DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning the Children's Habilitation Residential Program (CHRP) waiver service description and service provider updates, Section 8.500
Rule Number: MSB 20-06-17-A
Division / Contact / Phone: Benefits and Services Management / Kathleen Homan / 5749

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 20-06-17-A, Revision to the Medical Assistance Act Rule concerning the Children's Habilitation Residential Program (CHRP) waiver service description and service provider updates at 10 CCR 2505-10 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) 10 CCR 2505-10 8.500 Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.508 with the proposed text beginning at 8.508.20.A through the end of 8.508.180. This rule is effective November 30, 2020.

*to be completed by MSB Board Coordinator

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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 basis of this rule change is to align the CHRP rules with the waiver amendment approved by the Centers for Medicare and Medicaid Services (CMS) effective July 1, 2020. The purpose is to amend the rule to update the service limitations of Supported Community Connections from an "hour per week" to "hours or units per year." Additionally, the names of two services: Supported Community Connections and In-Home Supports services are being changed. Lastly, Host Homes are being added as a provider for youth ages 18-20.

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:

   The waiver was granted under Section 1915(c) of the Social Security Act, 42 U.S.C. § 1396n (2020).

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   25.5-5-306 and 25.5-6-903, C.R.S (2020).

Initial Review **09/11/2020** Final Adoption **10/09/2020**
Proposed Effective Date **11/30/2020** Emergency Adoption

DOCUMENT #01

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REGULATORY ANALYSIS

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

   The proposed rule will affect children and youth with intellectual and developmental disabilities and complex behavior support needs, as well as the family of those children and youth. The benefit of the proposed rule is to expand provider capacity for Habilitation (residential) services by allowing Host Homes as a provider type for youth aged 18-20. The name changes for two of the services help to better describe and present the service. Lastly, changing the service limitations for Community Connector service adds flexibility in how the service can be used for families and youth.

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

   The proposed rule expands options for youth and families to access Habilitation services and supportive services. These changes will improve member outcomes and decrease the use of high-cost crisis 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.

   It is not anticipated that the proposed rule will increase utilization of waiver services as the eligibility criteria for the waiver has not changed. The service limitations of Community Connector services are being changed to allow further flexibility in its use, but the limitations are not being increased. The proposed rule increases choice of provider for current and projected enrollees. It is anticipated that the changes to the CHRP waiver will reduce the financial impact on other systems such as Child Welfare, emergency crisis services, and the juvenile justice system.

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

Improved system efficiency and investment in services to help mitigate crises will improve access and outcomes for members. Additionally, increasing the potential provider pool allows for more options for youth receiving Habilitation (residential) services. It is anticipated that this will result in decreased utilization of high cost residential services, including out of state services, and supporting youth to remain in the community rather than residential facilities.

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

   Many changes have been made to the waiver to meet the needs of this population. However, there are still limited providers across the state. As a result, families may still have to engage the child-welfare system, emergency services, hospitalization, and out of state services which are must more costly and intrusive than the proposed rule. There are no less costly or less intrusive methods to achieve the purpose of the proposed rule.

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

   There are not any alternative methods to achieve the purpose for the proposed rule. In order to ensure compliance with Federal and State requirements for reimbursement of waiver services, the authority for provider qualifications and reimbursement needs to be a regulatory requirement to align with the Federally approved waiver.

8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

8.508.20.A DEFINITIONS

1. Abuse: As defined at §25.5-10-202 (1) (a)-(c), C.R.S.

2. Adverse Action: A denial, reduction, termination, or suspension from a Long-Term Services and Supports (LTSS) program or service.

3. Applicant: A child or youth who is seeking a Long-Term Care eligibility determination and who has not affirmatively declined to apply for Medicaid or participate in an assessment.

4. Caretaker: As defined at § 25.5-10-202(1.6)(a)-(c), C.R.S.

5. Caretaker neglect: As defined at § 25.5-10-202(1.8)(a)-(c), C.R.S.

6. Case Management Agency (CMA): A public or private not-for-profit 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 sections 25.5-10-209.5 C.R.S. and pursuant to a provider participation agreement with the state department.

7. Child Placement Agency: As defined at 12 CCR 2509-8; § 7.701.2 (F).

8. Client: A child or youth who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community Based Services (HCBS)

9. Client Representative: A person who is designated 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, or a parent of a minor child; or (b) an individual, family member or friend selected by the client to speak for an/or act on the client's behalf.

10. Community Centered Board: A private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., 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.

11. Complex Behavior: Behavior that occurs related to a diagnosis by a licensed physician, psychiatrist, or psychologist that includes one or more substantial disorders of the cognitive, volitional or emotional process that grossly impairs judgment or capacity to recognize reality or to control behavior.

12. Complex Medical Needs: Needs that occur as a result of a chronic medical condition as diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12) months, requires skilled care, and that without intervention may result in a severely life altering condition.

13. Comprehensive Assessment: An initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the client experiences significant change in need or in level of support.

14. Cost Containment: 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.

15. Criminal Activity: A criminal offense that is committed by a person; a violation of parole or probation; and any criminal offense that is committed by a person receiving services that results in immediate incarceration.

16. Crisis: An event, series of events, and/or state of being greater than normal severity for the Client and/or family that becomes outside the manageable range for the Client and/or their family and poses a danger to self, family, and/or the community. Crisis may be self-identified, family identified, and/or identified by an outside party.

17. Critical Incident: Incidents of Mistreatment; Abuse; Neglect; Exploitation, Criminal Activity; Damage to Client's Property/Theft; Death unexpected or expected; Injury/Illness to Client; Medication Mismanagement; Missing Person; Unsafe Housing/Displacement; and/or Other Serious Issues.

18. Department: The Colorado Department of Health Care Policy and Financing the single state Medicaid agency.

19. Damage to Client's Property/Theft: Deliberate damage, destruction, theft or use a Client's belongings or money. If the incident involves Mistreatment by a Caretaker that results in damage tor Client's property or theft in the incident shall be listed as Mistreatment.

20. Developmental Delay: 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 CCB.

21. Early and Periodic Screening Diagnosis and Treatment (EPSDT): As defined in Section 8.280.1.

22. Exploitation: As defined in §25.5-10-202(15.5)(a)-(d), C.R.S.

23. Extraordinary Needs: A level of care due to Complex Behavior and/or Medical Support Needs that is provided in a residential child care facility or that is provided through community based programs, and without such care, would place a child at risk of unwarranted child welfare involvement or other system involvement.

24. Family: As defined at § 25.5-10-202~~)~~(16)(a)(I)-(IV)(b), C.R.S.

25. Foster Care Home: A family care home providing 24-hour care for a child or children and certified by either a County Department of Social/Human Services or a child placement agency. A Foster Care Home, for the purposes of this waiver, shall not include a family member as defined in § 25.5 10-202(16)(a)(I)-(IV)(b), C.R.S.

26. Guardian: 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 guardian ad litem.

27. Guardian ad litem or GAL": 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.

28. Home and Community Based Services (HCBS) Waivers: Services and supports authorized through a 1915 (c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

29. Host Home: ~~means residential habilitation provided in group living environments through GRSS or IRSS as defined by 8.500.1.S and 8.500.1.W.~~ A twenty-four (24) hour residential setting with no more than three (3) Clients receiving Habilitation.

30. Host Home Provider: An individual(s) who provides residential supports in his/her home to persons receiving Habilitation services who are not family members as defined in~~t~~ § 25.5-10-202~~)~~(16)(a)(I)-(IV)(b), C.R.S.

31. Increased Risk Factors: Situations or events that when occur at a certain frequency or pattern historically have led to Crisis.

