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Title of Rule: Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
Rule Number: MSB 19-06-06-A
Division / Contact / Phone: Payment Reform / Erin Johnson / x4370

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 19-06-06-A, Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
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) Section 8.700, Colorado Department of Health Care Policy and Financing, Child Health Plan *Plus* (10 CCR 2505-3).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.700 with the proposed text beginning at 8.700.1 through the end of 8.700.1. Replace the current text at 8.700.3 with the proposed text beginning at 8.700.3.A.1 through the end of 8.700.3.A.1. Replace the current text at 8.700.5.B with the proposed text beginning at 8.700.5.B through the end of 8.700.5.B. Replace the current text at 8.700.6.D with the proposed text beginning at 8.700.6.D through the end of 8.700.6.D.9. This rule is effective September 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
Rule Number: MSB 19-06-06-A
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STATEMENT OF BASIS AND PURPOSE

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

   This rule revision contains multiple changes to current FQHC rules, including: adding new billable behavioral health provider types; revising outstationing payment to FQHCs; changing the current Alternative Payment Methodology (APM) to reimburse different cost-based rates for physical health, dental, and specialty behavioral health services; and adding a quality component to FQHC rates that will be effective July 1, 2020. This rule change is necessary to account for several changes occurring for ACC 2.0. This rule change is also necessary to change the FQHC payment methodology. The Department has been working on this payment reform activity for FQHCs for over two years.

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. 1396a(bb)(2017)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018); Section 25.5-4-401 C.R.S.

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

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Title of Rule: Revision to the Medical Assistance Rule concerning the FQHC Rule, Section 8.700
Rule Number: MSB 19-06-06-A
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REGULATORY ANALYSIS

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

   This rule will affect the 293,503 Medicaid members that receive medical services at Federally Qualified Health Centers.

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

   Total expenditures for services received at FQHCs during the last fiscal year was $166,604,324.16 or approximately $567.64 per member. The rule change is intended to be budget neutral as the Department is modifying the single encounter rate to three separate encounter rates. Expenditures will increase for certain services and decrease for other services, however, the total cost per visit will remain the same.

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.

   It is anticipated that the proposed rule will be budget neutral to the Department. The addition of eligible behavioral health providers is a change in policy that primarily codifies already existing practices, therefore there will be no additional reimbursable visits. The change in policy regarding the separate rates for separate services will cause rates for specific services to increase or decrease depending on the individual health center's allocation of costs - however, the total costs per visit will remain the same. The quality component that puts a portion of the FQHC APM rates at-risk will potentially decrease FQHC rates, however, the budget impact will not occur until 2020.

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

   Through this rule revision, the Department is making many policy changes that impact FQHCs. However, the intention of each policy change is to incentivize quality

over volume and give FQHCs more flexibility in delivering care. If the Department does not make these changes, the current incentive structure would remain in place.

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

   It would be less intrusive to not make these changes, however, current policy reimburses FQHCs an all-inclusive encounter rate that does not take into account the specific service rendered. The new policy for separate rates will incentivize MCEs to contract with FQHCs as they will reimburse FQHCs at a service specific rate. The quality component will create an incentive structure that allows FQHCs to prove their quality and for the Department to hold FQHCs accountable for the quality of service they provide.

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

   The Department seriously considered maintaining the current all-inclusive encounter rate instead of creating three separate rates for separate services. However, this idea was rejected as it would lead to inconsistencies in payment across the Department's FQHC APMs and decreases MCE willingness to contract with FQHCs.

8.700 FEDERALLY QUALIFIED HEALTH CENTERS

8.700.1 DEFINITIONS

A.~~1.~~ Federally Qualified Health Center (FQHC) means a hospital-based or freestanding center that meets the FQHC definition found in Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015). Title 42 of the Code of Federal Regulations, Part 405, Subpart X (2015) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to C.R.S. 24-4-103(12.5)(V)(b), the agency shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule:

B.~~2.~~ Visit means a one-on-one, face-to-face encounter between a center client and physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, or licensed addiction counselor providing the services set forth in Section 8.700.3.A. Group sessions do not generate a billable encounter for any FQHC services.

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

8.700.2 CLIENT CARE POLICIES

8.700.2.A The FQHCs health care services shall be furnished in accordance with written policies that are developed with the advice of a group of professional personnel that includes one or more physicians and one or more physician assistants or nurse practitioners. At least one member of the group shall not be a member of the FQHC staff.

8.700.2.B The policies shall include:

1. A description of the services the FQHC furnishes directly and those furnished through agreement or arrangement. See Section 8.700.3.A.3.

2. Guidelines for the medical management of health problems that include the conditions requiring medical consultation and/or client referral, the maintenance of health care records and procedures for the periodic review and evaluation of the services furnished by the FQHC.

3. Rules for the storage, handling and administration of drugs and biologicals.

8.700.3 SERVICES

8.700.3.A The following services may be provided by a certified FQHC:

1. General services

a. Outpatient primary care services that are furnished by a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse midwife visiting nurse, clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor, licensed addiction counselor or supervised person pursuing mental health licensure as defined in their respective practice acts.

i. Outpatient primary care services that are furnished by a supervised person pursuing mental health therapy licensure as a licensed clinical social worker, licensed professional counselor, licensed marriage and family therapist, or psychologist in the state of Colorado as defined in their respective practice acts.

b.~~c.~~ Part-time or intermittent visiting nurse care.

c.~~d.~~ Services and medical supplies, other than pharmaceuticals, that are furnished as a result of professional services provided under Section 8.700.3.A.1.a and b.

2. Emergency services. FQHCs furnish medical emergency procedures as a first response to common life-threatening injuries and acute illness and must have available the drugs and biologicals commonly used in life saving procedures.

3. Services provided through agreements or arrangements. The FQHC has agreements or arrangements with one or more providers or suppliers participating under Medicare or Medicaid to furnish other services to clients, including physician services (whether furnished in the hospital, the office, the client's home, a skilled nursing facility, or elsewhere) and additional and specialized diagnostic and laboratory services that are not available at the FQHC.

8.700.3.B A certified FQHC may also provide any service authorized for payment outside the per visit encounter rate by Section 8.700.6.B.

8.700.4 PHYSICIAN RESPONSIBILITIES

8.700.4.A A physician shall provide medical supervision and guidance for physician assistants and nurse practitioners, prepare medical orders, and periodically review the services furnished by the clinic. A physician shall be present at the clinic for sufficient periods of time to fulfill these responsibilities and must be available at all times by direct means of communications for advice and assistance on patient referrals and medical emergencies. A clinic operated by a nurse practitioner or physician assistant may satisfy these requirements through agreements with one or more physicians.

8.700.5 ALLOWABLE COST

8.700.5.A The following types and items of cost for primary care services are included in allowable costs to the extent that they are covered and reasonable:

1. Compensation for the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor and licensed addiction counselor and licensure candidates for clinical psychologist, clinical social worker, licensed marriage and family therapist, and

licensed professional counselor who owns, is employed by, or furnishes services under contract to an FQHC.

2. Compensation for the duties that a supervising physician is required to perform.

3. Costs of services and supplies related to the services of a physician, dentist, dental hygienist, physician assistant, nurse practitioner, nurse-midwife, visiting nurse, qualified clinical psychologist, podiatrist, clinical social worker, licensed marriage and family therapist, licensed professional counselor or licensed addiction counselor.

4. Overhead cost, including clinic or center administration, costs applicable to use and maintenance of the entity, and depreciation costs.

5. Costs of services purchased by the clinic or center.

8.700.5.B Unallowable costs include but are not limited to expenses that are incurred by an FQHC and that are not for the provision of covered services, according to applicable laws, rules, and standards applicable to the Medical Assistance Program in Colorado. An FQHC may expend funds on unallowable cost items, but these costs may not be used in calculating the per visit encounter rate for Medicaid clients.

Unallowable costs, include, but are not necessarily limited to, the following:

1. Offsite Laboratory/X-Ray;

2. Costs associated with clinics or cost centers which do not provide services to Medicaid clients; and,

43. Costs of services reimbursed separately from the FQHC encounter rate as described in Section 8.700.6.B.

8.700.6 REIMBURSEMENT

8.700.6.A FQHCs shall be reimbursed separate per visit encounter rates based on 100% of reasonable cost for physical health services, dental services, and specialty behavioral health services. An FQHC may be reimbursed for up to three separate encounters with the same client occurring in one day and at the same location, so long as the encounters submitted for reimbursement are any combination of the following: physical health encounter, dental encounter, or specialty behavioral health encounter. Distinct dental encounters are allowable only when rendered services are covered and paid by the Department's dental Administrative Service Organization (ASO). Distinct specialty behavioral health encounters are allowable only when rendered services are covered and paid by either the Regional Accountable Entity (RAE) or through the short-term behavioral health services in the primary care setting policy.

8.700.6.B The following services are reimbursed separately from the FQHC encounter rate. These services shall be reimbursed in accordance with the following:

1. Long-Acting Reversible Contraception (LARC) devices shall be reimbursed separately from the FQHC encounter rate. In addition to payment of the encounter rate for the insertion of the device(s), the LARC device(s) must be billed in accordance with Section 8.730 and shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

2. Services provided in an inpatient hospital setting shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

3. The provision of complete dentures and partial dentures must be billed in accordance with Section 8.201. and Section 8.202. and shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

4. Dental services provided in an outpatient hospital setting shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

5. The Prenatal Plus Program shall be billed and reimbursed in accordance with Section 8.748.

6. The Nurse Home Visitor Program shall be billed and reimbursed in accordance with Section 8.749.

7. An FQHC that operates its own pharmacy that serves Medicaid clients must obtain a separate Medicaid billing number for pharmacy and bill all prescriptions utilizing this number in accordance with Section 8.800.

8. Antagonist injections for substance use disorders provided at the FQHC shall be reimbursed the lower of:

   a. Submitted charges; or

   b. Fee schedule as determined by the Department.

8.700.6.C A physical health encounter, a dental encounter, and a specialty behavioral health encounter on the same day and at the same location shall count as three separate visits.

1. Encounters with more than one health professional, and multiple encounters with the same health professional that take place on the same day and at a single location constitute a single visit, except when the client, after the first encounter, suffers illness or injury requiring additional diagnosis or treatment.

8.700.6.D Encounter rates calculations

~~a)~~ Effective July 1, 2018, FQHCs will be paid three separate encounter rates for three separate services: physical health services, dental services, and specialty behavioral health services. Physical health services are covered services reimbursed through the

Department's MMIS, except the short-term behavioral health services in the primary care setting policy. Dental services are services provided by a dentist or dental hygienist that are reimbursed by the Department's dental ASO. Specialty behavioral health services are behavioral health services covered and reimbursed by either the RAE or by the MMIS through the short-term behavioral health services in the primary care setting policy. The Department will perform an annual reconciliation to ensure each FQHC has been paid at least their per visit Prospective Payment System (PPS) rate. If an FQHC has been paid below their per visit PPS rate, the Department shall make a one-time payment to make up for the difference.

1. The PPS rate is defined by Section 702 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) included in the Consolidated Appropriations Act of 2000, Public Law 106-554, Dec. 21, 2000. BIPA is incorporated herein by reference. No amendments or later editions are incorporated.

   Copies are available for a reasonable charge and for inspection from the following person at the following address: Custodian of Records, Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Any material that has been incorporated by reference in this rule may be examined at any state publications depository library.

2. ~~a)~~ Each alternative payment rate shall be the lower of the service specific annual rate or the service specific base rate. The annual rate and the base rate shall be calculated as follows:

   a.~~1.~~ The annual rate for the physical health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for physical health services and visits. The annual rate for the dental rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for dental services and visits provided by a dentist or dental hygienist. The annual rate for the specialty behavioral health rate shall be the FQHCs current year's audited, calculated, and inflated cost per visit for behavioral health services and visits either covered and reimbursed by the RAE or by the short-term behavioral health services in the primary care setting policy.

   b.~~2.~~ The new base rates shall be the audited, calculated, inflated, and weighted average encounter rate for each separate rate, for the past three years. Base rates are recalculated (rebased) annually. Initial Base rates shall be calculated when the Department has two year's data of costs and visits.

   c.~~3.~~ Beginning July 1, 2020, A portion of the FQHCs physical health and specialty behavioral health alternative payment methodology rates are at-risk based on the FQHC's quality modifier. An FQHC's quality modifier is determined by the FQHC's performance on quality indicators in the previous Calendar Year.

