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Title of Rule: Revision to the Medical Assistance Act Rule concerning eConsults Specialist to Specialist, Section 8.095
Rule Number: MSB 24-12-05-A
Division / Contact / Phone: Health Policy Office / 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 24-12-05-A, Revision to the Medical Assistance Act Rule concerning eConsults Specialist to Specialist, Section 8.095

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) 8.095, 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 8.095 with the proposed text beginning at 8.095.1.A through the end of 8.095.4.C.2.b. This rule is effective June 14, 2025.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning eConsults Specialist to Specialist, Section 8.095
Rule Number: MSB 24-12-05-A
Division / Contact / Phone: Health Policy Office / 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).

   The Department implemented telemedicine eConsults between treating primary care providers and consulting specialty providers on February 1, 2024 after the adoption of the associated Medical Services Board rule number MSB 23-02-09-A. The Department received feedback during the rule presentations before the board that eConsult requests should not be limited to primary care providers, but also be available to specialty providers seeking consultation with other specialty providers. The Department took this into consideration and engaged stakeholders about expanding eConsults to requests between specialty providers. The proposed rule expands the authority to request an eConsult to a member's treating provider who has education, training, or qualification in a specialty field other than primary care and is a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), or physician assistant (PA). This will increase access to eConsults for members treated by specialty providers and result in more efficient and informed rendering of care.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   C.R.S. §§ 25.5-1-301 to 303
   C.R.S. § 25.5-4-103 (25.7)
   C.R.S. § 25.5-5-321.5

Initial Review	**03/14/25**	Final Adoption	**04/11/25**
Proposed Effective Date	**06/14/25**	Emergency Adoption	

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Title of Rule: Revision to the Medical Assistance Act Rule concerning eConsults Specialist to Specialist, Section 8.095
Rule Number: MSB 24-12-05-A
Division / Contact / Phone: Health Policy Office / 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.

   Members treated by specialty providers, and specialty providers, are affected by the proposed rule.

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

   Access to eConsults between specialty providers, where an in-person referral isn't necessary, will be timelier and facilitate earlier diagnosis and intervention, while also improving member management of chronic conditions that require specialist care. Co-management of members with complex, multi-specialty needs is expected to improve with the advent of eConsults between specialty providers.

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

   The probable costs to the Department are the additional eConsults requested by specialty providers. The Department anticipates this to be $394,940.

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

   The probable costs of the proposed rule are additional eConsults requested by specialty providers. The Department estimates this to be $394,940. The probable benefit of the proposed rule is increased access to eConsults for members treated by specialty providers who would benefit from the timeliness of an eConsult when an in-person referral isn't necessary. Such members may receive earlier diagnosis and intervention, and improved management of chronic conditions. The probable cost of inaction is requiring in-person referrals between specialty providers when an eConsult, where appropriate, would result in more efficient and timely care. There are no probable benefits of inaction.

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

   There is no less costly or less intrusive method to extend eConsults to consultations between specialty providers.

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 extending eConsults to consultations between specialty providers.

8.095 Telemedicine

8.095.1.A DEFINITIONS

1. Electronic Consultation (eConsult) means an asynchronous dialogue initiated by a Treating Practitioner seeking a Consulting Practitioner's expert opinion without a face-to-face member encounter with the Consulting Practitioner.

2. Electronic Consultation Platform (eConsult Platform) means a web-based and application-based electronic system authorized by the Department that allows for an asynchronous exchange between a Treating Practitioner and a Consulting Practitioner to securely share health information and discuss member care. An eConsult Platform may be either:

    a. State Platform: A platform contracted with the Department as the state's eConsult Platform.

    b. Approved Platform: Any platform other than the State Platform that meets the criteria identified by the Department.

3. Electronic Health Entity (eHealth Entity) means a group practice that delivers services exclusively through telemedicine and is enrolled in a provider type that has an eHealth specialty. eHealth entities:

    a. Cannot be Primary Care Medical Providers;

    b. Can be either in-state or out-of-state.

4. Facilitated Visit means a Telemedicine visit where the rendering provider is at a distant site and the member is physically present with a support staff team member who can assist the provider with in-person activities.

5. HIPAA means the federal "Health Insurance Portability and Accountability Act of 1996", PUB. L. 104-191, as amended~~, which is incorporated herein by reference. Pursuant to C.R.S. § 24-4-103(12.5) (2022), 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~~.

6. Primary Care Medical Provider (PCMP) means an individual physician, advanced practice nurse or physician assistant, who contracts with a Regional Accountable Entity (RAE) in the Accountable Care Collaborative (ACC), with a focus on primary care, general practice, internal medicine, pediatrics, geriatrics, or obstetrics and gynecology.

7. Consulting Practitioner means a provider who has education, training, or qualifications in a specialty field other than primary care.

8. Telemedicine means the delivery of medical and health-care services and any diagnosis, consultation, or treatment using interactive audio (including but not limited to telephone and relay calls), interactive video (including but not limited to interactive audiovisual modalities), or interactive data communication (including but not limited to live chat and excluding text messaging, electronic mail, and facsimile transmission).

9. Treating Practitioner means a member's treating physician or other qualified health care practitioner who is a primary care provider contracted with a Regional Accountable Entity to participate in the Accountable Care Collaborative as a Network Provider. Beginning July 1, 2025, a Treating Practitioner may also be a member's treating provider who has education, training, or qualification in a specialty field other than primary care and is a medical doctor (MD), doctor of osteopathy (DO), nurse practitioner (NP), or physician assistant (PA).

8.095.2 CLIENT ELIGIBILITY

8.095.2.A. All Colorado Medicaid clients are eligible for medical and behavioral services delivered by telemedicine.

8.095.3 PROVIDER ELIGIBILITY

8.095.3.A. Any licensed provider enrolled with Colorado Medicaid is eligible to provide telemedicine services within the scope of the provider's practice.

8.095.3.B. Providers that meet the definition of an eHealth Entity shall enroll as the eHealth specialty.