32. Informed Consent: An assent that is expressed in writing, freely given, and preceded by the following:

A fair explanation of the procedures to be followed, including an identification of those which are experimental;

A description of the attendant discomforts and risks;

A description of the expected benefits;

A disclosure of appropriate alternative procedures together with an explanation of the respective benefits, discomforts and risks;

An offer to answer any inquiries regarding the procedure(s);

An instruction that the person giving consent is free to withdraw such consent and discontinue participation in the project or activity at any time; and,

A statement that withholding or withdrawal of consent shall not prejudice future availability of services and supports.

33. Injury/Illness to Client: An injury or illness that requires treatment beyond first aid which includes lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, and skin wounds; an injury or illness requiring immediate emergency medical treatment to preserve

life or limb; an emergency medical treatment that results in admission to the hospital; and a psychiatric crisis resulting in unplanned hospitalization.

34. Institution: A hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the State Plan.

35. Intellectual and Developmental Disability: A disability that manifests before the person reaches twenty-two (22) years of age, that constitutes a substantial disability to the affected person, and that is attributable to an intellectual and developmental disability or related conditions, including Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the condition or conditions result in impairment of general intellectual functioning or adaptive behavior similar to that of a person with an intellectual and developmental disability. Unless otherwise specifically stated, the federal definition of “developmental disability” found in 42 U.S.C. sec. 15001 et seq., does not apply.

“Impairment of general intellectual functioning” 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 intellectual and developmental disabilities” 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” 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.

36. Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID): A publicly or privately operated facility that provides health and habilitation services to a client with developmental disabilities or related conditions.

37. Kin: As defined in 12 CCR 2509-1, Section 7.000.2.A.

38. Kinship Foster Care Home: As defined in 12 CCR 2509-1, Section 7.000.2.A.

39. Level of Care (LOC): The specified minimum amount of assistance a Client must require in order to receive services in an institutional setting under the Medicaid State Plan.

40. Level of Care Determination: An eligibility determination by a CCB of an Individual for a Long-Term Services and Supports (LTSS) program.

41. Level of Care Evaluation: A comprehensive evaluation with the Individual seeking services and others chosen by the Individual to participate, conducted by the case manager utilizing the Department's prescribed tool, with supporting diagnostic information from the Individual's medical providers, for the purpose of determining the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports (LTSS) programs.

42. Licensed Child Care Center (less than 24 hours): As defined in§ 26-6-102 (5), C.R.S. and as described in 12 CCR 2509-8; §7.701.

43. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Clients of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

44. Medicaid Eligible: The Applicant or Client meets the criteria for Medicaid benefits based on the financial determination and disability determination.

45. Medicaid State Plan: 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.

46. Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

47. Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or there is a risk to public safety.

48. "Mistreated" or "Mistreatment": As defined at § 25.5-10-202(29.5)(a)-(e), C.R.S.

49. Natural Supports: Unpaid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

50. Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.

51. Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or lesser likelihood of success of Crisis interventions.

52. Prior Authorization: Approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the CMA.

53. Professional: Any person, not including family, performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

54. Professional Medical Information Page (PMIP): The medical information form signed by a Licensed Medical Professional used to verify that a Client needs institutional Level of Care.

55. Relative: A person related to the Client by blood, marriage, adoption or common law marriage.

56. Residential Child Care Facility: As defined in 12 CCR 2509-8; §7.705.1.

57. Retrospective Review: The Department's review after services and supports are provided to ensure the Client received services according to the service plan and standards of economy, efficiency and quality of service.

58. Separation: The restriction of a Client for a period of time to a designated area from which the is not physically prevented from leaving, for the purpose of providing the Client an opportunity to regain self-control.

59. Service Provider: A Specialized Group Facility, Residential Child Care Facility, Foster Care Home, Kinship Foster Care Home, Child Placement Agency, Licensed Child Care Facility (non-24 hours), and/or Medicaid enrolled provider.

60. Service Plan: The written document that specifies identified and needed services, to include Medicaid and non-Medicaid covered services regardless of funding source, to assist a Client to remain safely in the community and developed in accordance with Department regulations.

61. Service Planning: The process of working with the Client receiving services and people chosen by the Individual, to identify goals, needed services, and appropriate service providers based on the Comprehensive Assessment and knowledge of the available community resources. Service planning informs the Individual seeking or receiving services of his or her rights and responsibilities.

62. Specialized Group Facility: As defined in 12 CCR 2509-8; § 7.701.2(B).

63. Support: Any task performed for the Client where learning is secondary or incidental to the task itself or an adaptation is provided.

64. Support Level: A numeric value determined by the Support Need Level Assessment that places Clients into groups with other Clients who have similar overall support needs.

65. Support Need Level Assessment: The standardized assessment tool used to identify and measure the support requirements for HCBS-CHRP waiver participants.

66. Targeted Case Management (TCM): Has the same meaning as in Section 8.761.

67. Third Party Resources: Services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to community resources, services provided through private insurance, non-profit services and other government programs.

68. Unsafe Housing/Displacement: An individual residing in an unsafe living condition due to a natural event (such as fire or flood) or environmental hazard (such as infestation) and is at risk of eviction or homelessness.

69. Waiver Service: Optional services defined in the current federally approved waivers and do not include Medicaid State Plan benefits.

70. Wraparound Facilitator: A person who has a Bachelor's degree in a human behavioral science or related field of study and is certified in a wraparound training program. Experience working with LTSS populations in a private or public social services agency may substitute for the Bachelor's degree on a year for year basis. When using a combination of experience and education to qualify, the education must have a strong emphasis in a human behavioral science field. The wraparound certification must include training in the following:

    Trauma informed care.

Youth mental health first aid.

Crisis supports and planning.

Positive Behavior Supports, behavior intervention, and de-escalation techniques.

Cultural and linguistic competency.

Family and youth serving systems.

Family engagement.

Child and adolescent development.

Accessing community resources and services.

Conflict resolution.

Intellectual and developmental disabilities.

Mental health topics and services.

Substance abuse topics and services.

Psychotropic medications.

Motivational interviewing.

Prevention, detection, and reporting of Mistreatment, Abuse, Neglect, and Exploitation.

71. Wraparound Transition Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a transition to the family home after out of home placement.

72. Wraparound Plan: A single plan that incorporates all relevant supports, services, strategies, and goals from other service/treatment plans in place and supports a Client and his or her family, including a plan to maintain stabilization, prevent Crisis, and/or for de-escalation of Crisis situations.

73. Wraparound Support Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

74. Wraparound Transition Team: Case managers, Licensed Medical Professionals, behavioral health professionals, therapeutic support professionals, representatives from education, and other relevant people involved in the support/treating the Client and his or her family.

8.508.30 SCOPE OF SERVICES

A. The HCBS-CHRP waiver provides services and supports to eligible children and youth with Intellectual and Developmental Disability, and who are at risk of institutionalization pursuant to §25.5-6-903, C.R.S. The services provided through this waiver serve as an alternative to ICF/IID placement for children from birth to twenty-one years (21) of age who meet the eligibility criteria and the Level of Care as determined by a Level of Care Evaluation and Determination. The services provided through the HCBS-CHRP waiver are limited to:

1. Habilitation

2. Hippotherapy

3. Intensive Support

4. Massage Therapy

5. Movement Therapy

6. Respite

7. ~~Supported Community Connection~~ Community Connector

8. Transition Support

B. HCBS-CHRP waiver services shall be provided in accordance with these rules and regulations.

8.508.100 SERVICE DESCRIPTIONS

A. Habilitation

1. Services may be provided to Clients who require additional care for the Client to remain safely in home and community based settings. The Client must demonstrate the need for such services above and beyond those of a typical child of the same age.

2. Habilitation services include those that assist Clients in acquiring, retaining, and improving the self-help, socialization, and adaptive skills necessary to reside successfully in home and community based settings.

3. Habilitation services under the HCBS-CHRP waiver differ in scope, nature, supervision, and/or provider type (including provider training requirements and qualifications) from any other services in the Medicaid State Plan.