3. ~~a)~~ New FQHCs shall file a preliminary FQHC Cost Report with the Department. Data from the preliminary report shall be used to set reimbursement base rates for the first year. The base rates shall be calculated using the audited cost report showing actual data from the first fiscal year of operations as an FQHC. These shall be the FQHCs base rates until the FQHC's final base rates are set.

a.~~b)~~ New base rates may be calculated using the most recent audited Medicaid FQHC cost report for those FQHCs that have received their first federal Public Health Service grant with the three years prior to rebasing, rather than using the inflated weighted average of the most recent three years audited encounter rates.

4. ~~a)~~ The Department shall audit the FQHC cost report and calculate the new annual and base reimbursement rates. If the cost report does not contain adequate supporting documentation, the FQHC shall provide requested documentation within ten (10) business days of request. Unsupported costs shall be unallowable for the calculation of the FQHCs new encounter rate.

   a.~~b)~~ Freestanding and hospital-based FQHCs shall file the Medicaid cost reports with the Department on or before the 90th day after the end of the FQHCs' fiscal year. FQHCs shall use the Medicaid FQHC Cost Report developed by the Department to report annual costs and encounters. An extension of up to 75 days may be granted based upon circumstances. Failure to submit a cost report within 180 days after the end of a freestanding FQHCs' fiscal year shall result in suspension of payments.

   b.~~c)~~ The new reimbursement encounter rates for FQHCs shall be effective 120 days after the FQHCs fiscal year end. The old reimbursement encounter rates (if less than the new audited rate) shall remain in effect for an additional day above the 120-day limit for each day the required information is late; if the old reimbursement encounter rates are more than the new rate, the new rates shall be effective the 120th day after the FQHCs fiscal year end.

5. ~~a)~~ If an FQHC changes its scope of service after the year in which its base PPS rate was determined, the Department will adjust the FQHC's PPS rate in accordance with section 1902(bb) of the Social Security Act.

   a.~~b)~~ An FQHC must apply to the Department for an adjustment to its PPS rate whenever there is a documented change in the scope of service of the FQHC. The documented change in the scope of service of the FQHC must meet all of the following conditions:

      i.~~1.~~ The increase or decrease in cost is attributable to an increase or decrease in the scope of service that is a covered benefit, as described in Section 1905(a)(2)(C) of the Social Security Act, and is furnished by the FQHC.

      ii.~~2.~~ The cost is allowable under Medicare reasonable cost principles set forth in 42 CFR Part 413.5.

      iii.~~3.~~ The change in scope of service is a change in the type, intensity, duration, or amount of services, or any combination thereof.

      iv.~~4.~~ The net change in the FQHC's per-visit encounter rate equals or exceeds 3% for the affected FQHC site. For FQHCs that file consolidated cost reports for multiple sites in order to establish the initial PPS rate, the 3% threshold will be applied to the average per-visit encounter rate of all sites for the purposes of calculating the cost associated with a scope-of-service change.

v.~~5.~~ The change in scope of service must have existed for at least a full six (6) months.

b.~~c)~~ A change in the cost of a service is not considered in and of itself a change in scope of service. The change in cost must meet the conditions set forth in Section 8.700.6.D.5.b and the change in scope of service must include at least one of the following to prompt a scope-of-service rate adjustment. If the change in scope of service does not include at least one of the following, the change in the cost of services will not prompt a scope-of-service rate adjustment.

i.~~1.~~ The addition of a new service not incorporated in the baseline PPS rate, or deletion of a service incorporated in the baseline PPS rate;

ii.~~2.~~ The addition or deletion of a covered Medicaid service under the State Plan;

iii.~~3.~~ Changes necessary to maintain compliance with amended state or federal regulations or regulatory requirements;

iv.~~4.~~ Changes in service due to a change in applicable technology and/or medical practices utilized by the FQHC;

v.~~5.~~ Changes resulting from the changes in types of patients served, including, but not limited to, populations with HIV/AIDS, populations with other chronic diseases, or homeless, elderly, migrant, or other special populations that require more intensive and frequent care;

vi.~~6.~~ Changes resulting from a change in the provider mix, including, but not limited to:

a.~~i.~~ A transition from mid-level providers (e.g. nurse practitioners) to physicians with a corresponding change in the services provided by the FQHC;

b.~~ii.~~ The addition or removal of specialty providers (e.g. pediatric, geriatric, or obstetric specialists) with a corresponding change in the services provided by the FQHC (e.g. delivery services);

c.~~iii.~~ Indirect medical education adjustments and a direct graduate medical education payment that reflects the costs of providing teaching services to interns and/or residents; or,

d.~~iv.~~ Changes in operating costs attributable to capital expenditures (including new, expanded, or renovated service facilities), regulatory compliance measures, or changes in technology or medical practices at the FQHC, provided that those expenditures result in a change in the services provided by the FQHC.

c.~~d)~~ The following items do not prompt a scope-of-service rate adjustment:

i.~~1.~~ An increase or decrease in the cost of supplies or existing services;

ii.~~2~~ An increase or decrease in the number of encounters;

iii.~~3.~~ Changes in office hours or location not directly related to a change in scope of service;

iv.~~4.~~ Changes in equipment or supplies not directly related to a change in scope of service;

v.~~5.~~ Expansion or remodel not directly related to a change in scope of service;

vi.~~6.~~ The addition of a new site, or removal of an existing site, that offers the same Medicaid-covered services;

vii.~~7.~~ The addition or removal of administrative staff;

viii.~~8.~~ The addition or removal of staff members to or from an existing service;

ix.~~9.~~ Changes in salaries and benefits not directly related to a change in scope of service;

x.~~10.~~ Change in patient type and volume without changes in type, duration, or intensity of services;

xi.~~11.~~ Capital expenditures for losses covered by insurance; or,

xii.~~12.~~ A change in ownership.

d.~~e)~~ An FQHC must apply to the Department by written notice within ninety (90) days of the end of the FQHCs fiscal year in which the change in scope of service occurred, in conjunction with the submission of the FQHC's annual cost report. Only one scope-of-service rate adjustment will be calculated per year. However, more than one type of change in scope of service may be included in a single application.

e.~~f)~~ Should the scope-of-service rate application for one year fail to reach the threshold described in Section 8.700.6.D.5.b.4, the FQHC may combine that year's change in scope of service with a valid change in scope of service from the next year or the year after. For example, if a valid change in scope of service that occurred in FY 2016 fails to reach the threshold needed for a rate adjustment, and the FQHC implements another valid change in scope of service during FY2018, the FQHC may submit a scope-of-service rate adjustment application that captures both of those changes. An FQHC may only combine changes in scope of service that occur within a three-year time frame, and must submit an application for a scope-of-service rate adjustment as soon as possible after each change has been implemented. Once a change in scope of service has resulted in a successful scope-of-service rate adjustment, either individually or in combination with another change in scope of service, that change may no longer be used in an application for another scope-of-service rate adjustment.

f.g) The documentation for the scope-of-service rate adjustment is the responsibility of the FQHC. Any FQHC requesting a scope-of-service rate adjustment must submit the following to the Department:

i.1. The Department's application form for a scope-of-service rate adjustment, which includes:

a.i. The provider number(s) that is/are affected by the change(s) in scope of service;

b.ii. A date on which the change(s) in scope of service was/were implemented;

c.iii. A brief narrative description of each change in scope of service, including how services were provided both before and after the change;

d.iv. Detailed documentation such as cost reports that substantiate the change in total costs, total health care costs, and total visits associated with the change(s) in scope; and

e.v. An attestation statement that certifies the accuracy, truth, and completeness of the information in the application signed by an officer or administrator of the FQHC;

ii.2. Any additional documentation requested by the Department. If the Department requests additional documentation to calculate the rate for the change(s) in scope of service, the FQHC must provide the additional documentation within thirty (30) days. If the FQHC does not submit the additional documentation within the specified timeframe, the Department, at its discretion, may postpone the implementation of the scope-of-service rate adjustment.

g.h) The reimbursement rate for a scope-of-service change applied for January 30, 2017 or afterwards will be calculated as follows:

i.1. The Department will first verify the total costs, the total covered health care costs, and the total number of visits before and after the change in scope of service. The Department will also calculate the Adjustment Factor (AF = covered health care costs/total cost of FQHC services) associated with the change in scope of service of the FQHC. If the AF is 80% or greater, the Department will accept the total costs as filed by the FQHC. If the AF is less than 80%, the Department will reduce the costs other than covered health care costs (thus reducing the total costs filed by the FQHC) until the AF calculation reaches 80%. These revised total costs will then be the costs used in the scope-of-service rate adjustment calculation.

ii.2. The Department will then use the appropriate costs and visits data to calculate the adjusted PPS rate. The adjusted PPS rate

will be the average of the costs/visits rate before and after the change in scope of service, weighted by visits.

iii.~~3.~~ The Department will calculate the difference between the current PPS rate and the adjusted PPS rate. The "current PPS rate" means the PPS rate in effect on the last day of the reporting period during which the most recent scope-of-service change occurred.

iv.~~4.~~ The Department will check that the adjusted PPS rate meets the 3% threshold described above. If it does not meet the 3% threshold, no scope-of-service rate adjustment will be implemented.

v.~~5.~~ Once the Department has determined that the adjusted PPS rate has met the 3% threshold, the adjusted PPS rate will then be increased by the Medicare Economic Index (MEI) to become the new PPS rate.

h.~~i)~~ The Department will review the submitted documentation and will notify the FQHC in writing within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable. The new PPS rate will take effect one hundred twenty (120) days after the FQHC's fiscal year end.

i.~~j)~~ Changes in scope of service, and subsequent scope-of-service rate adjustments, may also be identified by the Department through an audit or review process.

i.~~1.~~ If the Department identifies a change in scope of services, the Department may request the documentation as described in Section 8.700.6.D.5.g from the FQHC. The FQHC must submit the documentation within ninety (90) days from the date of the request.

ii.~~2.~~ The rate adjustment methodology will be the same as described in Section 8.700.6.D.5.h.

iii.~~3.~~ The Department will review the submitted documentation and will notify the FQHC by written notice within one hundred twenty (120) days from the date the Department received the application as to whether a PPS rate change will be implemented. Included with the notification letter will be a rate-setting statement sheet, if applicable.

iv.~~4.~~ The effective date of the scope-of-service rate adjustment will be one hundred twenty (120) days after the end of the fiscal year in which the change in scope of service occurred.

j.~~k)~~ An FQHC may request a written informal reconsideration of the Department's decision of the PPS rate change regarding a scope-of-service rate adjustment within thirty (30) days of the date of the Department's notification letter. The informal reconsideration must be mailed to the Department of Health Care Policy and Financing, 1570

Grant St, Denver, CO 80203. To request an informal reconsideration of the decision, an FQHC must file a written request that identifies specific items of disagreement with the Department, reasons for the disagreement, and a new rate calculation. The FQHC should also include any documentation that supports its position. A provider dissatisfied with the Department's decision after the informal reconsideration may appeal that decision through the Office of Administrative Courts according to the procedures set forth in 10 CCR 2505-10 Section 8.050.3, PROVIDER APPEALS.

6. The performance of physician and mid-level medical staff shall be evaluated through application of productivity standards established by the Centers for Medicare and Medicaid Services (CMS) in CMS Publication 27, Section 503; "Medicare Rural Health Clinic and FQHC Manual". If an FQHC does not meet the minimum productivity standards, the productivity standards established by CMS shall be used in the FQHCs' rate calculation.

7. Pending federal approval, the Department will offer, as a pilot program, a second Alternative Payment Methodology (APM 2) that will reimburse FQHCs a Per Member Per Month (PMPM) rate. FQHCs may opt into APM 2 annually. This reimbursement methodology will convert the FQHC's current Physical Health cost per visit rate into an equivalent PMPM rate using historical patient utilization, historical attribution, and the Physical Health cost per visit rate for the specific FQHC. Physical health services rendered to patients not attributed to the FQHC will pay at the appropriate encounter rate. Dental and specialty behavioral health services for all patients will be paid at the appropriate encounter rate. Year 2 rates for FQHCs participating in APM 2 will be set using trended data. Year 3 rates will be set using actual data.