8.095.4 COVERED SERVICES

8.095.4.A. Covered Telemedicine services must:

1. Meet the same standard of care as in-person care;

2. Be compliant with state and federal regulations regarding care coordination;

3. Be services the Department has approved for delivery through Telemedicine;

4. Be within the provider's scope of practice and for procedure codes the provider is already eligible to bill;

5. Be provided only where contact with the provider was initiated by the member for the services rendered; and

6. Be provided only after the member's consent, either verbal or written, to receive telemedicine services is documented.

8.095.4.B. eHealth Entities shall only provide:

1. Covered Telemedicine services, including Facilitated Visits.

8.095.4.C. Beginning February 1, 2024, a Treating Practitioner may request an eConsult with a Consulting Practitioner. eConsult services must:

1. Be requested by the Treating Practitioner through an eConsult Platform;

2. Be responded to by the Consulting Practitioner through an eConsult Platform;

   a. The Consulting Practitioner may send the eConsult to another Consulting Practitioner in a different specialty practice through an eConsult Platform, when clinically appropriate.

b. For eConsults between specialty providers, the Consulting Practitioner must be in a different specialty field than the Treating Practitioner who requested the eConsult.

3. The Consulting Practitioner must, when clinically appropriate, provide clinical guidance pertaining to the eConsult electronically to the requesting Treating Practitioner through an eConsult Platform; and,

4. All dialogue between the Treating Practitioner and the Consulting Practitioner pertaining to an eConsult must be through an eConsult Platform.

8.095.5 PRIOR AUTHORIZATION REQUIREMENTS

8.095.5.A. The use of Telemedicine does not change prior authorization requirements for the underlying services provided.

8.095.6 RECORDKEEPING.

8.095.6.A. eHealth Entities must maintain a Release of Information in compliance with current HIPAA standards to facilitate communication with the member's PCMP.

8.095.7 REIMBURSEMENT

8.095.7.A Pursuant to C.R.S. § 25.5-5-320(2) (2022), the reimbursement rate for a Telemedicine service shall, as a minimum, be set at the same rate as the Colorado Medicaid rate for a comparable in-person service.

8.095.7.B. eConsults

1. eConsults are reimbursed after the eConsult is closed by the requesting Treating Practitioner and the following conditions are met:

   a. The eConsult is conducted instead of face-to-face in-person visit referral to a Consulting Practitioner;

   b. The eConsult is provided to the Treating Practitioner by the Consulting Practitioner through an eConsult Platform, with clinical guidance where appropriate; and,

   c. The eConsult is closed after the Treating Practitioner reviews the care plan provided by the Consulting Practitioner.

2. Treating Practitioners may directly submit a procedure code specific fee-for-service claim for reimbursement.

3. Consulting Practitioners who utilize an Approved Platform may directly submit a procedure code specific fee-for-service claim for reimbursement for all closed eConsults that meet the criteria in Section 8.095.7.B.1.

4. Consulting Practitioners who utilize the State Platform must only be reimbursed through the State Platform for all closed eConsults that meet the criteria in Section 8.095.7.B.1.

5. eConsults must be delivered through an eConsult Platform to be eligible for reimbursement.

8.095.8 NON-COVERED SERVICES

8.095.8.A Services not otherwise covered by Colorado Medicaid are not covered when delivered through Telemedicine.

8.095.8.B eConsults that are not delivered, and responded to, through an eConsult Platform.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Act Rule concerning Cover All Coloradans Rule Clarifications, Sections 8.205 & 8.715
Rule Number: MSB 24-12-09-B
Division / Contact / Phone: Health Policy Office / 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 24-12-09-B, Revision to the Medical Assistance Act Rule concerning Cover All Coloradans Rule Clarifications, Sections 8.205 & 8.715

3. This action is an adoption of: an amendment

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

   Sections(s) 8.205.2.B. and 8.715.2.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 8.205 with the proposed text beginning at 8.205.2 through the end of 8.205.2.B. Replace the current text at 8.715 with the proposed text beginning at 8.715.2.A through the end of 8.715.2.F. This rule is effective June 14, 2025.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Cover All Coloradans Rule Clarifications, Sections 8.205 & 8.715
Rule Number: MSB 24-12-09-B
Division / Contact / Phone: Health Policy Office / 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).

   The Department brought two rules to comply with House Bill 22-1289 (Cover All Coloradans) to the Medical Services Board, which were adopted on first reading at the October 11, 2024 meeting and received final adoption at the November 8, 2024 meeting. Those rulemakings amended the Medicaid (rule number MSB 24-06-25-A) and Child Health Plan Plus (rule number CHP 24-07-18-A) eligibility rules by removing citizenship requirements and barriers to provide full coverage Medicaid and Child Health Plan Plus to non-citizens who are pregnant, and/or postpartum, and/or 18 years of age and younger, if they are eligible and enrolled, per Cover All Coloradans.

   The Department has since identified additional sections of rule that could exclude non-citizens otherwise covered under Cover All Coloradans in the eligibility rules for the Medicaid Statewide Managed Care System and the Breast and Cervical Cancer Program. The proposed rule provides regulatory clarification by incorporating exceptions for non-citizens covered under Cover All Coloradans in the eligibility rules for those programs and services.

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:

   U.S.C. § 1396a(10)(a)(ii); C.F.R. §§ 42.435.301 et seq.; U.S.C. § 1397bb(b)

4. State Authority for the Rule:

   CRS §§ 25.5-1-301 through 25.5-1-303; 25.5-2-104; 25.5-2-105; 25.5-5-201(6)(a) (2024); 25.5-8-103(4)(a)(I) & (b)(1), (2024)

Initial Review	**03/14/25**	Final Adoption	**04/11/25**
Proposed Effective Date	**06/14/25**	Emergency Adoption	

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Title of Rule: Revision to the Medical Assistance Act Rule concerning Cover All Coloradans Rule Clarifications, Sections 8.205 & 8.715
Rule Number: MSB 24-12-09-B
Division / Contact / Phone: Health Policy Office / 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.

   The classes of person affected by the proposed rule are non-citizens covered under House Bill 22-1289 (Cover All Coloradans).