4. Habilitation is a twenty-four (24) hour service and includes the following activities:

   a. Independent living training, which may include personal care, household services, infant and childcare when the Client has a child, and communication skills.

   b. Self-advocacy training and support which may include assistance and teaching of appropriate and effective ways to make individual choices, accessing needed services, asking for help, recognizing Abuse, Neglect, Mistreatment, and/or Exploitation of self, responsibility for one's own actions, and participation in meetings.

   c. Cognitive services which includes assistance with additional concepts and materials to enhance communication.

   d. Emergency assistance which includes safety planning, fire and disaster drills, and crisis intervention.

   e. Community access supports which includes assistance developing the abilities and skills necessary to enable the Client to access typical activities and functions of community life such as education, training, and volunteer activities.

Community access supports includes providing a wide variety of opportunities to develop socially appropriate behaviors, facilitate and build relationships and Natural Supports in the community while utilizing the community as a learning environment to provide services and supports as identified in the Client's Service Plan. These activities are conducted in a variety of settings in which the Client interacts with non-disabled individuals (other than those individuals who are providing services to the Client). These services may include socialization, adaptive skills, and personnel to accompany and support the individual in community settings, resources necessary for participation in activities and supplies related to skill acquisition, retention, or improvement and are based on the interest of the Client.

f. Transportation services are encompassed within Habilitation and are not duplicative of the non-emergent medical transportation that is authorized in the Medicaid State Plan. Transportation services are more specific to supports provided by Foster Care Homes, Kinship Foster Care Homes, Specialized Group Facilities, and Residential Child Care Facilities to access activities and functions of community life.

g. Follow-up counseling, behavioral, or other therapeutic interventions, and physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

h. Medical and health care services that are integral to meeting the daily needs of the Client and include such tasks as routine administration of medications or providing support when the Client is ill.

B. Habilitation may be provided in a Foster Care Home or Kinship Foster Care Home certified by a licensed Child Placement Agency or County Department of Human Services, Specialized Group Facility licensed by the Colorado Department of Human Services, or Residential Child Care Facility licensed by the Colorado Department of Human Services.

C. Habilitation may be provided for clients age eighteen (18) to twenty (20) in a Host Home. The Host Home must meet all requirements as defined in Section ~~10 CCR 2505-10~~ 8.600.

1. Habilitation capacity limits:

a. A Foster Care Home or Kinship Foster Care Home may serve a maximum of one (1) Client enrolled in the HCBS-CHRP waiver and two (2) other foster children, or two (2) Clients enrolled in the HCBS-CHRP waiver and no other foster children, unless there has been prior written approval by the Department. Placements of three (3) Clients approved for the HCBS-CHRP waiver may be made if the Service Provider can demonstrate to the Department that the Foster Care Home provider has sufficient knowledge, experience, and supports to safely meet the needs of all of the children in the home. In any case, no more than three (3) Clients enrolled in the HCBS-CHRP waiver will be placed in the same foster home. Emergency placements will not exceed the maximum established limits. Foster Care Homes that exceed established capacity at the time the rule takes effect will be grandfathered in; however, with attrition, capacity must comply with the rule.

Foster Care Home Maximum Capacity

HCBS-CHRP waiver	Non HCBS-CHRP	Total Children
1	2	3
2	0	2

3	0	3

b. Placement of a Client in a Specialized Group Facility is prohibited if the placement will result in more than eight (8) children including one (1) Client enrolled in the HCBS-CHRP waiver, or five (5) foster children including two (2) Clients enrolled in the HCBS-CHRP waiver, unless there has been prior written approval by the Department. If placement of a child in a specialized group Facility will result in more than three (3) Clients enrolled in the HCBS-CHRP waiver, then the total number of children placed in that specialized group Facility must not exceed a maximum of six (6) total children. Placements of more than three (3) Clients enrolled in the HCBS-CHRP waiver may be made if the Service Provider can demonstrate to the he Department hat the facility staff have sufficient knowledge, experience, and supports to safely meet the needs of all of the children in the facility.

Specialized Group Facility Maximum Capacity

HCBS-CHRP waiver	Non HCBS-CHRP waiver	Total Children
1	8	9
2	5	7

c. Only one (1) HCBS-CHRP Client and two (2) HCBS- Persons with Developmental Disabilities (DD) or HCBS- Supported Living Services (SLS) waiver participants; or two (2) HCBS-CHRP participants and one HCBS-DD or HCBS-SLS waiver participant may live in the same foster care home.

~~C~~D. The Service Provider or child placement agency shall ensure choice is provided to all Clients in their living arrangement.

E.~~D~~. The Foster Care Home or Kinship Foster Care Home provider must ensure a safe environment and safely meet the needs of all Clients living in the home.

F~~E~~. The Service Provider shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification before any child or youth can be placed in that home. If emergency placement is needed outside of business hours, the Service Provider or child placement agency shall provide the CMA a copy of the Foster Care Home or Kinship Foster Care Home certification the next business day.

G~~F~~. Hippotherapy

1. Hippotherapy is a therapeutic treatment strategy that uses the movement of a horse to assist in the development/enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavioral, and communication skills.

2. Hippotherapy may be provided only when the provider is licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

3. Hippotherapy must be used as a treatment strategy for an identified medical or behavioral need.

4. Hippotherapy must be an identified need in the Service Plan.

5. Hippotherapy must be recommended or prescribed by a licensed physician or therapist who is enrolled as a Medicaid provider. The recommendation must clearly identify the need for hippotherapy, recommended treatment, and expected outcome.

6. The recommending therapist or physician must monitor the progress of the hippotherapy treatment at least quarterly.

7. Hippotherapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT, or from a Third Party Resource.

8. Equine therapy and therapeutic riding are excluded.

HG. Intensive Support

1. This service aligns strategies, interventions, and supports for the Client, and family, to prevent the need for out of home placement.

2. This service may be utilized in maintaining stabilization, preventing Crisis situations, and/or de-escalation of a Crisis.

3. Intensive support services include:

   a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the child or youth and family.

   b. Identification of needs for Crisis prevention and intervention including, but not limited to:

      i. Cause(s) and triggers that could lead to a Crisis.

      ii. Physical and behavioral health factors.

      iii. Education services.

      iv. Family dynamics.

      v. Schedules and routines.

      vi. Current or history of police involvement.

      vii. Current or history of medical and behavioral health hospitalizations.

      viii. Current services.

      ix. Adaptive equipment needs.

      x. Past interventions and outcomes.

      xi. Immediate need for resources.

      xii. Respite services.

      xiii. Predictive Risk Factors.

      xiv. Increased Risk Factors.

4. Development of a Wraparound Plan with action steps to implement support strategies, prevent, and/or manage a future Crisis to include, but not limited to:

a. The unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and family.

b. Environmental modifications.

c. Support needs in the family home.

d. Respite services.

e. Strategies to prevent Crisis triggers.

f. Strategies for Predictive and/or Increased Risk Factors.

g. Learning new adaptive or life skills.

h. Behavioral or other therapeutic interventions to further stabilize the Client emotionally and behaviorally and to decrease the frequency and duration of any future behavioral Crises.

i. Medication management and stabilization.

j. Physical health.

k. Identification of training needs and connection to training for family members, Natural Supports, and paid staff.

l. Determination of criteria to achieve stabilization in the family home.

m. Identification of how the plan will be phased out once the Client has stabilized.

n. Contingency plan for out of home placement.

o. Coordination among Family caregivers, other Family members, service providers, Natural Supports, Professionals, and case managers required to implement the Wraparound Plan.

p. Dissemination of the Wraparound Plan to all individuals involved in plan implementation.

5. ~~In-Home Support~~Child and Youth Mentorship.

a. The type, frequency, and duration of in-home support services must be included in a Wraparound Plan.

b. Child and Youth Mentorship ~~In-Home Support Services~~ includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the child or youth with self-care, learning self-advocacy, and protective oversight.

c. Service may be provided in the Client's home or community as determined by the Wraparound Plan.