8. The Department will perform an annual reconciliation to ensure the PMPM reimbursement compensates APM 2 providers in an amount that is no less than their PPS per visit rate. The Department shall perform PPS reconciliations should the FQHC participating in APM 2 realize additional cost, not otherwise reimbursed under the PMPM, incurred as a result of extraordinary circumstances that cause traditional encounters to increase to a level where PMPM reimbursement is not sufficient for the operation of the FQHC.

9. PMPM and encounter rates for FQHC participating in APM 2 shall be effective on the 1st day of the month that falls at least 120 days after an FQHC's fiscal year end.

8.700.6.E The Department shall notify the FQHC of its rates.

8.700.8 REIMBURSEMENT FOR OUTSTATIONING ADMINISTRATIVE COSTS

8.700.8.A The Department shall reimburse freestanding FQHCs for reasonable costs associated with assisting clients in the Medicaid application process. Beginning with the 2019 Cost Report Cycle, this outstationing payment shall be made based upon actual cost and is included as an allowable cost in an FQHC cost report.

8.700.8.B

1. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. For any hospital-based FQHC Medicaid cost report audited and finalized after July 1, 2005, Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

2. Hospitals with hospital-based FQHCs shall receive federal financial participation for reasonable costs associated with assisting potential beneficiaries in the Medicaid application process. Effective with the hospital cost report year 2010 and forward, the Department will make an interim payment to Denver Health Medical Center for estimated reasonable costs associated with outstationing activities based on the costs included in the as-filed Medicare cost report. This interim payment will be reconciled to actual costs after the cost report is audited. Denver Health Medical Center shall receive federal financial participation for eligible expenditures. To receive the federal financial participation, Denver Health Medical Center shall provide the state's share of the outstationing payment by certifying that the interim estimated administrative costs and the final audited administrative costs associated with outstationing activities are eligible Medicaid public expenditures. Such certifications shall be sent to the Safety Net Programs Manager.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning the Children's Extensive Supports (CES) waiver, Section 8.503
Rule Number: MSB 19-05-07-A
Division / Contact / Phone: Benefits and Services Management Division / Lindsay Westlund / 303-866-5453

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 19-05-07-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning the Children's Extensive Supports (CES) waiver, Section 8.503
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) 8.503, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.503 with the proposed text beginning at 8.503 through the end of 8.503.170. This rule is effective September 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning the Children's Extensive Supports (CES) waiver, Section 8.503
Rule Number: MSB 19-05-07-A
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STATEMENT OF BASIS AND PURPOSE

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

   The rule revisions to section 8.503 are necessary to remove dated language and update incorrect citations of C.R.S. The Department has removed the heading "Professional services" as it's own service cateogry for the following: massage, movement threapy, and hippotherapy. Instead, each of these services is now it's own service with definition, eligibility for, and scope. Updating offensive language aligns with the Department's commitment to person-centeredness. Updating outdated citations allow for all stakeholders to more easily reference other rules and statues that are applicable to the CES waiver. Removing the heading of "professional services" will assist the Department in future goals to align like benefits and services among other waivers.

   Additionally, the Department must add in a service definition for Youth Day Services. The Department received guidance from the Centers for Medicare and Medicaid Services (CMS) to differentiate Respite and Respite for youth older than 12 years of age. CMS approved of Youth Day in the updated CES waiver application. The Department must add regulations surrounding this service so that it may be operationalized per the approved waiver application.

   The Department is removing regulation that mandates third party documentation be provided as part of the client eligiblity review process for the CES waiver at section 10 CCR 2505-10 8.503.30.A.8.b-c. The Department is committed to ensuring waiver services are accessed appropriately by those members who need this support. The third party documentation required for review for eligibility purposes is more a barrier than useful reporting tool. Most eligiblity critieria for review is provided by the families or caregivers of the child needing services. Too often, the requirement for third party documentaiton creates an unneccessary burden for families to collect as corraboration of already reported behaviors. The Deaprtment is removing this requirement of third party documentation to more closely align with other waivers in Colorado, that allow for the self reporting of needs and supports to determine eligibility.

2. An emergency rule-making is imperatively necessary

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

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

DOCUMENT #

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

Explain:

3. Federal authority for the Rule, if any:

   The Home and Community Based Services Childrens Extensive Supports program (HCBS-CES) 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.

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   C.R.S. 25.5-6-409

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Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning the Children's Extensive Supports (CES) waiver, Section 8.503
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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.

   Children enrolling or on the Children's Extensive Supports (CES) waiver will be affected by this proposed rule in that they will have access to all services approved by the Centers for Medicare and Medicaid Services (CMS), including Youth Day Services. The children and families of children enrolling or on the CES waiver will be affected in that there is potential for a shorter waiting period for determination of eligibility when third party documentation is no longer required for enrollment. Stakeholders reviewing the CES waiver rule will be able to navigate this rule and other rules and statute more easily with updated citations and the removal of dated language.

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

   Quantitatively, we may see the enrollment approvals for this waiver require less time by the State's Utilization Review Contractor (URC). The URC may be able to approve enrollments more quickly without having to wait for additional third-party documentation. The URC will also be able to provide a denial more quickly as there will be less documentation to review.

   Quantitatively, case managers will be able to submit an enrollment application more quickly to the URC, without having to wait on the family gathering third party documentation, which will enable CM's to spend less time on the CES enrollment application allowing them to provide case management to more families/children requiring services.

   Qualitatively, the Department will be providing regulations with person centered language that enforces the goals and perspectives that all people should be treated with respect.

   Qualitatively, the Department will be able to offer an additional service to the families of children served on this waiver that will provide additional support to those parents/ caregivers who are seeking volunteer or employment opportunities. Youth Day

Services will improve access to care and supervision for youth enrolled in the CES waiver while their caregivers work, volunteer or take classes.

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

   The probable decrease in costs, by implementing these changes, is likely to the URC and case management agencies who will no longer have to use resources to gather and review and third-party documentation. The other changes will not have a probable cost to the Department as there is no authority to increase spending limits for CES waiver participants or services. These changes will be made within current monetary and budgetary restrictions.

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

   The benefits of action on this change include: an additional waiver service available to members to choose to utilize within current spending limits, the Department's commitment to person centered language and culture, and the benefit of having up to date references for review by stakeholders. One cost is updating training on the enrollment process for case management and the URC by the Department; however, the benefit will outweigh this cost in the long run when the Department has improved upon enrollment processes without changing the requirements for eligibility.

   The cost of inaction is to continue to operationalize a waiver without all the approved services available to members. Continue to reference dated materials and use poor language in our rules which do not meet our commitment to person centeredness.

   The cost of inaction to removing third party documentation is a process that burdens families without providing the Department the security of only eligible individuals accessing this waiver. It's an additional step, not found in other waiver enrollment processes and will continue to impart burdens on families seeking supports and services.

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

   There are no other options or methods for operationalizing the approved waiver service, Youth Day Service, than by revising rule to add language to meet this end.

   There are no other options for changing dated language and updating citations than to make these changes at times when other more substantial changes are needed.

   The Department has considered other ways to decrease the burden placed on our members, their families, and our case management agencies while applying for the

CES waiver; and the Department has found other steps to take to meet this end goal of creating a more LEAN process. The only way to remove the duplicative requirement of third-party documentation is by way of a regulatory revision.

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 updated citations and removing outdated language than by rule revisions. There are no other ways to remove the third-party documentation required by this waiver enrollment than by removing it in regulation. The Department is pursuing other non-regulatory ways to improve the CES waiver enrollment process which include operational memos, revision to enrollment documents and trainings. There are no other ways for the Department to operationalize a new service without creating a scope, limitations and definitions in rule.

8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (HCBS-CES)

8.503 DEFINITIONS

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

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

AGE APPROPRIATE means the guidelines as defined at Sections 8.400-499, Appendix A: Age Appropriate Guidelines for the use of ULTSS 100.2 Assessment on Children.

APPLICANT means an individual who is seeking a Long-Term Services and Support ~~Long Term Care~~ eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

~~AUTHORIZED REPRESENTATIVE (AR) means an individual designated by the client, parent or legal guardian of a minor, if appropriate, who has the judgment and ability to direct CDASS on the client's behalf and meets the qualifications as defined at 10 CCR 2505-10 Sections 8.510.6 and 8.510.7.~~

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

CLIENT means and individual who meets Long-Term Services and Supports eligibility requirements and has been approved for and agreed to receive Home and Community Based Services (HCBS).

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

~~CLIENT means an individual who has met Long Term client representative may be (A) a legal representative including but not limited to a court appointed guardian, a parent of a minor child, or a spouse, or (B) an individual, family member or friend selected by the parent or guardian of the client to speak for or act on the clients' behalf.~~

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

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

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

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

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

DEVELOPMENTAL DELAY means as defined in Section 8.600.4.

~~a child who is:~~

~~Birth up to age five (5) and has a developmental delay defined as the existence of at least one of the following measurements:~~

~~Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of the five domains of development when compared with chronological age,~~

~~Equivalence of 1.5 standard deviations or more below the mean in one (1) or more of the five domains of development,~~

~~Has an established condition defined as a diagnosed physical or mental condition that, as determined by a qualified health professional utilizing appropriate diagnostic methods and procedures, has a high probability of resulting in significant delays in development, or~~

~~Birth up to age three (3) who lives with a parent who has been determined to have a developmental disability by a Community Centered Board.~~

DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.

~~a disability that is manifested before the person reaches twenty-two (22) years of age, which constitutes a substantial disability to the affected individual, and is attributable to mental retardation or related conditions which include Cerebral palsy, Epilepsy, Autism or other neurological conditions when such condition result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with mental retardation, unless otherwise specifically stated, the federal definition "Developmental Disability" found in 42 U.S.C. Section 6000 *et seq*.~~

~~"Impairment of general intellectual functioning" means that the person has been determined to have an intellectual quotient equivalent which is two or more standard deviations below the mean (70 or less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent. when an individual's general intellectual functioning cannot be measured by a standardized instrument, then the assessment of a qualified professional shall be used.~~

~~"Adaptive behavior similar to that of a person with mental retardation" means that the person has overall adaptive behavior which is two or more standard deviations below the mean in two or more skill areas (communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure, and work), as measured by an instrument which is standardized, appropriate to the person's living environment, and administered and clinically determined by a qualified professional. these adaptive behavior limitations are a direct result of, or are significantly influenced by,~~

~~the person's substantial intellectual deficits and may not be attributable to only a physical or sensory impairment or mental illness.~~

~~"Substantial intellectual deficits" means an intellectual quotient that is between 71 and 75 assuming a scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is standardized, appropriate to the nature of the person's disability, and administered by a qualified professional. the standard error of measurement of the instrument should be considered when determining the intellectual quotient equivalent.DIVISION FOR DEVELOPMENTAL DISABILITIES (DDD) means the Operating Agency for Home and Community Based Services- Children's Extensive Support (HCBS-CES) to persons with developmental delays or disabilities within the Colorado Department of Human Services.~~

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

~~the child health component of the Medicaid State Plan for a Medicaid eligible client up to 21 years of age.~~

FAMILY means a relationship as it pertains to the Cclient and is defined as:

A mother, father, brother, sister, ~~or any combination,~~

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

An adoptive parent,

One or more individuals to whom legal custody of a person with a Ddevelopmental Ddisability has been given by a court,

A spouse or,~~,~~

The Cclient's child.

~~,~~

~~FISCAL MANAGEMENT SERVICE ORGANIZATION means the entity contracted with the Department as the employer of record for attendants, to provide personnel management services, fiscal management services and skills training to a parent or guardian or authorized representative of a client receiving CDASS.~~

FUNCTIONAL ELIGIBILITY means that the Aapplicant meets the criteria for Long-Term Services and Supports ~~Long Term Care services~~ as determined by the Department.

FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long Term Care instrument and medical verification on the Professional Medical Information Page to determine if the Aapplicant or Cclient meets the Iinstitutional Level o~~O~~f Care (LOC).

GUARDIAN means a person who has qualified as a guardian of a minor or incapacitated person pursuant to testamentary or court appointment but excludes a Guardian Ad Litem (C.R.S. 15-10-201).

Guardian ad litem (GAL) means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in article 33 of title 22, C.R.S. and who, if appointed to represent a child in a dependency or neglect proceeding pursuant to article 3 of title 19, C.R.S., shall be an attorney-at-law licensed to practice in Colorado (C.R.S. 13-91-103).