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 qualitative impact of the proposed rule is clarifying that non-citizens covered under Cover All Coloradans are eligible for the Medicaid Statewide Managed Care System and the Breast and Cervical Cancer Program. The quantitative impact is utilization of those programs by non-citizens covered under Cover All Coloradans.

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

   As of November 2024, the Department anticipated that Cover All Coloradans will increase Medicaid caseload by approximately 2,200 members and increase CHP+ caseload by approximately 230 members, in calendar year 2025. This policy will also create two new programs that mirror the existing Medicaid and CHP+ programs except that these new programs will not be a state/federal partnership. Instead, the two new programs be exclusively funded by the State of Colorado. These two new programs can be thought of as Medicaid and CHP+ "look-a-like" programs and are expected to have a caseload of approximately 6,000 in the Medicaid "look-a-like" program and 7,000 individuals in the CHP+ look-a-like" program. The Department anticipates that the estimated total fiscal impact of coverage of Medicaid and CHP+ programs for these members will be $25 million and $1.3 million, respectively. The Department anticipates that the estimated total impact of the new state-only funded Medicaid and CHP+ programs will be approximately $7 million each or $9 million total. Given the program go live date of January 1, 2025, the Department did not have enough data to accurately update forecast projections during the February forecast period, thus the November projections remain the official Department estimates.

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There is no new cost to the Department or any other agency to implement the proposed rule because it is a technical change that clarifies that members covered under Cover All Coloradans are not excluded from the Medicaid Statewide Managed Care System and the Breast and Cervical Cancer Program. There is also no new anticipated impact on state revenue as a result of this proposed rule change.

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

   The probable costs of the proposed rule are utilization of the subject programs by non-citizens covered under Cover All Coloradans. The probable benefit of the proposed rule is clarifying the eligibility for the subject programs and services for non-citizens covered under Cover All Coloradans. The probable cost of inaction is lack of regulatory clarity for the eligibility for the subject programs. There are no probable benefits of inaction.

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 clarifying the eligibility for the subject programs and services for non-citizens covered under Cover All Coloradans.

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 clarifying the eligibility for the subject programs and services for non-citizens covered under Cover All Coloradans.

8.205 MEDICAID STATEWIDE MANAGED CARE SYSTEM

8.205.2 ~~CLIENT~~ MEMBER ELIGIBILITY

8.205.2.A. A Medicaid ~~Client~~ member with full Medicaid benefits must be enrolled into the Medicaid Statewide Managed Care System, with the exception of the individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE) as defined in Section 8.497.

8.205.2.B. The following individuals are not eligible for enrollment in the Medicaid Statewide Managed Care System:

1. Qualified Medicare Beneficiary only (QMB-only).

2. Qualified Disabled and Working Individuals (QDWI)

3. Qualified Individuals 1 (QI 1).

4. Special Low Income Medicare Beneficiaries (SLMB).

5. Undocumented immigrants, with the exception of individuals who meet the criteria in Section 8.100.3(G)(1)(g)(viii).

6. Individuals enrolled in the Program of All-Inclusive Care for the Elderly (PACE).

7. Individuals between ages 21 and 64 who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.

8. Individuals who are incarcerated.

9. Individuals while determined presumptively eligible for Medicaid.

8.715 BREAST AND CERVICAL CANCER PROGRAM

8.715.2 ELIGIBILITY REQUIREMENTS

8.715.2.A. ~~Clients~~ Members shall meet all requirements of the CWCCI program.

8.715.2.B. ~~Clients~~ Members shall enroll for screening at participating Breast and Cervical Cancer assessment sites through the CWCCI.

8.715.2.C. ~~Clients~~ Members shall:

1. Be a woman who has not yet attained the age of 65.

2. Be a resident of Colorado.

3. With the exception of individuals who meet the criteria in Section 8.100.3(G)(1)(g)(viii), ~~B~~be a citizen of the United States or a qualified alien as described in 8.100.~~5~~3(G)(1)(g)(ii)-(iv) and~~(A)(2) through~~ 8.100.~~53(A)(4)~~3(G)(1)(g)(vi)-(vii).

4. Have been screened by a Qualified Entity and found to be In Need of Treatment for breast or cervical cancer, including precancerous conditions as determined through pathological tests.

5. Not have creditable coverage as described in 8.715.3.

6. Not be eligible under another Medicaid program.

7. Be a ~~client~~ member who has previously qualified and enrolled in a NBCCED program in another state and chooses to transfer her enrollment to CWCCI.

8.715.2.D. ~~Clients~~ Members shall not have been previously screened or received treatment for breast or cervical cancer prior to July 1, 2002.

8.715.2.E. ~~Clients~~ Members shall not be considered to be In Need of Treatment if it is determined she only requires routine follow-up monitoring services.

8.715.2.F. ~~Clients~~ Members shall be willing to seek Medicaid approved breast or cervical cancer or precancerous treatment within three months of the date of eligibility. If a ~~client~~ member does not seek such treatment within three months of the date of presumptive eligibility, the ~~client~~ member shall be removed from the program on the last day of the third month. The ~~client~~ member will be re-entered in the BCCP program at such time as treatment is scheduled to begin. If treatment has not been started within one month of the scheduled date, the ~~client~~ member will be disenrolled.

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Title of Rule: Revision to Medical Assistance Act Concerning Managed Care Grievance Resolution Timeline, Section 8.209
Rule Number: MSB 24-11-05-A
Division/Contact/Phone: Health Policy Office/Rachel Larson/Rachel.larson@state.co.us

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 24-11-05-A, Revision to Medical Assistance Act Concerning Managed Care Grievance Resolution Timeline, Section 8.209

3. This action is an adoption of: an amendment

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

   Sections(s) 8.209.3.A, 8.209.3.C, 8.209.5.D., 8.209.5.E, 8.209.5.F, 8.209.5.G., 8.209.5.H., Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10, 8.200) pages 67-68, 73-74.

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 8.209 with the proposed text beginning at 8.209.2.E through the end of 8.209.3.C. Replace the current text at 8.209.5 with the proposed text beginning at 8.209.5.B through the end of 8.209.5.I.2. This rule is effective June 14, 2025.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to Medical Assistance Act Concerning Managed Care Grievance Resolution Timeline, Section 8.209
Rule Number: MSB 24-11-05-A
Division/Contact/Phone: Health Policy Office/Rachel Larson/Rachel.larson@state.co.us

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).

