineligibility for private duty nursing services shall not affect eligibility for other HCBS-PLWA or Medicaid services.

.953 FAMILY/IN-HOME CAREGIVER REQUIREMENTS

There shall be documented evidence of:

A. A family/in-home caregiver who is reliable, willing, capable, and available to assume care for the recipient; and
B. Designated alternative caregiver(s) who are reliable, willing, capable, and available to provide relief to the family/in-home caregiver, and
C. Demonstration of the specific skills necessary to care for the recipient; and
D. Ability to maintain a home environment that allows for safe home care.

8.496.954 HOME ENVIRONMENTAL REQUIREMENTS

Living arrangements that will allow safe home care must be demonstrated including:

A. Adequate electrical power including back-up power system for life-sustaining equipment; and
B. Adequate room for equipment and supplies; and
C. A clean environment; and

D. A communication system (i.e. telephone, citizen's band radio (CB), radiotelephone, etc.) available 24 hours a day; and

E. Financial stability of family/in-home caregiver, which is adequate to continue environmental support.

.955 PRIVATE DUTY NURSING REQUIREMENTS

Private Duty Nursing Services shall be provided by a Medicaid-reimbursable home health agency using registered nurses or licensed practical nurses who hold a current Colorado Board of Nursing license.

Medicaid-reimbursable home health agency is defined in the §8.520 of this manual.

.956 HOME HEALTH AGENCY PROVIDER REQUIREMENTS

A Medicaid-reimbursable home health agency may be authorized by the single entry point agency to provide private duty nursing services if the agency:

A. Has previous experience in providing hourly private duty nursing services; and

B. Has available nursing personnel with appropriate documented skills for the client's care; and

C. Is willing to contract with a supplemental home health agency, if necessary, to meet the staffing needs of the client, with assurance that this relationship is adequately supervised, and meets the conditions of Medicare/Medicaid participation; and

D. Is willing to have the primary nurse and other personnel, as appropriate, spend time in the hospital prior to discharge, to refine skills and become familiar with individualized care requirements of the HCBS-PLWA client.

8.496.957 DURABLE MEDICAL EQUIPMENT/SUPPLY PROVIDER REQUIREMENTS

A Medicaid certified company supplying life-sustaining and other equipment in the home shall be selected based upon the ability to provide:

A. Twenty-four hour availability of professionals, for equipment repair or phone assistance, as necessary; and

B. Pediatric expertise for recipients under 15 years of age; and

C. Preventative maintenance of equipment; and

D. Written instructions in the home for the operation and maintenance of equipment, including emergency procedures.

.958 ROLES AND RESPONSIBILITIES

A. Role and Responsibilities of the Attending Physician . The attending physician shall:

1. Determine that the client is medically stable and appropriate for home care; and

2. Determine that the client needs intensive and prolonged skilled nursing on more than an intermittent basis; and

3. Certify, on a State-prescribed form, at least every sixty (60) days, that without private duty nursing services the client would require care in a hospital; and

4. Prescribe a plan of care at least every sixty (60) days, which is appropriate to assure the safety of the client in the home setting. The physician's plan of care must include:

a. The client's diagnosis(es) and prognosis: and

b. A statement of each discipline involved in home care; and

c. The frequency, duration, and purpose of each discipline involved: and

d. A brief clinical summary, including pertinent medical and/or psychological/social issues; and

e. Short and long-term goals.; and

f. Referrals being explored; and

g. Involvement of informal resources (i.e., community organizations).

B. Role and Responsibilities of the Single Entry Point Agency . The single entry point agency shall:

1. Identify eligible HCBS-PLWA clients who are appropriate for home care; and

2. Coordinate, in conjunction with the health care team (physician, hospital discharge planner, home health agency), a home care plan that is safe, appropriate, and meets state requirements; and

3. In coordination with the client and the client's family or guardian, include a process in the care plan by which the client may receive necessary care if the client's family or service provider is unavailable due to an emergency situation or to an unforeseen circumstance. The client and the client's family or guardian shall be duly informed of these alternative care provisions at the time the plan is initiated.