~~an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court. Guardianship may include a limited, emergency, and temporary substitute court appointed guardian but not a guardian ad litem.~~

HOME AND COMMUNITY BASED SERVICES (HCBS) WAIVERS means services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Cclient who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or iIntermediate cCare fFacility for individuals with intellectual disabilities (ICF-IDD).~~the Mentally Retarded (ICF/MR).~~

INSTITUTION means a hospital, nursing facility, facility or ICF-IID~~/MR~~ for which the Department makes Medicaid payments under the state plan.

INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID)~~THE MENTALLY RETARDED (ICF/MR)~~ means a publicly or privately operated facility that provides health and habilitation services to a Cclient with developmental disabilities or related conditions.

LEGALLY RESPONSIBLE PERSON means the parent of a minor child or the person legally obligated to provide care to the Client~~, or the client'lientthe~~.

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

LICENSED MEDICAL PROFESSIONAL means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses; physician, physician assistant and nurse governed by the Colorado Medical Practice~~License~~ Act and the Colorado Nurse Practice Act.

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

~~LONG TERM CARE (LTC) SERVICES means services provided in nursing facilities or, Intermediate Care Facilities for the Mentally Retarded (ICF/MR), or Home and Community Based Services (HCBS), Long Term Home Health Services, the program of All-Inclusive Care for the Elderly, Swing Bed and Hospital Back Up program (HBU).~~

MEDICAID ELIGIBLE means an~~the~~ Aapplicant or Cclient meets the criteria for Medicaid benefits based on the Aapplicant's financial determination and disability determination when applicable.

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

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

NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur in the Cclient's everyday life such as, but not limited to, community supports and relationships with Ffamily members, friends, co-workers, neighbors and acquaintances.

~~OPERATING AGENCY means the Department of Human Services, Division for Developmental Disabilities, which manages the operations of the Home and Community Based Services for Persons with~~

~~Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers under the oversight of the Department of Health Care Policy and Financing.~~

ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDS) means a public or privately managed service organization that provides, at minimum, targeted case management and contracts with other qualified providers to furnish services authorized in the HCBS-DD, HCBS-SLS and HBCS-CES waivers.

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

PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the C~~c~~lient needs institutional Level o~~O~~f Care.

PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency or typical community service agency as defined in~~2 CCR 5~~Section 8.600.4~~16.200 *et seq.*~~, that has received program approval to provide HCBS-CES waiver services.

RELATIVE means a person related to the C~~c~~lient by virtue of blood, marriage, adoption or common law marriage.

RETROSPECTIVE REVIEW means the Department or the Department's contractor ~~Operating Agency's~~ review after services and ~~support~~Supports are provided to ensure the C~~c~~lient received services according to the ~~service plan~~Service Plan and that the Case Management Agency complied with the requirements set forth in statute, waiver and regulation.~~ standards of economy, efficiency and quality of service.~~

SERVICE PLAN means the written document that specifies identified and needed services, regardless of funding source, to assist a C~~c~~lient to remain safely in the community and developed in accordance with the Department's ~~ and the Operating Agency's~~ rules~~. set forth in 10 CCR 2505-10, Section 8.400.~~

SUPPORT is any task performed for the C~~c~~lient where learning is secondary or incidental to the task itself or an adaptation is provided.

TARGETED CASE MANAGEMENT SERVICES (TCM) means case management services provided to individuals enrolled in the HCBS-CES, HCBS-CHRP, HCBS–DD, and HCBS–SLS waivers in accordance with Section 8.760 et seq. Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities: comprehensive assessment and periodic reassessment, development and periodic revision of a Service Plan, referral and related activities, and monitoring.

~~a Medicaid State Plan benefit for a target population which includes: facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources including but not limited to medical, social, educational and other resources to ensure non-duplication of HCBS waiver services and the monitoring of the effective and efficient provision of HCBS waiver services across multiple funding sources.~~

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

UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the Department ~~of Health Care Policy and Financing~~ to review the HCBS-CES waiver applications for determination of eligibility based on the additional targeting criteria.

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

8.503.10 HCBS-CES WAIVER ADMINISTRATION

~~8.503.10.~~A. This section hereby incorporates the terms and provisions of the federally-approved Home and Community Based Services-Children's Extensive Support (HCBS-CES) waiver CO.4180.R03.00. To the extent that the terms of that federally-approved waiver are inconsistent with the provisions of this section, the waiver will control

~~8.503.10.~~B. HCBS-CES waiver for C~~c~~lients ages birth through seventeen years of age with D~~d~~evelopmental D~~d~~elays or disabilities is administered through the designated Operating Agency.

~~8.503.10.~~C. HCBS-CES waiver services shall be provided in accordance with the federally approved HCBS-CES waiver document and these rules and regulations.~~, and the rules and regulations of the Colorado Department of Human Services, Division for Developmental Disabilities, of the Department of Health Care Policy and Financing. 2 CCR 503-1 and promulgated in accordance with the provisions of Section 25.5-6-404(4), C.R.S.~~

~~8.503.10.D. In the event a direct conflict arises between the rules and regulations of the Department and the Operating Agency, the rules and regulations of the Department shall control.~~

~~8.503.10.~~D~~E~~. HCBS-CES waiver services are available only to address needs identified in the Functional Needs Assessment and authorized in the S~~s~~ervice P~~p~~lan and when the service or ~~support~~Support is not available through the Medicaid State Plan, EPSDT, ~~natural supports~~Natural Supports, or third party payment sources.

~~8.503.10.~~E~~F~~. HCBS-CES waiver:

1. Shall not constitute an entitlement to services from either the Department or its agents~~the Operating Agency~~;~~,~~

2. Shall be subject to annual appropriations by the Colorado G~~g~~eneral A~~a~~ssembly;~~,~~

3. Shall limit the utilization of the HCBS-CES waiver based on the federally approved capacity, ~~,~~ C~~c~~ost C~~c~~ontainment, the maximum costs and the total appropriations;~~,~~ and,

4. May limit ~~the~~ enrollment when utilization of the HCBS-CES waiver program is projected to exceed the spending authority.

8.503.20 GENERAL PROVISIONS

~~8.503.20.~~A. ~~THE FOLLOWING PROVISIONS SHALL APPLY TO THE HCBS-CES WAIVER~~The following provisions apply to the HCBS – CES waiver:~~.~~

1. HCBS-CES waiver services are provided as an alternative to ICF~~-~~/IID~~MR~~ services for an eligible C~~c~~lient to assist the F~~f~~amily to ~~support~~Support the C~~c~~lient in the home and community.

2. HCBS-CES waiver is waived from the requirements of Section 1902(a) (10) (b) of the Social Security Act concerning comparability of services. The availability and comparability of services may not be consistent throughout the state of Colorado.

3. A Cc~~l~~lient enrolled in the HCBS-CES waiver shall be eligible for all other Medicaid services for which the Cc~~l~~lient qualifies and shall first access all benefits available under the Medicaid State Plan or Medicaid EPSDT prior to accessing services under the HCBS-CES waiver. Services received through the HCBS-CES waiver may not duplicate services available through the Medicaid State Plan.

8.503.30 CLIENT ELIGIBILITY

~~8.503.30.~~A. To be eligible for the HCBS-CES waiver, an individual shall meet the target population criteria as ~~follows~~:

1. Is unmarried and less than eighteen years of age,

2. Be determined to have a Dd~~e~~evelopmental Dd~~i~~isability which includes Dd~~e~~evelopmental Dd~~e~~elay if under five (5) years of age,

3. Can be safely served in the community with the type and amount of HCBS-CES waiver services available and within the federally approved capacity and Cc~~o~~ost Cc~~o~~ontainment limits of the HCBS-CES waiver,

4. Meet ICF~~-/~~IID~~MR~~ L~~l~~evel O~~o~~f Cc~~a~~are as determined by the Functional Needs Assessment,

5. Meet the Medicaid financial determination for Long Term Care (LTC)~~-~~ eligibility as specified at ~~10 CCR 2505-10,~~ Section 8.100 *et seq.* and,

6. Reside in an eligible HCBS-CES waiver setting as defined as the following:

   a.~~)~~ With biological, adoptive parent(s), or legal Gg~~u~~ardian,

   b.~~)~~ In an out-of-home placement and can return home with the provision of HCBS-CES waiver services with the following requirement~~: that must be approved by the HCBS-CES waiver administrator:~~

      i.~~)~~ The case ~~manger~~manager will work in conjunction with the residential caregiver to develop a transition plan that includes timelines and identified services or ~~support~~Supports requested during the time the Cc~~l~~lient is not residing in the Ff~~a~~mily home. The case manager will submit the transition plan to the Department for approval prior to the start of services.

7. Be determined to meet the Federal Social Security Administration's definition of disability,

8. Be determined by the Department or it~~s~~ agent ~~Utilization Review Contractor (URC)~~ to meet the additional targeting criteria eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:

   a.~~)~~ The individual demonstrates a behavior or has a medical condition that requires direct human intervention, more intense than a verbal reminder, redirection or brief observation of status, at least once every two hours during the day and on a weekly average of once every three hours during the night. The behavior or

medical condition must be considered beyond what is typically Aage Aappropriate and due to one or more of the following conditions:

i. A significant pattern of self-endangering behavior or medical condition which, without intervention will result in a life threatening condition or situation. Significant pattern is defined as the behavior or medical condition that is harmful to self or others as evidenced by actual events occurring within the past six (6) months,

ii.) A significant pattern of serious aggressive behavior toward self, others or property. Significant pattern is defined as the behavior is harmful to self or others, is evidenced by actual events occurring within the past six (6) months, or

iii. Constant vocalizations such as screaming, crying, laughing or verbal threats which cause emotional distress to caregivers. The term constant is defined as on the average of fifteen (15) minutes each waking hour.

b. In the instance of an annual reassessment, the reassessment must demonstrate in the absence of the existing interventions or preventions provided through Medicaid that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criterion listed above.

b). The above conditions shall be evidenced by third party statement or data that is corroborated by written evidence that:

i) The individual's behavior or medical needs have been demonstrated, or

ii.) In the instance of an annual reassessment, that in the absence of the existing interventions or preventions provided through the HCBS-CES waiver that the intensity and frequency of the behavior or medical condition would resume to a level that would meet the criteria listed above.

c Examples of acceptable evidence shall not be older than six months and shall include but not be limited to any of the following:

i.) Medical records,

ii) Professional evaluations and assessments,

iii.) Insurance claims,

iv) Behavior pharmacology clinic reports,

v.) Police reports,

vi) Social Services reports, or

vii.) Observation by a third party on a regular basis.

8.503.30.B. The Cclient shall maintain eligibility by meeting the HCBS-CES waiver eligibility as set forth in 10 CCR 2505-10, Section 8.503 and the following:

1. Receives at least one (1) HCBS-CES waiver service each calendar month,

2. Is not simultaneously enrolled in any other HCBS waiver, and

3. Is not residing in a hospital, nursing facility, ICF-/IIDMR, other institution or correctional facility.

8.503.40 HCBS-CES WAIVER SERVICES

8.503.40 A. The following services are available through the HCBS-CES waiver within the specific limitations as set forth in the federally approved HCBS-CES waiver:

1. Adaptive therapeutic recreational equipment and fees are services which assist a cClient to recreate within the cClient's community. These services include recreational equipment that is adapted specific to the cClient's disability and not those items that a typical age peer would commonly need as a recreation item.

a. The cost of item shall be above and beyond what is typically expected for recreation and recommended by a doctor or therapist.

b. Adaptive therapeutic recreational equipment may include adaptive bicycle, adaptive stroller, adaptive toys, floatation collar for swimming, various types of balls with internal auditory devices and other types of equipment appropriate for the recreational needs of a Cclient with a Ddevelopmental Ddisability.

c. A pass for admission to recreation centers for the Cclient only when the pass is needed to access a professional service or to achieve or maintain a specific therapy goal as recommended and supervised by a doctor or therapist. Recreation passes shall be purchased as day passes or monthly passes, whichever is the most cost effective.

d. Adaptive therapeutic recreation fees include those for water safety training.

e. The following items are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

i. Entrance fees for zoos,

ii. Museums,

iii. Butterfly pavilion,

iv. Movie, theater, concerts,

v. Professional and minor league sporting events,

vi. Outdoors play structures,

vii. Batteries for recreational items; and,

viii. Passes for Ffamily admission to recreation centers.

f. The maximum annual allowance for adaptive therapeutic recreational equipment and fees is one thousand (1,000.00) dollars per service planService Plan year.