In 10 CCR 2505-10-8.209.5.D, the timeframe to resolve grievances is fifteen (15) working days from the day the Managed Care Organization (MCO), Prepaid Inpatient Health Plans (PIHP), or Prepaid Ambulatory Health Plans (PAHP), receives the grievance. Comprehensive investigations frequently take longer than 15 days based on the complexity of individual grievances and gaining access to relevant records and information to fully investigate, so this proposed rule will align with investigatory best practices to ensure standards of care are being met and improve safety and quality of care for members. Aligning with investigatory best practices will ensure there is adequate time to conduct and complete investigations, to ensure that managed care entities are not rushing investigations to meet current timelines. This will in turn improve member safety and quality of care. Because 42 C.F.R. § 438.408(b) allows for up to 90 calendar days for resolution of grievances, the Department is requesting that 8.209.5.D be amended to reflect the 90 calendar days resolution timeframe. As part of this rulemaking, the Department is requesting that the Medical Services Board revise 8.209.5.E. to align with this federal regulation. Furthermore, the proposed revision to 8.209.5.E requires that MCOs, PIHPs, and PAHPs provide an expedited grievance process, which will be beneficial for members with medical concerns that require more urgent attention and review. Furthermore, the proposed revision to 8.209.5.E cites the federal requirements any extensions must meet. The remaining sections are renumbered/relettered to accommodate the above changes. There are also small amendments to Section 8.209.3 to incorporate identification of acronyms and to account for a monthly report requirement for MCOs, PIHPs and PAHPs to report resolution of expedited grievances. Finally, the

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Department proposes an amendment to 8.209.5.I to provide a second level review by the Department should the timelines for resolving the Grievances not be followed by the MCO, PIHP or PAHP.

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:

N/A

2. Federal authority for the Rule, if any:

   42 C.F.R. § 438.408(b)

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024); and Section 25.5-5-406.1, C.R.S. (2024).

Initial Review	**03/14/25**	Final Adoption	**04/11/25**
Proposed Effective Date	**06/14/25**	Emergency Adoption	

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Title of Rule: Revision to Medical Assistance Act Concerning Managed Care Grievance Resolution Timeline, Section 8.209
Rule Number: MSB 24-11-05-A
Division/Contact/Phone: Health Policy Office/Rachel Larson/Rachel.larson@state.co.us

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, providers, and MCO, PIHP or PAHP entities, are affected by the proposed rule. Health First Colorado members, providers, and MCO, PIHP or PAHP entities will benefit by a longer grievance timeline that allows more time for their grievances to be more fully investigated, which may lead to improved outcomes in overall member safety and welfare. Providers may ultimately benefit from improvements in their practices as a result of a more robust grievance process. Providers and MCO, PIHP, or PAHP entities may benefit by eliminating the administrative burden of having to unnecessarily request extensions on a recurrent basis. Additionally, the rule change allows for an expedited process for grievances of 72 hours in certain circumstances where an expedited review process is necessary which will benefit members who have grievances requiring immediate attention.

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

Quantitatively, the rule change would result in more grievances being fully examined to resolution and additionally would provide an expedited review process for those situations where the member's health or safety is at risk. Qualitatively, the results of those investigations could lead to beneficial changes to provider dynamics, interactions, healthcare provided, and overall better health outcomes for members.

Initial Review	**03/14/25**	Final Adoption	**04/11/25**
Proposed Effective Date	**06/14/25**	Emergency Adoption	

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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 should not be costs to the Department or any other agency or any anticipated effect on state revenues.

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

   The costs of the proposed rule are zero. The potential benefits of the proposed rule would allow more time for records to be received, grievances to be investigated, and fully analyzed to resolution. Additionally, the expedited grievance process would allow for situations where the Member's health or safety is at risk to be addressed quickly when necessary. The costs of inaction are that grievances may not be as fully investigated and therefore member safety and health could be compromised, or that there is unnecessary administrative burden to frequently request extensions. Additionally, the cost to not providing an expedited grievance process would not allow for urgent situations to be address and could be detrimental to member health and safety. There are no real benefits to inaction in this case.

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

   The purpose of the proposed rule amendment is to promote member safety and welfare by allowing adequate time for grievance investigations and by providing an expedited process for Grievances where a member's health or safety is at risk. Thus, there are likely no other less costly methods or less intrusive methods for achieving the purpose of the proposed rule that do not involve an extension of the grievance resolution timeframe and incorporation of an expedited process.

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

   The Department has tried shorter timelines and finds that shorter timelines can have a negative impact on the quality of investigations and that it is often necessary to issue extensions so that investigations can conclude at an appropriate time. Incorporating an expedited grievance process also allows for situations where a member's health or safety is at risk to be addressed more quickly if needed. This rule change is intended to align with best practices, meets the needs for investigations to best serve members and providers, and to eliminate the administrative burden that is required to request, evaluate, and issue extensions on a continual basis. Additionally, the expedited grievance process allows for situations necessitating faster decisions to have an option for that track as well.

8.209 MEDICAID MANAGED CARE GRIEVANCE AND APPEAL PROCESSES

8.209.1 GENERAL PROVISIONS

Medicaid members or their Designated Client Representatives enrolled in Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs) may access and utilize the Medicaid Managed Care Grievance and Appeal Systems. The Grievance and Appeal Systems shall include a Grievance process and an Appeal process for handling Grievances and Appeals at the MCO, PIHP, or PAHP level and access to the State Fair Hearing process for Appeals.

8.209.2 DEFINITIONS

8.209.2.A. Adverse Benefit Determination shall mean:

1. The denial or limited authorization of a requested service, including determinations based on the type or level of service, requirements for medical necessity, appropriateness, setting, or effectiveness of covered benefit;

2. The reduction, suspension or termination of a previously authorized service;

3. The denial, in whole or in part, of payment for a service;

4. The failure to provide services in a timely manner;

5. The failure to act within the timeframes provided in § 8.209.4 below;

6. The denial of a Medicaid member's request to exercise his or her right to obtain services outside the network for members in rural areas with only one MCO; or

7. The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other member financial liabilities.

8.209.2.B. Appeal shall mean, for the purposes of this Section 8.209 only, a request for review by an MCO, PIHP, or PAHP of an Adverse Benefit Determination.