6. Follow-up services.

a. Follow-up services include an evaluation to ensure that triggers to the Crisis have been addressed in order to maintain stabilization and prevent a future Crisis.

b. An evaluation of the Wraparound Plan should occur at a frequency determined by the Client's needs and include at a minimum, visits to the Client's home, review of documentation, and coordination with other Professionals and/or members of the Wraparound Support Team to determine progress.

c. Services include a review of the Client's ~~stability, and~~stability and monitoring of Increased Risk Factors that could indicate a repeat Crisis.

d. Revision of the Wraparound Plan should be completed as necessary to avert a Crisis or Crisis escalation.

e. Services include ensuring that follow-up appointments are made and kept.

7. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the Client, their Family, and their Wraparound Support Team.

8. All service and supports providers on the Wraparound Support Team must adhere to the Wraparound Plan.

9. Revision of strategies should be a continuous process by the Wraparound Support Team in collaboration with the Client, until the Client is stable and there is no longer a need for Intensive Support Services.

10. On-going evaluation after completion of the Wraparound Plan may be provided if there is a need to support the Client and his or her Family in connecting to any additional resources needed to prevent a future Crisis.

~~I~~H. Massage Therapy

1. Massage therapy is the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation, and muscle tension including WATSU.

2. Children with specific developmental disorders often experience painful muscle contractions. Massage has been shown to be an effective treatment for easing muscle contracture, releasing spasms, and improving muscle extension, thereby reducing pain.

3. Massage therapists must be licensed, certified, registered, and/or accredited by an appropriate national accreditation association.

4. The service must be used as a treatment strategy for an identified medical or behavioral need and included in the Service Plan.

5. Massage therapy services must be recommended or prescribed by a therapist or physician who is an enrolled Medicaid Provider. The recommendation must include the medical or behavioral need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the massage therapy treatment at least quarterly.

6. Massage therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.

J~~I~~. Movement Therapy

1. Movement therapy is 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, pain management, cognition and gross motor skills.

2. Movement therapy providers must be meet the educational requirements and is certified, registered and/or accredited by an appropriate national accreditation association.

3. Movement therapy is only authorized as a treatment strategy for a specific medical or behavioral need and identified in the Client's Service Plan.

4. Movement therapy must be recommended or prescribed by a therapist or physician who is enrolled Medicaid provider. The recommendation must include the medical need to be addressed and expected outcome. The recommending therapist or physician must monitor the progress and effectiveness of the movement therapy at least quarterly.

5. Movement Therapy is not available under CHRP benefits if it is available under the Medicaid State Plan, EPSDT or from a Third-Party Resource.

K~~J~~. Respite

1. Respite services are provided to children or youth living in the Family home on a short-term basis because of the absence or need for relief of the primary Caretaker(s)

2. Respite services may be provided in a certified Foster Care Home, Kinship Foster Care Home, Licensed Residential Child Care Facility, Licensed Specialized Group Facility, Licensed Child Care Center (less than 24 hours), in the Family home, or in the community.

3. Federal financial participation is not available for the cost of room and board, except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

4. Respite care is authorized for short-term temporary relief of the Caretaker for not more than seven (7) consecutive days per month, not to exceed twenty-eight (28) days in a calendar year.

5. During the time when Respite care is occurring, the Foster Care Home or Kinship Care Home may not exceed six (6) foster children or a maximum of eight (8) total children, with no more than two (2) children under the age of (two) 2. The respite home must be in compliance with all applicable rules and requirements for Family Foster Care Homes.

6. Respite is available for children or youth living in the Family home and may not be utilized while the Client is receiving Habilitation services.

L~~K~~. ~~Supported~~ Community ~~Connection~~ Connector

1. ~~Supported community connection~~ Community Connector services are provided one-on-one to deliver instruction for documented Complex Behavior that are exhibited by the Client while in the community, such as physically or sexually aggressive behavior towards others and/or exposing themselves.

2. Services must be provided in a setting within the community where the Client interacts with individuals without disabilities (other than the individual who is providing the service to the Client).

3. The targeted behavior, measurable goal(s), and plan to address must be clearly articulated in the Service Plan.

4. This service is limited to ~~five (5) hours per week~~ 260 hours or 1040 units per year.

5. A request to increase service hours can be made to the Department on a case-by-case basis.

M~~L~~. Transition Support

1. Transition support services align strategies, interventions, and Supports for the Client, and Family, when a Client transitions to the Family home from out-of-home placement.

2. Services include:

   a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and Family.

   b. Identification of transition needs including, but not limited to:

      i. Cause(s) of a Crisis and triggers that could lead to a Crisis.

      ii. Physical and behavioral health factors.

      iii. Education services.

      iv. Family dynamics.

      v. Schedules and routines.

      vi. Current or history of police involvement.

      vii. Current or history of medical and behavioral health hospitalizations.

      viii. Current services.

      ix. Adaptive equipment needs.

      x. Past interventions and outcomes.

      xi. Immediate need for resources.

      xii. Respite services.

      xiii. Predictive Risk Factors.

      xiv. Increased Risk Factors.

3. Development of a Wraparound Transition Plan is required, with action steps to implement strategies to address identified transition risk factors including, but not limited to:

a. Identification of the unique strengths, abilities, preferences, desires, needs, expectations, and goals of the Client and Family.

b. Environmental modifications.

c. Strategies for transition risk factors.

d. Strategies for avoiding Crisis triggers.

e. Support needs in the Family home.

f. Respite services.

g. Learning new adaptive or life skills.

h. Counseling/behavioral or other therapeutic interventions to further stabilize the Client emotionally and behaviorally to decrease the frequency and duration of future Crises.

i. Medication management and stabilization.

j. Physical health.

k. Identification of training needs and connection to training for Family members, Natural Supports, and paid staff.

l. Identification of strategies to achieve and maintain stabilization in the Family home.

m. Identification of how the Wraparound Plan will terminate once the child or youth has stabilized.

n. Coordination among Family, service providers, natural supports, professionals, and case managers required to implement the Wraparound Transition Plan.

o. Dissemination of a Wraparound Transition Plan to all involved in plan implementation.

4. ~~In-Home Support~~ Child and Youth Mentorship

a. The type, frequency, and duration of authorized services must be included in the Wraparound Plan.

b. Child and Youth Mentorship ~~In-home support services~~ includes implementation of therapeutic and/or behavioral support plans, building life skills, providing guidance to the Client with self-care, learning self-advocacy, and protective oversight.

c. Services may be provided in the Client's home or in community, as provided in the Wraparound Transition Plan.

~~d.~~

5. Follow-up services are authorized and may include:

a. Evaluation to ensure the Wraparound Transition Plan is effective in the Client achieving and maintaining stabilization in the Family home.

b. Evaluation of the Wraparound Transition plan to occur at a frequency determined by the Client's needs and includes but is not limited to, visits to the Client's home, review of documentation, and coordination with other professionals and/or members of the Wraparound Transition Support Team to determine progress.

c. Reviews of the Client's stability and monitoring of Predictive Risk Factors that could indicate a return to Crisis.

d. Revision of the Wraparound Plan as needed to avert a Crisis or Crisis escalation.

e. Ensuring that follow-up appointments are made and kept.

6. The Wraparound Facilitator is responsible for the development and implementation of the Wraparound Plan and follow-up services. The Wraparound Plan is guided and supported by the Client, their family, and their Wraparound Transition Team.

7. All service providers and supports on the Wraparound Transition Team must adhere to the Wraparound Transition Plan.

8. Revision of strategies should be a continuous process by the Wraparound Transition Team in collaboration with the Client, until stabilization is achieved and there is no longer a need for Transition Support Services.

9. On-going evaluation after completion of the Wraparound Transition Plan may be provided based on individual needs to support the Client and their family in connecting to any additional resources needed to prevent future Crisis or out of home placement.