2. Assistive technology includes services, supportSupports or devices that assist a Client to increase maintain or improve functional capabilities. This may include assisting the

Cclient in the selection, acquisition, or use of an assistive technology device and includes:

a. The evaluation of the assistive technology needs of a ~~client~~Client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the Cclient in the customary environment of the Cclient,

b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

c. Training or technical assistance for the Cclient, or where appropriate, the Ffamily members, Gguardians, care-givers, advocates, or authorized representatives of the Cclient,

d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-CES waiver, and

e. Adaptations to computers, or computer software related to the Cclient's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency's procedures.

f. Assistive technology devices and services are only available when the cost is higher than typical ~~expenses, and~~expenses and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid State Plan or third-party resource.

g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

h. When the expected cost is to exceed two thousand five hundred (2,500) dollars per device three estimates shall be obtained and maintained in the case record.

i. Training and technical assistance shall be time limited, goal specific and outcome focused.

j. The following items and services are specifically excluded under HCBS-CES waiver and not eligible for reimbursement:

    i. Purchase, training or maintenance of service animals,

    ii. Computers,

    iii. In home installed video monitoring equipment,

    iv. Medication reminders,

    v. Hearing aids,

    vi. ——Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of games,

vii. Training, or adaptation directly related to a school or home educational goal or curriculum; or

viii. Items considered as typical toys for children.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the Cclient or that enable the Cclient to function with greater independence in the ~~home, or~~home or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Department's procedures and the Department shall respond to exception requests within thirty (30) days of receipt.

3. Community connector services are intended to provide assistance to the Cclient to enable the Cclient to integrate into the Cclient's residential community and access naturally occurring resources. Community connector services shall:

a. Support the abilities and skills necessary to enable the Cclient to access typical activities and functions of community life such as those chosen by the general population.

b. Utilize the community as a learning environment to assist the Cclient to build relationships and ~~natural supports~~Natural Supports in the Cclient's residential community.

c. Be provided to a single Cclient in a variety of settings in which Cclients interact with individuals without disabilities, and

d. The cost of admission to professional or minor league sporting events, movies, theater, concert tickets or any activity that is entertainment in nature or any food or drink items are specifically excluded under the HCBS-CES waiver and shall not be reimbursed.

4. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.

a. Hippotherapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. ~~and~~ Hippotherapy can be reimbursed only when:

i. The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession;

ii. The intervention is related to an identified medical or behavioral need; and

iii. The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

i. Equine therapy,

ii. Therapeutic riding; and/~~or~~,

iii. Experimental treatments or therapies.

54. ~~—~~Home accessibility adaptations are physical adaptations to the primary residence of the C~~c~~lient, that are necessary to ensure the health and safety of the C~~c~~lient or that enable the C~~c~~lient to function with greater independence in the home. All adaptations shall be the most cost-effective means to meet the identified need. Such adaptations include:

a. The installation of ramps,

b. Widening or modification of doorways,

c. Modification of bathroom facilities to allow accessibility~~,~~ and assist with needs in A~~a~~ctivities of D~~d~~aily L~~l~~iving.

d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment or supplies that are necessary for the health and safety of the C~~c~~lient, and

e. Safety enhancing ~~support~~Supports such as basic fences or basic door and window ~~-~~alarms;

f. The following items are specifically excluded from home accessibility adaptations and shall not be reimbursed:

i. ~~i. —~~Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the Client's disability,

~~be on-going homeowner maintenance and are not related to the client's disability,~~

ii. Carpeting,

iii. Roof repair,

iv. Central air conditioning,

v. Air duct cleaning,

vi. Whole house humidifiers,

vii. Whole~~ole~~ house air purifiers,

viii. Installation and repair of driveways and sidewalks,

ix. Monthly or ongoing home security monitoring fees,

x. Home furnishings of any type,

xi. ~~xi. —~~Adaptations to rental units when the adaptation is not portable and cannot move with the renter, and

xii. Luxury upgrades.

g. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i. Improve entrance or egress to a residence; or,

ii. Configure a bathroom to accommodate a wheelchair.

h. Any request to add square footage to the home shall be prior authorized in accordance with the Department's procedures.

i. All devices and adaptations shall be provided in accordance with applicable state or local building codes and applicable standards of manufacturing, design and installation. Medicaid State Plan, EPSDT or third-party resources shall be utilized prior to authorization of HCBS-CES waiver services.

j. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the Cclient, enable the cClient to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with the Department's procedure.

65. Homemaker services are provided in the cClient's home and are allowed when the cClient's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of hHomemaker sServices:

a. Basic homemaker services includes cleaning, completing laundry, completing basic household care or maintenance within the cClient's primary residence only in the areas where the cClient frequents.

i. This assistance may take the form of hands-on assistance by actually performing a task for the cClient or cueing to prompt the cClient to perform a task.

ii. Lawn care, snow removal, air duct cleaning and animal care are specifically excluded under HCBS-CES waiver and shall not be reimbursed.

b. Enhanced homemaker services include basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning.

i. Habilitation services shall include direct training and instruction to the cClient in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the cClient or enhanced prompting and cueing.

ii. The provider shall be physically present to provide step by step verbal or physical instructions throughout the entire task:

1). When such ~~support~~Support is incidental to the habilitative services being provided,

2). To increase independence of the ~~c~~Client,

c. Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the ~~c~~Client.

d. Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the C~~c~~lient's disability.

7. Massage therapy ~~Massage~~ includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes WATSU.

a. Massage therapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Massage therapy is reimbursed only when:

i. The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession;~~,~~

ii. The intervention is related to an identified medical or behavioral need; and~~,~~

iii. The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

i. Acupuncture,

ii. Chiropractic care, and,

iii. Experimental treatments or therapies.

8. Movement therapy includes the use of music therapy and/ or dance therapy as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.

a. Movement therapy is provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need and Movement therapy can be reimbursed only when:

i. The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession;

ii. The intervention is related to an identified medical or behavioral need; and,

iii. The Medicaid State Plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

b. The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:

i. Fitness training (personal trainer),

ii. Warm water therapy,

iii. Experimental treatments or therapies, and

iv. Yoga.

96. Parent education provides unique opportunities for parents or other care givers to learn how to ~~support~~Support the child's strengths within the context of the child's disability and enhances the parent's ability to meet the special needs of the child. Parent ~~E~~education includes:

a. Consultation and direct service costs for training parents and other care-givers in techniques to assist in caring for the C~~c~~lient's needs, including sign language training,

b. Special resource materials,

c. Cost of registration for parents or caregivers to attend conferences or educational workshops that are specific to the C~~c~~lient's disability, and

d. Cost of membership to parent ~~support~~Support or information organizations and publications designed for parents of children with disabilities.

e. The maximum service limit for parent education is one thousand (1,000) units per ~~service plan~~Service Plan year.

f. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i. Transportation,

ii. Lodging,

iii. Food, and~~or~~

iv. Membership to any political organizations or any organization involved in lobby activities.

~~7. Professional services are provided by a licensed, certified, registered or accredited professional and the intervention is related to an identified medical or behavioral need. Professional services include:~~

~~a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.~~

~~b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.~~

~~c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes WATSU.~~

~~d. Professional services can be reimbursed only when:~~

~~i. The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,~~

~~ii. The intervention is related to an identified medical or behavioral need; and~~

~~iii. The Medicaid state plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.~~

~~iv). The following items are excluded under the HCBS-CES waiver and are not eligible for reimbursement:~~

~~1. Acupuncture,~~

~~2. Chiropractic care,~~

~~3. Fitness training (personal trainer),~~

~~4. Equine therapy,~~

~~5. Art therapy,~~

~~6. Warm water therapy,~~

~~7. Therapeutic riding,~~

~~9. Yoga.~~

10~~8~~. Respite is provided to C~~c~~lients on a short-term basis, because of the absence or need for relief of the primary caregivers of the C~~c~~lient.

a. Respite may be provided:

i. In the C~~c~~lient's home or a ~~,~~ private residence,

ii. The private residence of a respite care provider, or

iii. In the community.

b. Respite is to be provided in an Aage Aappropriate manner.

~~i. The eligible client age twelve (12) or older may receive respite during the time the care-giver works because same age typical peers do not need ongoing supervision at that age and the need for the respite is based on the client's disability.~~

i~~i~~. A Cclient eleven (11) years of age and younger, will not receive respite during the time the parent works, pursues continuing education or volunteers, because this is a typical expense for all parents of young children.

c. When the cost of care during the time the parents works is more for an eligible Cclient, eleven (11) years of age or younger, than it is for same age peers, then respite may be used to pay the additional cost. Parents shall be responsible for the basic and typical cost of child care.

d. Respite may be provided for siblings, age eleven (11) and younger, who reside in the same home of an eligible Cclient when supervision is needed so the primary caretaker can take the Cclient to receive a state plan benefit or a HCBS-CES waiver service.

e. Respite shall be provided according to an individual or group rates as defined below:

i.~~)~~ Individual: the Cclient receives respite in a one-on-one situation. There are no other Cclients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty-four (24)-hour period.

ii.~~ii)~~ Individual day: the Cclient receives respite in a one-on-one situation for cumulatively more than ten (10) hours in a twenty-four (24)-hour period. A full day is ten (10) hours or greater within a twenty-four (24)- hour period.

iii.~~)~~ Overnight group: the Cclient receives respite in a setting which is defined as a facility that offers twenty-four (24)-hour supervision through supervised overnight group accommodations. The total cost of overnight group within a twenty-four (24)-hour period shall not exceed the respite daily rate.

iv.~~)~~ Group: the Cclient receives care along with other individuals, who may or may not have a disability. The total cost of group within a twenty-four (24)-hour period shall not exceed the respite daily rate. The following limitations to respite service shall apply:

1) Sibling care is not allowed for care needed due to parent's work, volunteer, or education schedule or for parental relief from care of the sibling.

f. Federal financial participation shall not to be claimed for the cost of room and board except when provided, as part of respite care furnished in a facility

approved pursuant to ~~2 CCR 503-1, Section 16.221~~Section 8.602 by the state that is not a private residence.

g. The total amount of respite provided in one ~~service plan~~Service Plan year may not exceed an amount equal to thirty (30) day units and one thousand eight hundred eighty (1,880) individual units. The Department~~Operating Agency~~ may approve a higher amount based on a need due to the C~~c~~lient's age, disability or unique F~~f~~amily circumstances.

h. Overnight group respite may not substitute for other services provided by the provider such as Personal Care, Behavioral Services or other services not covered by the HCBS-CES waiver.

i. Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight or group respite rate shall not exceed the respite daily rate.

j. The purpose of respite is to provide the primary caregiver a break from the ongoing daily care of a C~~c~~lient. Therefore, additional respite units beyond the service limit will not be approved for C~~c~~lients who receive skilled nursing, certified nurse aid services, or home care allowance from the primary caregiver.

11~~9~~. Specialized medical equipment and supplies include devices, controls, or appliances that are required due to the C~~c~~lient's disability and that enable the C~~c~~lient to increase the C~~c~~lient's ability to perform A~~a~~ctivities of D~~d~~aily ~~l~~Living or to safely remain in the home and community. Specialized Medical Equipment and Supplies include:

a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. Specially designed clothing for a C~~c~~lient if the cost is over and above the costs generally incurred for a C~~c~~lient's clothing;

c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-CES waiver.

d. The following items are specifically excluded under the HCBS-CES waiver and not eligible for reimbursement:

i. Items that are not of direct medical or remedial benefit to the C~~c~~lient, vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water walkers, resistance water therapy pools, experimental items and~~or~~ wipes for any purpose other than incontinence.