8.209.2.C. Designated Client Representative shall mean any person, including a treating health care professional, authorized in writing by the member or the member's legal guardian to represent his or her interests related to complaints or Appeals about health care benefits and services.

8.209.2.D. Grievance shall mean an oral or written expression of dissatisfaction about any matter other than an Adverse Benefit Determination, including but not limited to quality of care or services provided and aspects of interpersonal relationships such as rudeness of provider or employee, or failure to respect the member's rights.

8.209.2.E. Managed Care Organization (MCO) shall mean an entity that has, or is seeking to qualify for, a comprehensive risk contract under 42 C.F.R. § 438.2 (2024) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 438.2 excludes later amendments to, or editions of the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E. 17th Avenue, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at www.ecfr.gov.~~,~~ ~~and that is~~The MCO shall be:

1. A Federally qualified HMO that meets the advance directives requirements of subpart I of 42 C.F.R. § 489~~, in accordance with 42 C.F.R. § 489~~ (2024), which is hereby incorporated ~~herein~~ by reference. The incorporation of ~~this Section~~42 C.F.R. § 489 ~~excludes later amendments to, or editions of, the referenced material. Pursuant to C.R.S.~~ § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: ~~Colorado Department of Health Care Policy and Financing,~~ 303 E. 17th Avenue, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at www.ecfr.gov.; or

2. Any public or private entity that meets the advance directives requirements and is determined by the Secretary of the U.S. Department of Health and Human Services to also make the services it provides to its Medicaid members as accessible (in terms of timelines, amount, duration, and scope) as those services are to other Medicaid beneficiaries within the area served by the entity; and meets the solvency standards of 42 C.F.R. § 438.116 (2024), which is hereby incorporated by reference. The incorporation of 42 C.F.R. § 438.116 excludes later amendments to, or editions of, the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: 303 E. 17th Avenue, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at www.ecfr.gov.

8.209.2.F. Prepaid Inpatient Health Plan (PIHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; provides, arranges for, or otherwise has responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.209.2.G. Prepaid Ambulatory Health Plan (PAHP) shall mean an entity that provides medical services to members under contract with the State agency, and on the basis of prepaid capitation payments, or other payment arrangements that do not use State plan payment rates; does not provide, arrange for, or otherwise has a responsibility for the provision of any inpatient hospital or institutional services for its members; and does not have a comprehensive risk contract.

8.209.2.H. State Fair Hearing shall mean the formal adjudication process for Appeals described at ~~10 CCR 2505-10, §~~Section 8.057.

8.209.3 GRIEVANCE AND APPEAL SYSTEM

8.209.3.A. The Grievance and Appeal System means the processes the ~~MCO~~Managed Care Organizations (MCOs), Prepaid Inpatient Health Plans (PIHPs), or Prepaid Ambulatory Health Plans (PAHPs), ~~PIHP, and PAHP~~ implement to handle appeals of an adverse benefit determination and grievances, as well as the processes to collect and track information about ~~them~~grievances and appeals.

8.209.3.B. The MCO, PIHP, or PAHP shall provide a Department-approved description of the Grievance, Appeal and State Fair Hearing procedures and timeframes to all providers and subcontractors at the time the provider or subcontractor enters into a contract with the MCO, PIHP, or PAHP. The description shall include:

1. The member's right to request a State Fair Hearing after the MCO, PIHP, or PAHP has made a determination on a member's Appeal, which is adverse to the member.

    a. The method to obtain a hearing

2. The member's right to file Grievances and Appeals.

3. The requirements and timeframes for filing Grievances and Appeals.

4. The availability of assistance in the filing process.

5. The toll-free numbers that the member can use to file a Grievance or an Appeal by telephone.

6. The fact that, when requested by a member:

    a. Benefits will continue if the member files an Appeal or a request for State Fair Hearing within the timeframes specified for filing~~; and~~

    ~~b. The member may be required to pay the cost of services furnished while the Appeal is pending if the final decision is adverse to the member.~~

8.209.3.C. The MCO, PIHP, or PAHP shall maintain record of Grievances and Appeals and submit a ~~quarterly~~ monthly report to the Department, including expedited Grievances in Section 8.209.5.E. The record of each Grievance and Appeal shall include:

1. A general description of the reason for the Grievance or Appeal;

2. The date and time the Grievance or Appeal was received;

3. The date of each review, or if applicable, review meeting;

4. The resolution at each level of the Grievance or Appeal, if applicable;

5. The date of resolution of the Grievance or Appeal; and

6. The name of the member for whom the Grievance or Appeal was filed.

[SECTION 8.209.4 is unaffected by this Rule change and will remain as is]

8.209.5 GRIEVANCE PROCESS

8.209.5.A. The member of the MCO, PIHP, or PAHP can file a Grievance expressing his/her dissatisfaction with any matter other than an Adverse Benefit Determination at any time.

8.209.B. The MCO, PIHP, or PAHP shall send the member written acknowledgement of each Grievance within two (2) business~~working~~ days of receipt.

8.209.5.C. The MCO, PIHP, or PAHP shall ensure that the individuals who make decisions on Grievances are individuals who were not involved in any previous level of review or decision-making, nor a subordinate of any such individual, and who have the appropriate clinical expertise, as determined by the Department, in treating the member's condition or disease if deciding a Grievance that involves clinical issues.

8.209.5.D. The MCO, PIHP, or PAHP shall accept Grievances orally or in writing.

1. The MCO, PIHP, or PAHP shall ~~dispose of~~resolve each Grievance and provide notice to the affected parties as expeditiously as the member's health condition requires, not to exceed ~~fifteen (15)~~ninety (90) ~~working~~ calendar days from the day the MCO, PIHP, or PAHP receives the Grievance.