8.508.101 USE OF RESTRAINTS

A. The definitions contained at 12 CCR 2509-8; § 7.714.1 (2019) are hereby incorporated by reference. The definition for "Client Representative" in 12 CCR 2509-8.7.714.1 is specifically excluded. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

B. Service Providers shall comply with the requirements for the use of Restraints in 12 CCR 2509-8: §§ 7.714.53 through 7.714.537 (2019) which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

C. All records of restraints shall be reviewed by a supervisor of the Service Provider within 24 hours of the incident. If it appears that the Client has been restrained excessively, frequently in a short period of time, or frequently by the same staff member, the Client's Service Plan must be reviewed.

D. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of restraints in Sections 8.608.2, 3, & 4 for Clients receiving Habilitation services age eighteen (18)- twenty (20).

8.508.102 RIGHTS MODIFICATIONS

A. Cruel and aversive therapy, or cruel and unusual discipline is prohibited.

B. Service Providers shall comply with the requirements for Client Rights in 12 CCR 2509-8; §7.714.52 (2019) which are hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public

inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

C. Rights modifications are based on the specific assessed needs of the child or youth, not the convenience of the provider.

D. Rights modifications may only be imposed if the Client poses a danger to self, Family, and/or the community.

E. The case manager is responsible for obtaining Informed Consent and other documentation supporting any rights modifications/limitations and must maintain these materials in their file as a part of the Service Plan.

F. Any rights modification must be supported by a specific assessed need and justified in the Service Plan. The following must be documented in the Service Plan:

1. Identification of a specific and individualized need.
2. Documentation of the positive interventions and supports used prior to any modifications Service Plan.
3. Documentation of less intrusive methods of meeting the Client's needs that have been tried, and the outcome.
4. A description of the rights modification to be used that is directly proportionate to respond to the specific assessed need.
5. The collection and review of data used to measure the ongoing effectiveness of the modification.
6. Established time limits for periodic reviews, no less than every six (6) months, to determine if the modification is still necessary or if it can be terminated.
7. The Informed Consent of the Individual.
8. An assurance that interventions and Support will cause no harm to the Individual.

G. Specialized Group Facilities, Foster Care Homes, Kinship Foster Care Home, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours), and Child Placement Agencies must also ensure compliance with the Colorado Department Human Services rules regarding the use of restrictive interventions at 12 CCR 2509-8.

H. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of rights modifications at § 8.604.3 and for Clients receiving Habilitation services age eighteen (18)- twenty (20).

8.508.103 MEDICATION ADMINISTRATION

A. If medications are administered during the course of HCBS-CHRP service delivery by the waiver service provider, the following shall apply:

1. Medications must by prescribed by a Licensed Medical Professional. Prescriptions and/or orders must be kept in the Client's record.
2. HCBS-CHRP waiver service providers must complete on-site monitoring of the administration of medications to waiver participants including inspecting medications for labeling, safe storage, completing pill counts, reviewing and reconciling the medication administration records, and interviews with staff and participants.
3. Specialized Group Facilities, Residential Child Care Facilities, Licensed Child Care Facilities (less than 24 hours) must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; § 7.702.52 (C).
4. Foster Care Homes and Kinship Foster Care Homes must ensure compliance with the Colorado Department of Human Services rules regarding medication administration practices at 12 CCR 2509-8; §708.41.J.
5. Persons administering medications shall complete a course in medication administration through an approved training entity approved by the Colorado Department of Public Health and Environment.
6. Host Homes and Service Providers contracting with Host Home Providers must comply with the requirements for the use of medication administration ~~at~~at § 8.609.6.D.1-8 for Clients receiving Habilitation services age eighteen (18)- twenty (20).

8.508.160 SERVICE PROVIDERS

A. Service providers for habilitation services and services provided outside the Family home shall meet all of the certification, licensing and quality assurance regulations related to their provider type (Respite Service providers that provide ~~supported community connection~~community connector, movement therapy, massage therapy, hippotherapy, intensive support, and transition support in the family home must:
   1. Meet the required qualifications as defined in the federally approved HCBS-CHRP waiver.
   2. Maintain and abide by all the terms of their Medicaid Provider Agreement and section 8.130.
   3. Comply with all the provisions of this section 8.508; and
   4. Have and maintain any required state licensure.

B. Service providers shall maintain liability insurance in at least such minimum amounts as set annually by the Department.

C. A Family member may not be a Service Agency for another Family member. A Family member may be reimbursed for certain services as approved in the waiver.

D. Service Providers shall not discontinue or refuse services to a Client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

E. Service Providers must have written policies that address the following:
   1. Access to duplication and dissemination of information from the child's or youth's records in compliance with all applicable state and federal privacy laws.
   2. How to response to alleged or suspected abuse, mistreatment, neglect, or exploitation. The policy must require immediate reporting when observed by employees and contractors to the agency administrator or designee and include mandatory reporting requirements pursuant to sections 19-3-304, C.R.S. and 18-6.5-108, C.R.S.
   3. The use of restraints, the rights of Client's, and rights modifications pursuant to sections 8.508.101 and 8.508.102.
   4. Medication administration pursuant to Section 8.508.103.
   5. Training employees and contractors to enable them to carry out their duties and responsibilities efficiently, effectively and competently. The policy must include staffing ratios that are sufficient to meet the individualized support needs of each Client receiving services.
   6. Emergency procedures including response to fire, evacuation, severe weather, natural disasters, relocation, and staffing shortages.

F. Service Provides must maintain records to substantiate claims for reimbursement in accordance with Department regulations and guidance.

G. Service Providers must comply with all federal and state program reviews and financial audits of HCBS-CHRP waiver services.

H. Service Providers must comply with requests by the Department to collect, review, and maintain individual or agency information on the HCBS-CHRP waiver.

I. Service Providers must comply with requests by the CMA to monitor service delivery through Targeted Case Management.

8.508.180 CLIENT'S RIGHTS

A. Service Providers shall comply with the requirements for Client's Rights in 12 CCR 2509-8; § 7.714.31 (2019) which is hereby incorporated by reference. The incorporation of these regulations excludes later amendments to the regulations. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Copies of incorporated materials are provided at cost upon request.

B. Every Client has the right to the same consideration and treatment as anyone else regardless of race, color, national origin, religion, age, sex, gender identity, political affiliation, sexual orientation, financial status or disability.

C. Every Client has the right to access age appropriate forms of communication including text, email, and social media.

D. No Client, his/her Family members, Guardian or Client Representative may be retaliated against in their receipt of services or supports as a result of attempts to advocate on their own behalf.

E. Each Client receiving services has the right to read or have explained in each Client's and Family's native language, any policies and/or procedures adopted by the Service Agency.

F. Host Homes and Service Providers contracting with Host Home Providers must comply with the procedural requirements regarding rights at ~~t~~ § 8.604.2 for Clients receiving Habilitation services age eighteen (18)- twenty (20).

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Long Term Oxygen Annual Review, Section 8.580.5.C
Rule Number: MSB 20-07-06-A
Division / Contact / Phone: Health Programs / 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 20-07-06-A, Revision to the Medical Assistance Rule concerning Long Term Oxygen Annual Review, Section 8.580.5.C

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) 8.580.5.C, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.580 with the proposed text beginning at 8.580.5.C through the end of 8.580.C.2. This rule is effective November 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Long Term Oxygen Annual Review, Section 8.580.5.C
Rule Number: MSB 20-07-06-A
Division / Contact / Phone: Health Programs / 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 includes a permanent citation to the long term oxygen annual review requirement of 42 C.F.R. 440.70(b)(3)(iii), which was temporarily suspended for the COVID-19 public health emergency in emergency rule MSB 20-04-27-A along with the annual Certificate of Medical Necessity requirement. Clients certified for long term oxygen for twenty-four consecutive months no longer require a Certificate of Medical Necessity for oxygen, but still require a documented annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii). Documented annual reviews include a renewed prescription for oxygen or other medical record documentation. The rule purpose is to permanently include a citation to 42 C.F.R. 440.70(b)(3)(iii) in the long term oxygen rule.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 C.F.R. 440.70(b)(3)(iii)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   Section 25.5-4-416, C.R.S. (2019)

Initial Review **9/11/2020** Final Adoption **10/9/2020**
Proposed Effective Date **11/30/2020** Emergency Adoption

DOCUMENT #02

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Long Term Oxygen Annual Review, Section 8.580.5.C
Rule Number: MSB 20-07-06-A
Division / Contact / Phone: Health Programs / 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 receiving long term oxygen and providers supplying long term oxygen will be affected by the proposed rule and bear the cost of obtaining an annual review for long term oxygen, pursuant to 42 C.F.R. 440.70(b)(3)(iii). The Department is adding this existing federal regulation citation to rule for regulatory clarity, it is not a new requirement.