12~~10~~. Vehicle modifications are adaptations or alterations to an automobile or van that is the C~~c~~lient's primary means of transportation, to accommodate the special needs of the C~~c~~lient, are necessary to enable the C~~c~~lient to integrate more fully into the community and to ensure the health~~,~~ and safety of the C~~c~~lient.

a. Upkeep and maintenance of the modifications are allowable services.

b. Items and services specifically excluded from reimbursement under the HCBS-CES waiver include:

i. Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the Cclient,

ii. Purchase or lease of a vehicle, and

iii. Typical and regularly scheduled upkeep and maintenance of a vehicle.

c. The total cost of Home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed ten thousand (10,000) dollars over the five (5) year life of the HCBS-CES waiver without an exception granted by the Department. Costs that exceed this limitation may be approved for services, items or devices to ensure the health and safety of the Cclient, to enable the Cclient to function with greater independence in the home, or to decrease the need for paid assistance in another HCBS-CES waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure Cost cost-efficiency, prudentEffectiveness, prudent purchases and no unnecessary duplication.

13. Youth Day

a. Youth day service is the care and supervision of Clients ages 12 through 17 while the primary caregiver works, volunteers, or seeks employment.

b. Youth day service may be provided in the residence of the Client, youth day service provider, or in the community.

c. Youth day service shall be provided according to an individual or group rate as defined below:

i. Individual: The Client receives youth day services with a staff ratio of 1:1, billed at a 15-minute unit. There are no other youth in the setting also receiving youth day service, respite or third-party supervision.

ii. Group: The Client receives supervision in a group setting with other individuals who may or may not have a disability. Reimbursement is limited to the Client.

d. Limitations:

i. This service is limited to Clients ages 12 through 17.

ii. This service may not substitute for or supplant special education and related services included in a Client's Individualized Education Plan (IEP) developed under Part B of the Individuals with Disabilities Education Act, 20 Uu.Ss.cC. § 1400 (20~~04~~11). This includes after school care provided through any education system and funded through any education system for any student.

iii. This service may not be used to cover any portion of the cost of camp.

iv. This service is limited to ten (10) hours per calendar day.

8.503.50 SERVICE PLAN.

8.503.50.A The case management agency shall complete a service plan for each client enrolled in the HCBS-CES waiver in accordance with 10 CCR 2505-10 Section 8.519.11.B.2.8.400.

1. The service plan shall:

   a. Address the client's assessed needs and personal goals, including health and safety risk factors either by HCBS-CES waiver services or any other means,

   b. Be in accordance with the Department's and the Operating Agency's rules, policies and procedures,

   c. Be entered and verified in the Department prescribed system within ten (10) business days,

   d. Describe the types of services to be provided, the amount, frequency and duration of each service and the type of provider for each service,

   e. Include a statement of agreement, and.

   f. Be updated or revised at least annually or when warranted by changes in the HCBS-CES waiver client's needs,

2. The Service Plan shall document that the client has been offered a choice:

   a. Between HCBS-CES waiver services and institutional care,

   b. Among HCBS-CES waiver services, and

   c. Among qualified providers.

8.503.60 WAITLIST WAITING LIST PROTOCOL

8.503.60.A. When the HCBS-CES waiver reaches capacity for enrollment, a client Client determined eligible for HCBS-CES waiver benefits shall be placed on a statewide waiting list in accordance with these rules and the Department's Operating Agency procedures.

1. The Community Centered Board shall determine if an Aapplicant has Ddevelopmental Ddelay if under age five (5), or Ddevelopmental Ddisability if over age five (5) or older, prior to submitting the HCBS-CES waiver application to the Department or its agentutilization review contractor. Only a Cclient who is determined to have a Ddevelopmental Ddelay or Ddevelopmental Ddisability may apply for HCBS-CES waiver.

2. In the event a Cclient who has been determined to have a Ddevelopmental Ddelay is placed on the wait list prior to age five (5), and that Cclient turns five (5) while on the HCBS-CES waiver wait list, a determination of Ddevelopmental Ddisability must be completed in order for the Cclient to remain on the wait list.

3. The Ccase Mmanagement Aagency shall complete the Functional Needs Assessment, as defined in Department rules, to determine the Cclient's Level oOf Care.

4. The Ccase Mmanagement Aagency shall complete the HCBS-CES waiver application with the participation of the Ffamily. The completed application and a copy of the Functional Needs Assessment that determines the Cclient meets the ICF-/IIDMR Llevel oOf Ccare shall be submitted to the Utilization Review ContractorDepartment or its it's agent within fourteen (14) calendar days of parent signature.

5. ~~Support~~Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the ~~utilization review contractor~~Department or its~~it's~~ agent.

6. The ~~utilization review contractor~~Department or its~~it's~~ agent shall review the HCBS-CES waiver application. In the event the ~~utilization review contractor~~Department or its~~it's~~ agent needs additional ~~information,~~information; the C~~c~~ase M~~m~~anagement A~~a~~gency shall respond within two (2) business days of request.

7. Any C~~c~~lient determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide waiting list in the order in which the ~~utilization review contractor~~Department or its~~it's~~ agent received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the C~~c~~lient's appeal rights in accordance with ~~10 CCR 2505-10,~~ Section 8.057.

8. The C~~c~~ase M~~m~~anagement A~~a~~gency will create or update the consumer record to reflect the C~~c~~lient is waiting for the HCBS-CES waiver with the waiting list date as determined by the Department or its ~~it's~~ agent. ~~utilization review contractor.~~

8.503.70 ENROLLMENT

~~8.503.70~~ A. When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.

1. The C~~c~~ase M~~m~~anagement A~~a~~gency shall complete the HCBS-CES waiver application and the Functional Needs Assessment in the F~~f~~amily home with the participation of the F~~f~~amily. The completed application and a copy of the Functional Needs Assessment shall be submitted to the Department or its~~it's~~ agent within thirty (30) days of the authorized initial enrollment date.

    a. If it has been less than six (6) months since the review to determine waiting list eligibility by the Utilization Review Contractor and there has been no change in the C~~c~~lient's condition, the C~~c~~ase M~~m~~anagement ~~agency~~ Agency shall complete the Functional Needs Assessment and the parent may submit a letter to the ~~c~~Case M~~m~~anagement A~~a~~gency in lieu of the HCBS-CES waiver application stating there has been no change.

    b. If there has been any change in the C~~c~~lient's condition the C~~c~~ase M~~m~~anagement A~~a~~gency shall complete a Functional Needs Assessment and the HCBS-CES waiver application which shall be submitted to the ~~Utilization Review Contractor~~Department or its~~it's~~ agent.

~~3~~2. Services and ~~support~~Supports shall be implemented pursuant to the ~~service plan~~Service Plan within 90 days of the parent or G~~g~~uardian signature.

~~4~~3. All continued stay review enrollments shall be completed and submitted to the ~~utilization review contractor~~~~the~~ Department or its~~it's~~ agent at least thirty (30) days and not more than ninety (90) days prior to the end of the current enrollment period.

8.503.80 CLIENT RESPONSIBILITIES

8.503.80 A. The parent or legal Gguardian of a Cclient is responsible to assist in the enrollment of the Cclient and cooperate in the provision of services. Failure to do so shall result in the Cclient's termination from the HCBS-CES waiver. The parent or legal gGuardian shall:

1. Provide accurate information regarding the Cclient's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions; .

2. Cooperate with providers and Ccase Mmanagement Aagency requirements for the HCBS-CES waiver enrollment process, continued stay review process and provision of services;

3. Cooperate with the local Department of Human Services in the determination of financial eligibility;

4. Complete the HCBS-CES waiver application with fifteen (15) calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a continued stay review, at least thirty (30) days prior to the end of the current certification period;

5. Complete the Service PlanService Plan within thirty (30) calendar days of determination of HCBS-CES waiver additional targeting criteria eligibility as determined by the Utilization Review Contractor;Department or its it's agent.

6. Notify the case manager within thirty (30) days after changes:

   a. In the Cclient's supportSupport system, medical condition and living situation including any hospitalizations, emergency room admissions, nursing home placements or ICF-/IID MR placements;

   b. That may affect Medicaid financial eligibility such as prompt report of changes in income or resources;

   c. When the Cclient has not received an HCBS-CES waiver service for one calendar month;

   d. In the Cclient's care needs; and,

   e. In the receipt of any HCBS-CES waiver services.

8.503.90 PROVIDER REQUIREMENTS

8.503.90 A. A private for profit or not for profit agency or government agency shall ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver and shall:

1. Conform to all state established standards for the specific services they provide under HCBS-CES waiver,

2. Maintain program approval and certification from the Operating AgencyDepartment,

3. Maintain and abide by all the terms of their Medicaid provider agreement with the Department and with all applicable rules and regulations set forth in 10 CCR 2505-10, Section 8.130,

4. Discontinue HCBS-CES waiver services to a Cc~~l~~lient only after documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide HCBS-CES waiver services,

5. Have written policies governing access to duplication and dissemination of information from the Cc~~l~~lient's records in accordance with state statutes on confidentiality of information at Section 25.5-1-116, C.R.S., ~~as amended,~~

6. When applicable, maintain the required licenses and certifications from the Colorado Department of Public Health and Environment, and

7. Maintain Cc~~l~~lient records to substantiate claims for reimbursement according to Medicaid standards.

~~8.503.90.~~B. HCBS-CES waiver service providers shall comply with:

1. All applicable provisions of~~-~~ Article 10 of Title 25.5, C.R.S. ~~25.527~~, Article 10.5, C.R.S., ~~et seq 10.~~ and all rules and regulations as set forth in Section 8.600,

~~2 CCR 503-1, Section 16.100 *et seq*.,~~

2. All federal and~~or~~ state program reviews or financial audit of HCBS-CES waiver services,

3. The ~~Operating Agency's~~Department's on-site ~~certiication~~certification reviews for the purpose of program approval, on-going program monitoring or financial and program audits,

4. Requests from the County Departments of Human Services to access records of Cc~~l~~lients and to provide necessary Cc~~l~~lient information to determine and re-determine Medicaid financial eligibility,

5. Requests by the Department ~~of the Operating Agency~~ to collect, review and maintain individual or agency information on the HCBS-CES waiver, and

6. Requests by the Cc~~a~~ase M~~m~~anagement A~~a~~gency to monitor service delivery through targeted case management activities.

8.503.100 TERMINATION OR DENIAL OF HCBS-CES MEDICAID PROVIDER AGREEMENTS

~~8.503.100.~~A. The Department may deny or terminate an HCBS-CES waiver Medicaid provider agreement when:

1. The provider is in violation of any applicable certification standard or provision of the provider agreement and does not adequately respond to a corrective action plan within the prescribed period of time. The termination shall follow procedures at ~~10 CCR 2505-10, Section~~Section ~~8.076130 *et seq*~~.

2. A change of ownership occurs. A change in ownership shall constitute a voluntary and immediate termination of the existing provider agreement by the previous owner of the agency and the new owner must enter into a new provider agreement prior to being reimbursed for HCBS-CES waiver services.

3. The provider or its owner has previously been involuntarily terminated from Medicaid participation as any type of Medicaid service provider.

4. The provider or its owner has abruptly closed, as any type of Medicaid provider, without proper prior Cclient notification.

5. The provider fails to comply with requirements for submission of claims under ~~pursuant to 10 CCR 2505-10,~~ Section 8.040.2 or after actions have been taken by the Department, the Medicaid Fraud Control Unit or their authorized agents to terminate any provider agreement or recover funds.

6. Emergency termination of any provider agreement shall be in accordance with procedures at Section ~~10 CCR 2505-10 , Section~~ 8.07650.

8.503.110 ORGANIZED HEALTH CARE DELIVERY SYSTEM

~~8.503.110~~ A. The Organized Health Care Delivery System (OHCDS) for HCBS-CES waiver is the Community Centered Bboard as designated by the ~~Operating Agency~~Department in accordance with ~~C.R.S.~~ Section 25.5 -10-209, C.R.S.. ~~Section 27-10.5-103, C.R.S.~~

1. The OHCDS is the Medicaid provider of record for a Cclient whose services are delivered through the OHCDS.

2. The OHCDS shall maintain a Medicaid provider agreement with the Department to deliver HCBS-CES waiver services according to the current federally approved waiver.

3. The OHCDS may contract or employ for delivery of HCBS-CES waiver services.

4. The OCHDS shall:

   a. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS-CES waiver,

   b. Ensure that services are delivered according to the HCBS-CES waiver definitions and as identified in the Cclient's ~~service plan~~Service Plan,

   c. Ensure the contractor maintains sufficient documentation to ~~support~~Support the claims submitted, and

   d. Monitor the health and safety of HCBS-CES waiver Cclients receiving services from a subcontractor.