4. Determine the number of units of Private Duty Nursing (PDN), in conjunction with the home health agency, based on clients' specific needs and cost containment criteria; and

5. Gather, in conjunction with the health care team, all medical, social, safety, and cost information on state-prescribed forms; and

6. Verify that all eligibility requirements for private duty nursing services under the HCBS-PLWA program are met; and

7. If Department (or its designee) approval for private duty nursing services is received, plan for hospital discharge.

C. The role of the Single Entry Point (SEP) Agency in the management of private duty nursing services cases includes:

1. Providing overall coordination of home services and service providers; and

2. Monitoring cost effectiveness; and

3. Reviewing the home care plan submitted by the Home Health Agency for appropriate utilization of services; and

4. Monitoring and evaluating quality of care. The single entry point agency shall, as appropriate:

a. Attend discharge planning conferences to determine that home care is appropriate, to offer guidance, and to offer preliminary approval for home care; and

b. Assess the home prior to hospital discharge for a safe and appropriate environment; and

c. Conduct on-site visit to each client quarterly, to include an evaluation of:

1) Client/family/in-home caregiver status and satisfaction with services; and

2) Home care plan, to include utilization of alternative resources and striving toward maximum independence; and

d. Initiate corrective action.

If concerns are raised during quality assurance monitoring, the single entry point agency shall inform involved party(ies), in writing, of concerns. Written concern(s) shall be responded to within fifteen (15) days by the involved party and shall include a plan to address or correct any problem. This written plan shall be agreed upon by all involved, to include an anticipated date of correction, and signed by all involved in the concern.

D. Role and Responsibilities of the Home Health Agency . The home health agency shall:

1. Develop and implement each home care plan under the direction of the client's physician and in conjunction with the client and case manager in a manner that will fulfill the client's specific needs: and
2. Assist with the hospital discharge planning process by providing input and information regarding the home care plan, costs, and other state requirements to the single entry point agency; and
3. Assess the home prior to hospital discharge for a safe and appropriate environment; and
4. Communicate the case status with the single entry point agency on timely basis, including changes in physical conditions and/or psychological/social situations which may affect safety and home care needs and
5. Provide private duty nursing services by personnel who have:
    a. Appropriate licensure to practice nursing in Colorado: and
    b. Appropriate documented skills for the specific care required by the client; and
    c. Appropriate orientation and on-going in-service education to meet the client's specific needs.

E. Roles and Responsibilities of the Family/In-home Caregiver :

The role of the family/in-home caregiver in the management of private duty nursing home care will be to:

1. Meet all requirements specified in the Section on FAMILY/IN-HOME CAREGIVER REQUIREMENTS in this manual; and
2. Participate in the planning, coordination, and provision of home care services, including a routine for emergency situations; and
3. Communicate changes in care and care needs to service providers as appropriate; and
4. Work toward maximum independence, including, finding and using alternative resources as appropriate; and

F. Role and Responsibilities of the Client :

The role of the client in the management of private duty home care shall be to participate in home care planning, implementation and evaluation, as the client's ability allows.

8.496.959 REIMBURSEMENT

A. All private duty nursing (PDN) services must be prior authorized by the single entry point agency.

1. Verbal prior authorization must be obtained by the hospital discharge planner and/or the home health agency providing PDN services before hospital discharge.

2. Written prior authorization requests must be received by the Department or its designee from the single entry point agency within ten (10) days of start of private duty nursing services and must include all documentation as requested by the Department's guidelines and procedures.

B. Skilled nursing services for the Private Duty Nursing program shall be reimbursed under the Special Program Code for HCBS-PLWA, in units of one hour, at the following rates:

1. The maximum hourly rate for skilled nursing by a registered nurse shall be $27.39 and shall be subject to adjustment by the Department.

2. The maximum hourly rate for skilled nursing by a licensed practical nurse shall be $19.72 and shall be subject to adjustment by the Department.

8.496.960 NON-MEDICAL TRANSPORTATION shall be provided in accordance with §8.494.