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

   Clients are required to get an annual review for long term oxygen, documented in a renewed prescription for oxygen or other medical record documentation. To support claims for reimbursement for clients on long term oxygen twenty-four months or longer, providers will be required to maintain the client's annual review on file.

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

   There are no costs to the Department or to any other agency to implement or enforce the proposed rule and there is no anticipated effect on state revenues.

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

   Because this is an existing federal regulation and it is not a new requirement, there are no new costs of the proposed rule. The benefit of the proposed rule is regulatory clarity by including the federal regulation citation in Department rule.

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

   There are no less costly methods or intrusive methods to add this federal regulation citation to Department rule.

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

   There are no alternative methods to add this federal regulation citation to Department rule.

8.580 DURABLE MEDICAL EQUIPMENT – OXYGEN AND OXYGEN EQUIPMENT

8.580.5 COVERED SERVICES AND EQUIPMENT

8.580.5.C. Long Term Oxygen Therapy Certificate of Medical Necessity

1. Long Term Oxygen Therapy may be provided to clients for greater than ninety days with a prescription from an OPR provider identified in Section 8.580.3.A and a Certificate of Medical Necessity.

    a. The Certificate of Medical Necessity must:

        i. Be obtained by the rendering provider within one hundred twenty days of the client beginning oxygen therapy;

        ii. Be signed by a physician or licensed professional responsible for care of the client, which includes the medical director of a Nursing Facility;

        iii. Include the most recent blood gas study or oxygenation assessment, obtained within thirty days of the initial oxygen provision date on the Certificate of Medical Necessity.

    b. Recertification of the CMN required under Section 8.580.5.C.1 is required every twelve months or when the client's condition changes, whichever comes first. Pursuant to Public Law 116-127, the Families First Coronavirus Response Act, § 6008, continued coverage of oxygen is required during the Coronavirus Disease 2019 (COVID-19) public health emergency as it was covered prior the emergency. For the duration of the COVID-19 public health emergency, the CMN recertification required every twelve months under this section, and the requirement for annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii), is suspended. Clients must obtain recertification as soon as practicable after the COVID-19 public health emergency ends, as declared by the President of the United States on March 13, 2020, and every twelve months thereafter.

        i. Clients certified for twenty-four consecutive months no longer require a Certificate of Medical Necessity for oxygen, but still require a documented annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii). Documented annual reviews include a renewed prescription for oxygen or other medical record documentation.

2. Suppliers must have a completed and current Certificate of Medical Necessity on file to support claims for oxygen therapy and oxygen equipment for non-ventilator dependent

clients aged twenty and older requiring long term oxygen therapy lasting ninety days or more. For clients certified for twenty-four consecutive months, the most recent certified Certificate of Medical Necessity and the most recent annual review pursuant to 42 C.F.R. 440.70(b)(3)(iii) must be on file.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.4.A
Rule Number: MSB 20-08-19-B
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

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 20-08-19-B, Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Section 8.014.4.A.

3. This action is an adoption of: an amendment

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

   Sections(s) 8.014.4.A., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.014.4.A with the proposed text beginning at 8.014.4.A through the end of 8.014.4.A. This rule is effective November 30, 2020.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.4.A
Rule Number: MSB 20-08-19-B
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

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 removes the definition of "closest provider" as one within a 25-mile radius of the member's home. This rule is a response to the recent expansion of the NEMT broker model for the entire state. Many members in rural areas do not have a provider within 25 miles of their home. Removing this requirement will eliminate additional paperwork and work for medical providers and members, which will make it easier for members to get rides to their appointments.

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:

   Emergency rule-making is not necessary.

3. Federal authority for the Rule, if any:

   42 CFR 440.170 (2020)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   25.5-5-324, C.R.S. (2019)

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Non-Emergent Medical Transportation, Sections 8.014.4.A
Rule Number: MSB 20-08-19-B
Division / Contact / Phone: Health Programs Office / Ryan Dwyer / 303-866-6163

REGULATORY ANALYSIS

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

   Members utilizing or eligible for NEMT services (nearly all members with State Plan/Title XIX are eligible), NEMT providers, medical facilities, and the Department's NEMT broker.

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

   Affected members and medical providers will benefit from the removal of extra forms and the time spent requesting, working on, and submitting those forms. The Department's NEMT broker will benefit because it will not spend as much time processing paperwork, which will allow for increased attention to other administrative functions.

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

   There are no costs to the Department or to any other agency to implement and enforce the proposed rule.

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

   The benefit of removing this definition is that it will eliminate the need for paperwork, time spent on the phone, and time spent reviewing the forms that justify travel beyond 25 miles. Members will have an easier time scheduling their trips. Medical providers will be able to focus on providing care instead of filling out and faxing paperwork. The Department's NEMT broker will be able to focus on day-to-day operations and customer service instead of constantly reviewing documents.

   A potential cost resulting from this change is that members may receive trips to providers that are not the closest available. The broker will need to step up to ensure that trips are being properly approved.

The cost of inaction is that members and providers will become confused and frustrated by the authorization process. Some may give up and not go to their appointments. The benefit of inaction is that the Department can have more confidence that all trips beyond 25 miles are reviewed and approved, which may cut down on fraud and waste.

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

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

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

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

8.014 NON-EMERGENT MEDICAL TRANSPORTATION

8.014.1. DEFINITIONS

8.014.1.A. Access means the ability to make use of.

8.014.1.B. Air Ambulance means a Fixed-Wing or Rotor-Wing Air Ambulance equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.C. Ambulatory Vehicle means a passenger-carrying vehicle available for those clients able to walk and who do not rely on wheelchairs or other mobility devices, during boarding or transportation, which would necessitate a vehicle with a lift or other accommodations.

8.014.1.D. Ancillary Services mean services incurred indirectly when a client authorized to receive NEMT also requires the assistance of an Escort or financial assistance for meals or lodging.

8.014.1.E. At-Risk Adult means an adult who is unable to make personal or medical determinations, provide necessary self-care, or travel independently.

8.014.1.F. Child means a minor under the age of 18.

8.014.1.G. Day Treatment means facility-based services designed for Children with complex medical needs. Services include educational or day care services when the school or day care system is unable to provide skilled care in a school setting, or when the Child's medical needs put them at risk when around other Children.

8.014.1.H. Emergency Medical Transportation means Ground Ambulance or Air Ambulance transportation under Section 8.018 during which clients who are ill, injured, or otherwise mentally or physically incapacitated receive needed emergency medical services en route

8.014.1.I. Escort means a person who accompanies an At-Risk Adult or minor client.

8.014.1.J. Fixed-Wing Air Ambulance means a fixed wing aircraft that is certified as a Fixed-Wing Air Ambulance by the Federal Aviation Administration.

8.014.1.K. Ground Ambulance means a ground vehicle, including a water ambulance, equipped with medically necessary supplies to provide Emergency Medical Transportation.