5. The OHCDS is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The OCHDS shall:

   a. Establish reimbursement rates that are consistent with efficiency, economy and quality of care,

   b. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers,

   c. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to Cclients

   d. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and ~~Operating Agency procedures,~~the Department's procedures:

i. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

e. Collect and maintain the data used to develop provider rates and ensure data includes costs for the services to address the Cclient's needs, that are allowable activities within the HCBS-CES waiver service definition and that supportSupports the established rate, and

f. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency and Centers for Medicare and Medicaid Services (CMS).

g. Report by August 31 of each year, the names, rates and total payment made to the contractor.

8.503.120 PRIOR AUTHORIZATION REQUESTS

Prior Authorization Requests (PAR) shall be in accordance with Section 8.519.14.

~~8.503.120.A Prior Authorization Requests (PAR) shall be in accordance with 10 CCR 2505-10, Section 8.058.~~

~~1. A Prior Authorization Request shall be submitted to the Operating Agency through the Department's designated information management system.~~

~~2. The case management agency shall comply with the policies and procedures for the PAR review process as set forth by the Department and the Operating Agency.~~

~~3. The case management agency shall submit the PAR in compliance with all applicable regulations and ensure requested services are:~~

~~a. Consistent with the client's documented medical condition and functional capacity as indicated in the Functional Needs Assessment,~~

~~b. Adequate in amount, frequency and duration in order to meet the client's needs and within the limitations set forth in the current federally approved HCBS-CES waiver, and~~

~~c. Not duplicative of another authorized service, including services provided through:~~

~~i.) Medicaid State Plan benefits,~~

~~ii.) Third party resources,~~

~~iii.) Natural supports,~~

~~iv.) Charitable organizations, or~~

~~v.) Other public assistance programs.~~

~~4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to 10 CCR 2505-10, Section 8.058.4.~~

8.503.130 RETROSPECTIVE REVIEW PROCESS

~~8.503.130.~~A. Services provided to a C~~c~~lient are subject to a ~~retrospective review~~Retrospective Review by the Department or its agent ~~and the Operating Agency~~. This ~~retrospective review~~Retrospective Review shall ensure that services:

1. Identified in the ~~service plan~~Service Plan is based on the C~~c~~lient's identified needs as stated in the Functional Needs Assessment,

2. Have been requested and approved prior to the delivery of services,

3. Provided to a C~~c~~lient are in accordance with the ~~service plan~~Service Plan, and

4. Provided are within the specified HCBS service definition in the federally approved HCBS-CES waiver.

~~8.503.130.~~B. The C~~c~~ase M~~m~~anagement A~~a~~gency or provider shall be required to submit a plan of correction that is monitored for completion by the Department ~~and the Operating Agency~~or its agent when areas of non-compliance are identified in the ~~retrospective review~~Retrospective Review.

~~8.503.130.~~C. The inability of the provider to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

~~8.503.130.~~D. When the provider has received reimbursement for services and the review by the Department or ~~Operating Agency~~ its agent identifies that it is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of ~~provider status~~the provider agreement.

8.503.140 PROVIDER REIMBURSEMENT

~~8.503.140.~~A. Providers shall submit claims directly to the Department's fiscal agent through the Medicaid Management Information System (MMIS) or through a qualified billing agent enrolled with the Department's fiscal agent.

1. Provider claims for reimbursement shall be made only when the following conditions are met:

   a. Services are provided by a qualified provider as specified in the federally approved HCBS-CES waiver,

   b. Services have been prior authorized,

   c. Services are delivered in accordance to the frequency, amount, scope and duration of the service as identified in the C~~c~~lient's ~~service plan~~Service Plan, and

   d. Required documentation of the specific service is maintained and sufficient to support that the service is delivered as identified in the ~~service plan~~Service Plan and in accordance with the service definition.

2. Provider claims for reimbursement shall be subject to review by the Department or its agent~~and the Operating Agency~~. This review may be completed before or after payment has been made to the provider.

3. When the review identifies areas of non-compliance, the provider shall be required to submit a plan of correction that is monitored for completion by the Department or its agent.

~~and the Operating Agency.~~

4. When the provider has received reimbursement for services and the review by the Department or its agent~~or Operating Agency~~ identifies that the service ~~delivered~~delivered, or the claims submitted is not in compliance with requirements, the amount reimbursed will be subject to the reversal of claims, recovery of amount reimbursed, suspension of payments, or termination of provider status.

8.503.150 CLIENT RIGHTS

~~8.503.150.~~A. Client rights should be in accordance with ~~Sections 27-10.5-112- through 131 C.R.S~~C.R.S. ~~C.R.S.~~ Sections 25.5-10-218 through 231, C.R.S.~~.~~.

8.503.160 APPEAL RIGHTS

Case Management Agencies shall meet the requirements set forth at Section 8.519.22.

~~8.503.160.~~A. The CCB shall provide the long-term care ~~Long Term Care~~ notice of action form ~~(LTC 803)~~ to the A~~a~~pplicant and C~~c~~lient's parent or legal G~~g~~uardian within eleven~~ten~~ (1~~10~~) business days regarding the C~~c~~lient's appeal rights in accordance with ~~10 CCR 2505-10, Section~~Section 8.057 ~~*et seq.*~~ when:

1. The Client or A~~A~~pplicant is determined not to have a D~~d~~evelopmental D~~d~~elay or D~~d~~evelopmental D~~d~~isability,

2. The Client or A~~A~~pplicant is determined eligible or ineligible for Medicaid LTSS~~LTC~~ services,

3. The Client or A~~A~~pplicant is determined eligible or ineligible for placement on a waiting list for Medicaid LTSS~~LTC services~~, or

4. An Adverse Action occurs that affects the C~~c~~lient's HCBS-CES waiver enrollment status through termination or suspension.~~,~~

~~5. An Adverse Action occurs that affects the provision of HCBS-CES waiver services or,6. The Applicant or client requests such information.~~

~~8.503.160.~~B. The CCB shall appear and defend its~~represent their~~ decision at the Office of Administrative Courts as described in ~~10 CCR 2505-10,~~ Section 8.057 ~~*et seq.*~~ when the CCB has made a denial or A~~a~~dverse A~~a~~ction against a C~~c~~lient or Applicant.

~~8.503.160.~~C The CCB shall notify the Case Management Agency in the Client's Service Plan ~~all providers in the client's service plan~~ within one (1) working day of the adverse action.

D.~~C~~ The CCB shall notify the County Department of Human Services income maintenance technician within one (1) business day of an Adverse Action that affects Medicaid financial eligibility.

~~8.503.160.~~E. The CCB shall inform the ~~a~~Applicant's or Client's parent or legal G~~g~~uardian ~~shall be informed~~ of an A~~a~~dverse A~~a~~ction if the applicant or C~~c~~lient is determined ineligible ~~as set forth in client eligibility~~ and the following:

1. The Client or ~~A~~applicant, parent or legal G~~g~~uardian fails to submit the Medicaid financial application for ~~LTC~~LTSS to the financial eligibility site within thirty (30) days of ~~LTC~~LTSS referral,

2. A C~~c~~lient, parent or legal G~~g~~uardian fails to submit financial information for re-determination for ~~LTC~~LTSS to the financial eligibility site within the required re-determination timeframe,

3. The County Income Maintenance Technician has determined the C~~c~~lient no longer meets financial eligibility criteria as set forth in ~~10 CCR 2505-10,~~ Section 8.100,

4. The C~~c~~lient cannot be served safely within the C~~c~~ost C~~c~~ontainment as identified in the HCBS-CES waiver,

5. The C~~c~~lient requires ~~twenty four~~twenty-four (24) hour supports provided through Medicaid S~~s~~tate P~~p~~lan,

6. The resulting total cost of services provided to the C~~c~~lient, including Targeted Case Management, home health and HCBS-CES waiver services, exceeds the C~~c~~ost C~~c~~ontainment as identified in the HCBS-CES waiver,

7. The C~~c~~lient enters an I~~i~~nstitution for treatment with duration that continues for more than thirty (30) days,

8. The C~~c~~lient is detained or resides in a correctional facility, ~~and~~or,

9. The C~~c~~lient enters an institute for mental illness with a duration that continues for more than thirty (30) days.

~~8.503.160.F The client and parent or legal guardian shall be notified, pursuant to 10 CCR 2505-10, Section 8.057, when the following results in an adverse action that does not relate to HCBS-CES waiver client eligibility requirements:1. A HCBS-CES waiver service is reduced, terminated or denied because it is not a demonstrated need in the Functional Needs Assessment or because it is not available through the current federally approved HCBS-CES waiver,~~

~~82. A service plan for HCBS-CES waiver services exceed the limits as set forth in the in the federally approved HCBS-CES waiver,~~

~~3. The parent or legal guardian has failed to schedule an appointment for the Functional Needs Assessment of the client, service plan, or 6 month visit two (2) times in a thirty (30) day consecutive period,~~

~~4. The parent or legal guardian has failed to keep three (3) scheduled assessment appointments within a thirty (30) consecutive day period,~~

~~5. The parent or legal guardian failed to complete the HCBS-CES waiver application within fifteen (15) calendar days of the authorized enrollment date as determined by the Operating Agency,~~

~~6. The parent or legal guardian fails to complete the service plan within thirty (30) calendar days of the authorized enrollment date as determined by the Operating Agency,~~

~~7. The parent or legal guardian refuses to use the home care allowance to pay for services, or uses the home care allowance payment for services not identified in the service agreement,~~

8. The parent or legal guardian refuses to sign the statement of agreement or other forms as required to receive services,

9. The client enrolls in a different long term care program,

10. The client moves out of state. The client shall be discontinued effective upon the day after the date of the move.

a. A client who leaves the state on a temporary basis, with intent to return to Colorado, according to income maintenance staff manual 9 CCR 2503-1, Section 3.140.2, residence, shall not be discontinued unless one or more of the other client eligibility criteria are no longer met.

11. The parent or legal guardian voluntarily withdraws the client from HCBS-CES waiver. The client shall be discontinued from the program effective upon the day after the date on which the parent or legal guardian request is documented.

12. The CCB shall not send the LTC notice of action form when the basis for discontinuation is death of the client, but shall document the event in the client record and the date of action shall be the day after the date of death.

8.503.170 QUALITY ASSURANCE

8.503.170 A. The monitoring of HCBS-CES waiver services and the health and well-being of service recipients shall be the responsibility of the Operating Agency, under the oversight of the DepartmentDepartment or its it's agent.

1. The Operating AgencyDepartment or its it's agent shall conductmay conduct reviews of each agency providing HCBS-CES waiver services or cause to have reviews to be performed in accordance with guidelines established by the Department or Operating Agency and Department. The review shallwill apply rules and standards developed for programs serving Cclients with developmental disabilities.

2. The Operating Agencyprovider agency shall maintain or cause to be maintained for sixthree (63) years a complete file of all records, documents, communications, and other materials which pertain to the operation of the HCBS-CES waiver or the delivery of services under the HCBS-CES waiver. The Department shall have access to these records at any reasonable time.

3. The Department may deny or terminate the Medicaid provider agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Department within the prescribed period of time.

3. The Operating Agency shall recommend to the Department the suspension of payment, the denial or termination of the Medicaid provider agreement for any agency which it finds to be in violation of applicable standards and which does not adequately respond with a corrective action plan to the Operating Agency within the prescribed period of time or does not fulfill a corrective action plan within the prescribed period of time.

4. After having received the denial or termination recommendation and reviewing the supporting documentation, the Department shall take the appropriate action within a reasonable timeframe agreed upon by the Department and the Operating Agency.