2. A Grievance is resolved when ~~the Grievance:~~

a. The MCO, PIHP, or ~~PAHP hP~~AHP h~~H~~as reached a final conclusion with respect to the member's submitted Grievance; and,

b. The MCO, PIHP or PAHP has provided ~~to the member~~ a letter or email notice to the member, in accordance with the minimum standards of notice described at 42 C.F.R. § 438.10 (2024) which is hereby incorporated by reference. The incorporation of 42 C.F.R. § 438.10 excludes later amendments to, or editions of the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E. 17th Avenue, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at www.ecfr.gov. The letter or email notice shall include the following, so long as there is no conflict with C.R.S. § 12-30-204 and C.R.S. § 12-30-205:

1) Conclusions of the investigation; and

2) The date of the final conclusion of the investigation.

3. An escalation to another team does not mean a Grievance is resolved.

8.209.5.E. Expedited Grievance Process

1. Every MCO, PIHP or PAHP must include a process to rapidly assess, evaluate, and address within 72 hours from receipt of Grievance the safety of a member when there is concern that the Grievance involves an imminent and serious threat to the health of the member, including, but not limited to, severe pain, potential loss of life, limb or major bodily function. At a minimum, the process for expedited Grievances shall include:

a. Notice given to the member in a method that best suits the needs of the member within 72 hours- from receipt of a Grievance.

b. Notice shall include a status update, documentation of the date and time the Grievance was received, and any available alternative resources based upon the member's condition ~~and~~ to ensure member safety is being assessed.

2. The MCO, PIHP or PAHP must provide a monthly report to the Department of its expedited Grievance resolutions.

3. All other Grievances that do not fall under Section 8.209.5.E.1 shall be resolved through the standard Grievance resolution process timeframe and may not exceed 90 calendar days unless an extension is appropriate under Section 8.209.5.F.

8.209.5.~~E~~F. The MCO, PIHP, or PAHP may ~~extend~~ extend the ninety (90) day timeframe by up to 14 calendar days if the requirements of 42 C.F.R. § 438.408(c) are met. 42 C.F.R. § 438.408(c) (2024) is hereby incorporated by reference. The incorporation of 42 C.F.R. § 438.408(c) excludes later amendments to, or editions of the referenced material. Pursuant to § 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 303 E. 17th Avenue, Suite 1100, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request. Incorporated materials may also be obtained from the original issuer at www.ecfr.gov. ~~timeframes for the disposition of Grievances by up to fourteen (14) calendar days:~~

~~1. If the member requests the extension; or~~

~~2. The MCO, PIHP, or PAHP shows that there is a need for additional information and that the delay is in the member's best interest. The MCO, PIHP, or PAHP shall:~~

~~a. Make reasonable efforts to give the member prompt oral notice of the delay.~~

~~b. Give the member prior written notice of the reason for delay if the timeframe is extended and inform the Member of the right to file a grievance if the member disagrees with the decision.~~

8.209.5.~~F~~G. The MCO, PIHP, or PAHP shall notify the member in writing of the ~~disposition~~ resolution of a Grievance in the format established by the Department.

8.209.5.~~G~~H. The written notice shall include the results of the ~~disposition/~~resolution process and the date it was completed.

8.209.5.~~H~~I. If the member is dissatisfied with the ~~disposition~~ resolution of a Grievance provided by the MCO, ~~PHIP,~~PIHP or PAHP, or the Grievance is not resolved within the 90 days including any approved extensions, the member may bring the unresolved Grievance to the Department in accordance with the process outlined in the member handbook.

1. The Department will acknowledge receipt of the Grievance and ~~dispose of~~resolve the issue.

2. The ~~disposition~~ resolution offered by the Department will be final.

[SECTIONS 8.209.6 and 8.209.7 are unaffected by this Rule change and will remain as is]

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Services Board Act Rule Concerning Support Intensity Scale Assessment (SIS) and Interim Support Level Assessment (ISLA) Rule Revisions, Sections 8.612 & 8.7202.AA
Rule Number: MSB 24-12-20-A
Division / Contact / Phone:Office of Community Living / Mariah Kohlruss-Ecker / 303.866.5773

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 24-12-20-A, Revision to the Medical Services Board Act Rule Concerning Support Intensity Scale Assessment (SIS) and Interim Support Level Assessment (ISLA) Rule Revisions, Sections 8.612 & 8.7202.AA

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) 8.612 & 8.7202.AA, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

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

PUBLICATION INSTRUCTIONS*

Delete the text at 8.612 through the end of 8.612.4.E. Replace the text at 8.7100 with the proposed text beginning at 8.7100.A through the end of 8.7100.A.54.b. Replace the current text at 8.7202.AA with the proposed text beginning at 8.7202.AA. through the end of 8.7202.AA.5)d. This rule is effective June 14, 2025.

*to be completed by MSB Board Coordinator

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Rule Number: MSB 24-12-20-A
Division / Contact / Phone: Office of Community Living / Mariah Kohlruss-Ecker / 303.866.5773

STATEMENT OF BASIS AND PURPOSE

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

The Department is implementing an Interim Support Level Assessment (ISLA) to evaluate the support needs of Members enrolling onto the Home and Community Based Services Supported Living Services (HCBS-SLS) waiver and the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver. The ISLA will be used for specific services: Day Habilitation, Supported Employment, and Residential Habilitation, which require a Support Level to help determine the rate paid to providers. The new ISLA will replace the current Supports Intensity Scale (SIS) Assessment, which is a national proprietary assessment tool. The currently used version of the SIS will no longer be available to states after July 1, 2025. The Department will implement the new ISLA in a limited approach only for newly enrolling HCBS-SLS and HCBS-DD waiver Members who have not previously had a SIS Assessment and therefore do not have a Support Level. The Department will continue to utilize the SIS Support Levels for Members where this is applicable. There will be Members with SIS Support Levels and Members with ISLA Support Levels, but a single Member should never have both simultaneously. This will be in place until the new Colorado Single Assessment (CSA) has been fully implemented across Colorado.