8.014.1.L. Medicaid Client Transport (MCT) Permit means a permit issued by the Colorado Department of Regulatory Agencies Public Utilities Commission (PUC) in accordance with the PUC statute at Section 40-10.1-302, C.R.S.

8.014.1.M. Mode means the method of transportation.

8.014.1.N. Non-Emergent Medical Transportation (NEMT) means transportation to or from medically necessary non-emergency treatment. Non-emergency care may be scheduled or unscheduled. This may include Urgent Care transportation and hospital discharge transportation.

8.014.1.O. Program of All Inclusive Care for the Elderly (PACE) is a capitated rate benefit which provides all-inclusive long-term care to certain individuals as defined in Section 8.497.

8.014.1.P. Rotor-Wing Air Ambulance means a helicopter that is certified as an ambulance by the Federal Aviation Administration.

8.014.1.Q. State Designated Entity (SDE) means the organization responsible for administering NEMT. For the purposes of this rule, the responsible SDE is determined by the client's county of residence.

8.014.1.R. Stretcher Van means a vehicle that can legally transport a client in a prone or supine position when the client does not require medical attention en route. This may be by stretcher, board, gurney, or another appropriate device.

8.014.1.S. Taxicab means a motor vehicle operating in Taxicab Service, as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.T. Taxicab Service has the same meaning as defined in 4 CCR 723-6, § 6001(yyy) (2019), which is hereby incorporated by reference.

8.014.1.U. Trip means one-way transportation from the point of origin to the point of destination.

8.014.1.V. Urgent Care means an appointment for a covered medical service with verification from an attending physician or facility that the client must be seen or picked up from a discharged appointment within 48 hours.

8.014.1.W. Wheelchair Vehicle means a motor vehicle designed and used for the non-emergent transportation of individuals with disabilities who use a wheelchair. These vehicles include vans modified for wheelchair Access or wheelchair accessible minivans.

8.014.2. CLIENT ELIGIBILITY AND RESPONSIBILITIES

8.014.2.A. All Colorado Medical Assistance Program clients are eligible for NEMT services unless the client falls within the following eligibility groups on the date of the Trip:

1. Qualified Medicaid Beneficiary (QMB) Only

2. Special Low Income Medicare Beneficiary (SLMB) Only

3. Medicare Qualifying Individual-1 (QI-1) Only

4. Old Age Pension- State Only (OAP-state only)

8.014.2.B. Child Health Plan Plus clients are not eligible for NEMT.

8.014.2.C. PACE clients receive transportation provided by their PACE organization and are not eligible for NEMT.

8.014.2.D. NEMT services may be denied if clients do not observe the following responsibilities:

1. Comply with applicable state, local, and federal laws during transport.

2. Comply with the rules, procedures and policies of the SDE.

3. Obtain authorization from their SDE.

4. Clients must not engage in violent or illegal conduct while utilizing NEMT services.

5. Clients must not pose a direct threat to the health or safety of themselves or others, including drivers.

6. Clients must cancel their previously scheduled NEMT Trip if the ride is no longer needed, except in emergency situations or when the client is otherwise unable to cancel.

8.014.3. PROVIDER ELIGIBILITY AND RESPONSIBILITIES

8.014.3.A. Providers must enroll with the Colorado Medical Assistance Program as an NEMT provider.

8.014.3.B. Enrolled NEMT providers must:

1. Meet all provider screening requirements in Section 8.125;

2. Comply with commercial liability insurance requirements and, if applicable, PUC financial responsibility requirements established in the PUC statute at C.R.S. § 40-10.1-107;

3. Refrain from attempting to solicit clients known to have already established NEMT service with another provider;

4. Maintain and comply with the following appropriate licensure, or exemption from licensure, requirements:

   a. PUC common carrier certificate as a Taxicab;

   b. PUC MCT Permit as required by the PUC statute at C.R.S. § 40-10.1-302;

   c. Ground Ambulance license as required by Department of Public Health and Environment (CDPHE) rule at 6 CCR 1015-3, Chapter Four;

   d. Air Ambulance license as required by CDPHE rule at 6 CCR 1015-3, Chapter Five; or

   e. Exemption from licensure requirements in accordance with PUC statute at C.R.S. § 40-10.1-105.

5. Only provide NEMT services appropriate to their current licensure(s) and within the geographic limitations applicable to the licensure; and

6. Ensure that all vehicles and auxiliary equipment used to transport clients meet federal, state, and local safety inspection and maintenance requirements.

PUC statute at C.R.S. §§ 40-10.1-105, 40-10.1-107 and 40-10.1-302 (2019) and CDPHE rule at 6 CCR 1015-3, Chapters Four and Five (2019), are hereby incorporated by reference.

8.014.3.C. NEMT transportation providers must maintain a Trip report for each NEMT Trip provided and must, at a minimum, include:

1. The pick-up address;

2. The destination address;

3. Date and time of the Trip;

4. Client’s name or identifier;

5. Confirmation that the driver verified the client’s identity;

6. Confirmation by the client, Escort, or medical facility that the Trip occurred;

7. The actual pick-up and drop off time;

8. The driver's name; and

9. Identification of the vehicle in which the Trip was provided.

8.014.3.D. Multiple Loading

1. NEMT providers may not transport more than one client at the same time, unless the additional passenger is an Escort.

2. NEMT providers may transport more than one client at the same time if the trip occurs in a bus. Each client must agree to be transported with other clients and clients must sit at least six feet apart.

8.014.3.E. The Section 8.014.3 requirements do not apply to client reimbursement or bus or rail systems.

8.014.4. COVERED PLACES OF SERVICE

8.014.4.A. NEMT must be provided to the closest provider available qualified to provide the service the client is traveling to receive. ~~The closest provider is defined as a provider within a 25-mile radius of the client's residence, or the nearest provider if one is not practicing within a 25-mile radius of the client's residence.~~ Exceptions may be made by the SDE in the following circumstances:

1. If the closest provider is not willing to accept the client, the client may use NEMT to access the next closest qualified provider.

2. If the client has complex medical conditions that restrict the closest medical provider from accepting the patient, the SDE may authorize NEMT to be used to travel to the next closest qualified provider. The treating medical provider must send the SDE written documentation indicating why the client cannot be treated by the closest provider.

3. If a client has moved within the three (3) months preceding an NEMT transport, the client may use NEMT to their established medical provider seen in their previous locale. During these three (3) months, the client and medical provider must transfer care to the closest provider as defined at Section 8.014.4.B. or determine transportation options other than NEMT.

8.014.5. COVERED SERVICES

8.014.5.A. Transportation Modes

1. Covered Modes of transportation include:

a. Bus and public rail systems

i. Transit passes may be issued by the SDE when the cumulative cost of bus tickets exceeds the cost of a pass.

b. Personal vehicle mileage reimbursement

c. Ambulatory Vehicles

d. Wheelchair Vehicles

e. Taxicab Service

f. Stretcher Van

g. Ground Ambulance

h. Air Ambulance

i. Commercial plane

j. Train

8.014.5.B. NEMT Services

1. NEMT is a covered service when:

a. The client does not have Access to other means of transportation, including free transportation;

b. Transportation is required to obtain a non-emergency service(s) that is medically necessary, as defined in Section 8.076.1.8.; and

c. The client is receiving a service covered by the Colorado Medical Assistance Program.

2. NEMT services may be covered for clients even if the medical procedure is paid for by an entity other than the Colorado Medical Assistance Program.

3. Non-emergent ambulance service (Ground and Air Ambulance), from the client's pickup point to the treating facility, is covered when:

a. Transportation by any other means would endanger the client's life; or

b. The client requires basic life support (BLS) or advanced life support (ALS) to maintain life and to be transported safely.

i. BLS includes:

1. Cardiopulmonary resuscitation, without cardiac/hemodynamic monitoring or other invasive techniques;

2. Suctioning en route (not deep suctioning); and

3. Airway control/positioning.

ii. ALS includes ALS Levels 1 and 2 in accordance with 42 CFR § 414.605 (2019), which is hereby incorporated by reference.