8.503.210 POST ELIGIBILITY TREATMENT OF INCOME (PETI)

For individuals who are determined to be Medicaid eligible for the CES waiver through the application of the 300% income standard at 8.110.8, the case manager shall allow an amount equal to the 300% standard as the personal maintenance allowance (no other deductions are necessary). The PETI assessment form shall be completed monthly by the case management agency to ensure that the individual's income does not exceed the maximum allowed for continued eligibility.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Employment First, Section 8.500
Rule Number: MSB 18-12-27-A
Division / Contact / Phone: Community Living Office Benefits & Services Management / Russ Zigler / 303-866-5927

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 18-12-27-A, Revision to the Medical Assistance Rule Concerning Employment First, Section 8.500

3. This action is an adoption of: an amendment

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

   Sections(s) 8.500.6, 8.500.9, 8.500.14, 8.500.95, 8.500.98, and 8.500.104, 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*

Insert the newly proposed language at 8.500.6 with the proposed language beginning at 8.500.6.D through the end of 8.500.6.D. Insert the newly proposed text at 8.500.9 with the proposed text beginning at 8.500.9.B through the end of 8.500.9.B. Insert the newly proposed text at 8.500.14 with the proposed text beginning at 8.500.14.H through the end of 8.500.14.H.2. Insert the newly proposed text at 8.500.95 with the newly proposed text beginning at 8.500.95.D through the end of 8.500.95.D. Insert the newly proposed text at 8.500.98.C with the text beginning at 8.500.98.C through the end of 8.500.98.C. Insert the newly proposed text beginning at 8.500.104.G with the proposed text beginning at 8.500.104.G through the end of 8.500.104.G. This rule is effective September 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule Concerning Employment First, Section 8.500
Rule Number: MSB 18-12-27-A
Division / Contact / Phone: Community Living Office Benefits & Services Management / Russ Zigler / 303-866-5927

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 promulgates the requirements of Senate Bill 18-145, enacted in C.R.S. 25.5-10-204 (2018), which implements the Employment First Advisory Partnership recommendations to advance competitive integrated employment for Health First Colorado (Colorado Medicaid) clients eligible for Supported Employment services through the Home and Community Based Services for the Developmentally Disabled waiver and the Home and Community Based Services for Supported Living Services waiver. Rule provisions include requiring reporting of employment data for Supported Employment service eligible clients, training and certification requirements for select Supported Employment service providers, and reimbursement to providers for the costs of such training and certification.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. § 1396n(c)(5)(B) (2018); 42 C.F.R. § 440.180(c)(2)(iii) (2019)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   25.5-10-204, C.R.S. (2018)

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

DOCUMENT #

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule Concerning Employment First, Section 8.500
Rule Number: MSB 18-12-27-A
Division / Contact / Phone: Community Living Office Benefits & Services Management / Russ Zigler / 303-866-5927

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 eligible for Supported Employment services under the Home and Community Based Services for the Developmentally Disabled waiver and the Home and Community Based Services for Supported Living Services waiver, and select providers of such services, are affected by the proposed rule. Clients will benefit from employment data collection for annual reporting on Employment First progress and from services rendered by providers with nationally recognized Supported Employment training certificates or certifications. Providers will be reimbursed for costs associated with obtaining the required training certificate or certification, including training certificate and certification costs and wages paid to employees during the training.

   The annual budgetary impact of reimbursing providers for training and certification will be $303,158 in each fiscal year beginning SFY 2019-20 through SFY 2023-24 and is included in the appropriation from SB 18-145.

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

   Supported Employment Services are designed to support individuals with Intellectual or Developmental Disabilities (I/DD), acquire and be successful in community-based work opportunities. Nationally 85% of individuals with an I/DD are unemployed and studies have shown that employment can lead to better health outcomes and support better integration into the community. These rules will ensure that Supported Employment services are delivered with high quality in a person-centered way. These rules will lead to better employment outcomes for those individuals in services.

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.

These rules will increase cost to the Department, SB18-145 stipulates that the Department reimburses Supported Employment providers for trainings and certifications. SB18-145 approved this funding for reimbursement.

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

   Colorado is an Employment First State, which mandates that the first and most preferred outcome for anyone in Home and Community Based Services is to be employed. With the benefits of employment showing both better health outcomes and better community integration for those who are employed, it is important that the Department supports regulations designed to improve these services.

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

   The Department is statutorily required to promulgate the proposed rule under 25.5-10-204, C.R.S. (2018). There are no less costly methods 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.

   The Department is statutorily required to promulgate the proposed rule under 25.5-10-204, C.R.S. (2018). There are no alternative methods for achieving the purpose of the proposed rule.

8.500 HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD) WAIVER

8.500.6 SERVICE PLAN

8.500.6.D The Service Plan must be reported in the Department prescribed system and include the following employment information for individuals eligible for or receiving Supported Employment services, if applicable:

1. Sector and type of employment;

2. Mean wage per hour earned; and

3. Mean hours worked per week.

8.500.9 PROVIDER REQUIREMENTS

8.500.9.B Supported Employment provider training and certification requirements

1. Supported Employment service providers, including Supported Employment professionals who provide individual competitive integrated employment, as defined in 34 C.F.R. 361.5(c)(9) (2018), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and certification requirements. The incorporation of 34 C.F.R. 361.5(c)(9) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to C.R.S. § 24-4-103(12.5) (2018), 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, CO 80203. Certified copies of the incorporated material will be provided at cost upon request.

    a. Subject to the availability of appropriations for reimbursement in section 8.500.14.H. Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

        i. Deadlines.

1) Existing staff, employed by the Provider on or before July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

2) Newly hired staff, employed by the Provider after July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

a) Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

ii. Department approval required.

1) The Training Certificate or Certification required under section 8.500.9.B.1.a must be pre-approved by the Department.

a) Providers must submit the following information to the Department for pre-approval review:

i) Provider name.

ii) A current Internal Revenue Service Form W-9.

iii) Seeking approval for:

1) Training Certificate, or

2) Certification, or

3) Training Certificate and Certification.

iv) Name of training, if applicable, including:

1) Number of staff to be trained.

2) Documentation that the training is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

v) Name of Certification, if applicable, including:

1) Number of staff to receive Certification.

2) Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

vi) Dates of training, if applicable, including:

1) Whether a certificate of completion is received.

vii) Date of Certification exam, if applicable.

b) Department approval will be based on alignment with the following core competencies:

i) Core values and principles of Supported Employment, including the following:

1) The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.

ii) The Person-centered process, including the following:

1) The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-centered approach includes working with a team where the individual chooses the people involved on the team and receives: necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.

iii) Individualized career assessment and planning, including the following:

1) The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.

iv) Individualized job development, including the following:

1) Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.

v) Individualized job coaching, including the following:

1) Providing necessary workplace supports to clients with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.

vi) Job Development, including the following:

1) Effectively engaging employers for the purpose of community job development for clients with significant disabilities, which meets the needs of both the employer and the client.

c) The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and notify the Provider of its determination within 30 days of receiving the pre-approval request under 8.500.9.B.1.a.ii.1.a.

8.500.14 PROVIDER REIMBURSEMENT

8.500.14.H Reimbursement for a Supported Employment Training Certificate or Certification, or both, under section 8.500.9.B.1.a, which includes both the cost of attending a training or obtaining a certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse Providers for such costs.

1. Providers seeking reimbursement for completed training or certification, or both, approved under section 8.500.9.B.1.a.ii, must submit the following to the Department:

    a. Supported Employment Providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

        i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving a reimbursement request under section 8.500.14.H.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under section 8.500.9.B.1.a.ii.1.c and either notify the provider of the denial or, if approved, reimburse the provider.

    a. Reimbursement is limited to the following amounts and includes reimbursement for wages:

        i. Up to $300 per certification exam.

        ii. Up to $1,200 for each training.

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

8.500.95 SERVICE PLAN:

8.500.95.D The Service Plan must be reported in the Department prescribed system and include the following employment information for individuals eligible for or receiving Supported Employment services, if applicable:

1. Sector and type of employment.

2. Mean wage per hour earned.

3. Mean hours worked per week.

8.500.98 PROVIDER REQUIREMENTS

8.500.98.C Supported Employment provider training and certification requirements

1. Supported Employment service providers, including Supported Employment professionals who provide individual competitive integrated employment, as defined in 34 C.F.R. 361.5(c)(9) (2018), which is incorporated herein by reference, and excluding professionals providing group or other congregate services (Providers), must comply with the following training and certification requirements. The incorporation of 34 C.F.R. 361.5(c)(9) (2018) excludes later amendments to, or editions of, the referenced material. Pursuant to C.R.S. § 24-4-103(12.5) (2018), 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, CO 80203. Certified copies of the incorporated material will be provided at cost upon request.

    a. Subject to the availability of appropriations for reimbursement in section 8.500.104.G, Providers must obtain a nationally recognized Supported Employment training certificate (Training Certificate) or a nationally recognized Supported Employment certification (Certification).

        i. Deadlines.

            1) Existing staff, employed by the Provider on or before July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

            2) Newly hired staff, employed by the Provider after July 1, 2019, must obtain a Training Certificate or a Certification no later than July 1, 2024.

                a) Beginning July 1, 2024, newly hired staff must be supervised by existing staff until the newly hired staff has obtained the required Training Certificate or Certification.

        ii. Department approval required.

            1) The Training Certificate or Certification required under section 8.500.98.C.1.a must be pre-approved by the Department.

                a) Providers must submit the following information to the Department for pre-approval review:

                    i) Provider name.

ii) A current Internal Revenue Service Form W-9.

iii) Seeking approval for:

1. Training Certificate, or

2. Certification, or

3. Training Certificate and Certification.

iv) Name of training, if applicable, including:

1. Number of staff to be trained.

2. Documentation that the training is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

v) Name of Certification, if applicable, including:

1. Number of staff to receive Certification.

2. Documentation that the Certification is nationally recognized, which includes but is not limited to, standards that are set and approved by a relevant industry group or governing body nationwide.

vi) Dates of training, if applicable, including:

1. Whether a certificate of completion is received.

vii) Date of Certification exam, if applicable.

b) Department approval will be based on alignment with the following core competencies:

i) Core values and principles of Supported Employment, including the following:

1. The priority is employment for all working-age persons with disabilities and that all people are capable of full participation in employment and community life. These values and principles are essential to successfully providing Supported Employment services.

ii) The Person-centered process, including the following:

1. The process that identifies the strengths, preferences, needs (clinical and support), and desired outcomes of the individual and individually identified goals and preferences related to relationships, community participation, employment, income and savings, healthcare and wellness, and education. The Person-centered approach includes working with a team where the individual chooses the people involved on the team and receives: necessary information and support to ensure he or she is able to direct the process to the maximum extent possible; effective communication; and appropriate assessment.

iii) Individualized career assessment and planning, including the following:

1. The process used to determine the individual's strengths, needs, and interests to support career exploration and leads to effective career planning, including the consideration of necessary accommodations and benefits planning.

iv) Individualized job development, including the following:

1. Identifying and creating individualized competitive integrated employment opportunities for individuals with significant disabilities, which meet the needs of both the employer and the individuals. This competency includes negotiation of necessary disability accommodations.

v) Individualized job coaching, including the following:

1. Providing necessary workplace supports to clients with significant disabilities to ensure success in competitive integrated employment and resulting in a reduction in the need for paid workplace supports over time.

vi) Job Development, including the following:

1. Effectively engaging employers for the purpose of community job development for clients with significant disabilities,

which meets the needs of both the employer and the client.

c) The Department, in consultation with the Colorado Department of Labor and Employment's Division of Vocational Rehabilitation, will either grant or deny approval and notify the Provider of its determination within 30 days of receiving the pre-approval request under 8.500.98.C.1.a.ii.1.a.

8.500.104 PROVIDER REIMBURSEMENT

8.500.104.G Reimbursement for Supported Employment Training Certificate or Certification, or both, under section 8.500.98.C.1.a, which includes both the cost of attending a training or obtaining a certification, or both, and the wages paid to employees during training, is available only if appropriations have been made to the Department to reimburse providers for such costs.

1. Providers seeking reimbursement for a completed Training Certificate or Certification approved under section 8.500.98.C.1.a.ii.1.c must submit the following to the Department:

    a. Supported Employment Providers must submit all Training Certificate and Certification reimbursement requests to the Department within 30 days after the pre-approved date of the training or certification, except for trainings and certifications completed in June, the last month of the State Fiscal Year. All reimbursement requests for trainings or certifications completed in June must be submitted to the Department by June 30 of each year to ensure payment.

        i. Reimbursement requests must include documentation of successful completion of the training or certification process, to include either a Training Certificate or a Certification, as applicable.

2. Within 30 days of receiving documentation under section 8.500.104.G.1.a, the Department will determine whether it satisfies the pre-approved Training Certificate or Certification under section 8.500.98.C.1.a.ii and either notify the Provider of the denial or, if approved, reimburse the Provider.

    a. Reimbursement is limited to the following amounts, and includes wages:

        ii. Up to $300 per certification exam.

        iii. Up to $1,200 for each training.