Due to current Long-Term Services and Supports stabilization efforts, the Department has delayed full implementation of the CSA, which will ultimately replace the SIS Assessment. In the interim period, the Department has developed the ISLA and will test this ISLA (which is built from the questions in the CSA) to determine how well components of the ISLA/CSA map across to the SIS Support Level Algorithm, in order to provide parity between Members enrolling into the HCBS-DD or HCBS-SLS waivers in the period both pre and post SIS decommission. In other words, we are seeking to test out how closely the questions from the newly developed ISLA correlate to the similar questions from the SIS and therefore will adequately replace the SIS when used in the ISLA Support Level Algorithm. The Department will pilot the ISLA with newly enrolling Members while simultaneously conducting the SIS with these same Members in order to provide comparative data to the vendor who is developing ISLA algorithm to be used during the transitional year before implementation of the full CSA.

1. 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:

2. Federal authority for the Rule, if any:

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2024);

Initial Review	**03/14/25**	Final Adoption	**04/11/25**
Proposed Effective Date	**06/14/25**	Emergency Adoption	

DOCUMENT #

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SB 16-192; Requires the Department to eliminate the use of the SIS Assessment and implement a new Single Assessment for Members seeking and/or enrolled in Colorado's Long-Term Services and Supports (LTSS).

HB 16-1518; Required the Department to evaluate whether a consolidation of the I/DD waivers would allow for more people to be served, eliminate the use of the SIS Assessment and involve I/DD stakeholders in considering a new Single Assessment for LTSS.

Initial Review	**03/14/25**	Final Adoption	**04/11/25**
Proposed Effective Date	**06/14/25**	Emergency Adoption	

DOCUMENT #

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Rule Number: MSB 24-12-20-A
Division / Contact / Phone:Office of Community Living / Mariah Kohlruss-Ecker / 303.866.5773

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.

   All adult members that are newly enrolling onto the Home and Community Based Services Supported Living Services (HCBS-SLS) waiver and the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver will be affected by the proposed rule. In order to determine a Support Level that will be used for specific services such as Day Habilitation to help determine the rate paid to providers, Members who choose to receive these services must participate in this Interim Support Level Assessment (ISLA). There is not a class of persons receiving services that will bear any costs of this rule. The Department is working to streamline Case Management Agency (CMA) processes to mitigate any potential costs associated with these changes.

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

   Members with Intellectual and Developmental Disabilities (I/DD) and their guardians/family members will not experience any negative impacts to their needs and services as we implement this interim process. This is a gradual transitional step while the Department continues to develop the long-term Colorado Single Assessment (CSA) and Person-Centered Support Plan and automate these processes within the Care & Case Management system. The long-term goal after piloting the ISLA, then refining the ISLA Algorithm is to build upon the ISLA Algorithm for use when the CSA is launched. This will ensure more transparency, equitability in processes, and will be an improvement on both the existing SIS Assessment and the SIS/Support Level Algorithm. These improved outcomes will be achieved through using the “lessons learned” from the many years of SIS implementation and the stakeholder engagement where specific areas were identified for improvement in making the Single Assessment a more comprehensive and person-centered process as well as targeting areas for inclusion in the Support Level Algorithm which have heretofore not been well measured.

   There is not a means to quantify this experience for Members now, but the department plans to collect quantitative and qualitative data throughout the interim processes that will enable a more successful outcome for the long-term Colorado Single Assessment and Person-Centered Support Plan goals. There will be an ISLA Interview experience survey following each ISLA that is conducted and we expect to learn a great deal about how to make the ISLA Interview experience an improvement for our Members, to-date, and from their SIS Interview experiences historically.

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.

   Because this rule amendment includes steps that Case Management
   Agencies who serve Members with Intellectual and Developmental Disabilities
   must complete during this interim assessment process, there could be associated costs to the Department and the Case Management Agencies under contract with the Department. The Department is working with the Case Management Agencies to create efficient training and practices which minimize administrative burden to the Case Management Agencies.

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

   There are not increased costs, other than during the 3-month pilot period, when both the Supports Intensity Scale (SIS) and the Interim Support Level Assessment (ISLA) will be conducted for newly enrolling Members for use in a comparative analysis to determine the efficacy of this interim process. For the longer term, there are not increased costs, as the ISLA replaces the existing SIS Assessment.

   It is planned that this ISLA and Resource Allocation Algorithm process will be a gradual building block toward the long-term Colorado Single Assessment (CSA) and Person-Centered Budget Algorithm (PCBA) goals. This interim process may help avoid unintended consequences when the CSA and PCBA are fully implemented, based on the ISLA pilot experience and lessons learned.

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 to achieving the purpose of these rules. The currently used version of the SIS will no longer be available to states after July 1, 2025. This is an interim process that works as a steppingstone toward the long-term overall goals of having a Colorado Single Assessment (CSA) and Person-Centered Budget Algorithm (PCBA) in place. By moving forward with this rule, we are delaying the higher costs that we may encounter if we implement, as previously planned, the CSA in the Care & Case Management system at the same time as launching Community First Choice (CFC). The stakeholders were very concerned about too many intersecting initiatives being implemented at the same time and felt this would cause greater financial and capacity burdens in the Case Management Agency ecosystem leading to further instability.

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

   The Department considered several alternatives for achieving the purpose of this proposed rule (to determine Support Levels for the rate-setting factor for Day Services, Supported Employment Services, and Residential Services), including: requesting an extension on the use of the SIS-A past the hard deadline AAIDD had given states for decommissioning this assessment, adopting the 2nd Edition SIS Assessment, launching the Colorado Single Assessment (CSA) in the Care & Case Management system for only Members with Intellectual and Development Disabilities (IDD) and/or launching it isolated to ***only newly enrolling*** Members with Intellectual and Developmental Disabilities (IDD). All of these alternatives were considered, weighing the pros and cons, benefits and risks, potential unintended consequences and likely administrative burdens to the Case Management Agency ecosystem, HCPF and Members/families and it was determined that pursuing the Interim Support Level Assessment (ISLA) was the best path forward. This interim approach is the least disruptive; provides for the most continuity, consistency and parity for Members both pre/post Supports Intensity Scale (SIS) Decommission; allows for continued efforts to be focused on the Care & Case Management system and Case Management Agency ecosystem stabilization; and enables significant intersecting initiatives to be rolled out in a thoughtful, measured manner.