1. ALS Level 1 includes the provision of at least one ALS intervention required to be furnished by ALS personnel.

2. ALS Level 2 includes:

a. Administration of at least three medications by intravenous push/bolus or by continuous infusion, excluding crystalloid, hypotonic, isotonic, and hypertonic solutions (Dextrose, Normal Saline, Ringer's Lactate); or

b. The provision of at least one of the following ALS procedures:

i. Manual defibrillation/cardioversion.

ii. Endotracheal intubation.

iii. Central venous line.

iv. Cardiac pacing.

v. Chest decompression.

vi. Surgical airway.

vii. Intraosseous line.

4. NEMT may be provided to an Urgent Care appointment under the following circumstances:

a. A provider is available;

b. The appointment is for a covered medical service with verification from an attending physician that the client must be seen within 48 hours; and

c. The client is transported to an Urgent Care facility, which may include a trauma center if it is the nearest and most appropriate facility.

8.014.5.C. Personal Vehicle Mileage Reimbursement

1. Personal vehicle mileage reimbursement is covered for a privately owned, non-commercial vehicle when used to provide NEMT services in accordance with Section 8.014.5.B and owned by:

a. A client, a client’s relative, or an acquaintance; or

b. A volunteer or organization with no vested interest in the client.

2. Personal vehicle mileage reimbursement will only be made for the shortest Trip length in miles as determined by an internet-based map, Trip planner, or other Global Positioning System (GPS).

a. Exceptions can be made by the SDE if the shortest distance is impassable due to:

i. Severe weather;

ii. Road closure; or

iii. Other unforeseen circumstances outside of the client's control that severely limit using the shortest route.

b. If an exception is made under Section 8.014.5.C.2.a., the SDE must document the reason and pay mileage for the actual route traveled.

3. To be reimbursed for personal vehicle mileage, the client must provide the following information to the SDE within forty-five (45) calendar days of the final leg of the Trip:

a. Name and address of vehicle owner and driver (if different from owner);

b. Name of the insurance company and policy number for the vehicle; and

c. Driver's license number and expiration date.

8.014.5.D. Ancillary Services

1. Escort

a. The Colorado Medical Assistance Program may cover the cost of transporting one Escort when the client is:

i. A Child.

1. An Escort is required to accompany a client if the client is under thirteen (13) years old, unless the Child:

a. Is traveling to a Day Treatment program (Children are not eligible for NEMT travel to and from school-funded day treatment programs);

b. The parent or guardian signs a written release;

c. An adult will be present to receive the Child at the destination and return location; and

d. The Day Treatment program and the parents approve of the NEMT provider used.

2. Clients who are at least thirteen (13) years old, but younger than eighteen (18) years old, may travel without an Escort if:

a. The parent or guardian signs a written release; andAn adult will be present to receive the Child at the destination and return location.

ii. An At-Risk Adult unable to make personal or medical determinations, or to provide necessary self-care, as certified in writing by the client's attending Colorado Medical Assistance Program enrolled NEMT provider.

b. The Escort must be physically and cognitively capable of providing the needed services for the client.

i. If a client's primary caregiver has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay, a second Escort may be covered under Section 8.014.5.D.1.c.ii.

c. The Colorado Medical Assistance Program may cover the cost of transporting a second Escort for the client, if prior authorized under Section 8.014.7. A second Escort will only be approved if:

i. The client has a behavioral or medical condition which may cause the client to be a threat to self or to others if only one Escort is provided; or

ii. The client's primary caregiver Escort has a disability that precludes the caregiver from providing all of the client's needs during transport or extended stay.

2. Meals and Lodging

a. Meals and lodging for in-state treatment may be reimbursed when:

i. Travel cannot be completed in one calendar day; or

ii. The client requires ongoing, continuous treatment and:

1. The cost of meals and lodging is less than or equal to the cost of traveling to and from the treatment facility and the client's residence; or

2. The client's treating medical professional determines that traveling to and from the client's residence would put the client's health at risk.

b. Meals and lodging may be covered for the Escort(s) when the client is a Child or an At-Risk Adult who requires the Escort's continued stay under Section 8.014.5.D.1.

c. Reimbursement will only be made for meals and lodging for which clients and Escorts are actually charged, up to the per diem rate established by the Colorado Medical Assistance Program.

d. Meals and lodging will not be paid or reimbursed when those services are included as part of an inpatient stay.

8.014.6. NON-COVERED NEMT SERVICES AND GENERAL LIMITATIONS

8.014.6.A. The following services are not covered or reimbursable to NEMT providers as part of a NEMT service:

1. Services provided only as a convenience to the client.

2. Charges incurred while client is not in the vehicle, except for lodging and meals in accordance with Section 8.014.5.D.2.

3. Transportation to or from non-covered medical services, including services that do not qualify due to coverage limitations..

4. Waiting time.

5. Cancellations.

6. Transportation which is covered by another entity.

7. Metered taxi services.

8. Charges for additional passengers, including siblings or Children, not receiving a medical service, except when acting as an Escort under Section 8.014.5.D.1.

9. Transportation for nursing facility or group home residents to medical or rehabilitative services required in the facility's program, unless the facility does not have an available vehicle.

10. Transportation to emergency departments to receive emergency services. See Section 8.018 for Emergency Medical Transportation services.

11. Providing Escorts or the Escort's wages.

12. Trips to receive Home and Community Based Services

    a. Non-medical transportation should be utilized if other transportation options are not available to the client.

8.014.6.B. General Limitations

1. The SDE is responsible for ensuring that the client utilizes the least costly Mode of transportation available that is suitable to the client's condition.

8.014.7. AUTHORIZATION

8.014.7.A. All NEMT services must be authorized as required by the SDE.

1. Authorization requests submitted more than three months after an NEMT service is rendered will be denied.

2. NEMT services may be denied if proper documentation is not provided to the SDE.

8.014.7.B. If a client requests transportation via Wheelchair Vehicle, Stretcher Van, or ambulance, the SDE must verify the service is medically necessary with the client's medical provider

1. Medical or safety requirements must be the basis for transporting a client in the prone or supine position.

8.014.7.C. Out-of-State NEMT

1. NEMT to receive out of state treatment is permissible only if treatment is not available in the state of Colorado.

2. The following border towns are not considered out of state for the purposes of NEMT prior authorization:

   a. Arizona: Flagstaff and Teec Nos Pos.

   b. Kansas: Elkhart, Goodland, Johnson, Sharon Springs, St. Francis, Syracuse, Tribune.

   c. Nebraska: Benkelman, Cambridge, Chappell, Grant, Imperial, Kimball, Ogallala, and Sidney.

   d. New Mexico: Aztec, Chama, Farmington, Raton, and Shiprock.

   e. Oklahoma: Boise City.

   f. Utah: Monticello and Vernal.

   g. Wyoming: Cheyenne and Laramie.

8.014.7.D. Prior Authorization

1. The following services require prior authorization by Colorado Medical Assistance Program:

   a. Out-of-state travel, except to the border towns identified at section 8.014.7.C.2.

   b. Air travel, both commercial air and Air Ambulance.

   c. Train travel via commercial railway.

   d. Second Escort.

2. Prior authorization requests require the following information:

   a. NEMT prior authorization request form completed by SDE and member's physician and submitted to Colorado Medical Assistance Program according to form instructions.

      i. The Colorado Medical Assistance Program will return requests completed by non-physicians and incomplete requests to the SDE.

      ii. The Colorado Medical Assistance Program's determination will be communicated to the SDE. If additional information is requested, the SDE must obtain the information and submit to the Colorado Medical Assistance Program. If the request is denied, the SDE must send the client a denial notice.

8.014.8. INCORPORATIONS BY REFERENCE

The incorporation by reference of materials throughout section 8.014 excludes later amendments to, or editions of, the referenced materials. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business

hours, at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.