8.7100 Waiver/Program Eligibility Requirements

8.7100.A Definitions

26. Extreme Safety Risk to Self means a factor in addition to specific Support Level scores that are considered in the calculation of a Member's Support Level. This factor shall be identified when a Member:

    a. Displays self-destructiveness related to self-injury, suicide attempts, or other similar behaviors that seriously threaten the Member's safety; and,

    b. Has a Rights Modification in accordance with Sections 8.7001 or 8.7001.B.4 or has a court order that imposes line of sight supervision unless the Member is in a controlled environment that limits the ability of the Member himself or herself.

53. Extreme Safety Risk to Others means a factor in addition to specific Support Level ~~Intensity Scale~~ scores that are ~~is~~ considered in the calculation of a Member's Support Level. This factor shall be identified when a Member has:

a. A significant challenging behavior that poses a current and serious safety risk to others, involving harm to another person including arson, and poses a risk of repeating similar serious action; and has either,

b. A Rights Modification in accordance with Section 8.7001 that imposes line of sight supervision unless the Member is in a controlled environment; or,

c. A court order, parole and/or probation that imposes line of sight supervision unless the Member is in a controlled environment that limits their ability to engage in the behaviors that pose a serious risk or to leave the controlled environment unsupervised.

8.7202.AA Support Levels and Algorithms

1. Definitions
    a) Algorithm means a formula that establishes a set of rules that precisely defines a sequence of operations. An Algorithm is used to assign Members into one of six Support Levels in the Home and Community Based Services-Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.
    b) Respondent means a person participating in the Support Level Assessment who has knowledge of the Member's skills and abilities in various areas of their lives. The Member may be their own Respondent by themselves or with support for the Support Level Assessment. For Respondents who are not the Member, they must have recently observed the Member directly in one or more places such as home, work, or in the community.
    c) Interviewer means an individual formally trained in the administration and implementation of the Support Level Assessment by a Department approved trainer using the Department

approved curriculum.

d) Support Level means a numeric value determined using an Algorithm that places Members into groups with other Members who have similar overall support needs.
e) Virtual Meeting Platform means a form of communication that enables individuals in different physical locations to use their mobile or internet connected devices to meet in the same virtual room.

1) Support Level Assessments
    a) Since 2007, the Supports Intensity Scale (SIS-A) Assessment was required for enrollment into the HCBS-DD and HCBS-SLS waivers and used to determine a Member's Support Level.
        i) The Department will discontinue use of the Supports Intensity Scale (SIS-A) Assessment to determine Support Levels for initial enrollments into the HCBS-DD and HCBS-SLS waivers after June 30, 2025.
        ii) Supports Intensity Scale (SIS-A) Assessment Support Levels will continue to be utilized for those Members who have them assigned prior to July 1, 2025.
    b) Effective July 1, 2025, the Interim Support Level Assessment (ISLA) will replace the Supports Intensity Scale (SIS-A) Assessment used for initial HCBS-DD and HCBS-SLS enrollments to determine the Member's Support Level.
        i) The Interim Support Level Assessment (ISLA) will be used until the Department fully implements the Colorado Single Assessment (CSA) and Person-Centered Budget Algorithm (PCBA) for Resource Allocation across all HCBS waivers.
    c) SIS-A and ISLA Support Levels will be used simultaneously after July 1, 2025; however, a single Member shall never have both a SIS-A and ISLA Support Level simultaneously.
    d) The Case Management Agency shall conduct a Support Level Assessment for a Member at the time of initial enrollment into HCBS-DD and HCBS-SLS.
        i) Interviewers conducting Support Level Assessments shall be trained and qualified to perform the assessments.
        ii) The Interviewer conducting the Support Level Assessment shall not also act as a Respondent for the same assessment.
        iii) The Case Management Agency shall:
            (1) Notify the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, of the requirement for and the right to participate in the Support Level Assessment.
            (2) Support and encourage the Member to participate in the Support Level Assessment.
                (a) If the Member chooses not to participate in the Support Level Assessment, the Case Management Agency shall document their choice in the Member's record on the Department prescribed Information Management System; and,
                (b) Assist the Member or other Member Identified Team members to identify who will participate on their behalf (family, friends, unpaid support, etc.) and document their choice in the Department prescribed Information Management System.
            (3) Assist the Member to identify other Respondents (Legal Guardian, family, friends, unpaid support, etc.) whom they choose to participate in the Support Level Assessment.
            (4) Allow the Member to complete the Support Level Assessment as the only Respondent if they choose.
            (5) Document the Member's selection of Respondents or choice to be the only Respondent in the Department prescribed Information Management System.

(6) Follow person-centered practices by accommodating the Member's preference in completing the Support Level Assessment via in-person, in the Member's home, at an alternate location, or by virtual meeting platform.
(7) Inform the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, of the purpose of the Support Level Assessment, the Complaint Process, and the Support Level Review Process.
(8) Provide a copy of the completed Support Level Assessment to the Member within 30 calendar days of the assessment.
    (a) The Case Management Agency shall document provision of a copy of the Support Level Assessment to the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, in the Department prescribed Information Management System.

2) Support Levels
    a) A Support Level reflects the assessed support needs of a Member and is required for a Member enrolled in the Home and Community-Based Services-Developmental Disabilities (HCBS-DD) or the Home and Community-Based Services-Supported Living Services (HCBS-SLS) waiver.
    b) The Support Level is used as a factor for Day Habilitation, Supported Employment, and Residential Habilitation services to determine the rate paid to Providers.
    c) A Member shall be assigned into one of six Support Levels according to their overall support needs and based upon the standardized Algorithm for HCBS-DD or HCBS-SLS.
        i) The Supports Intensity Scale (SIS-A) Assessment converts subscale raw scores for each section into standard scores for each section, which are used in the Algorithm for Supports Intensity Scale (SIS-A) Assessment Support Levels.
        ii) Supports Intensity Scale (SIS-A) Assessment Algorithm factors:
            (a) Standard scores from Section 2: Parts A (Home Living Activities), B (Community Living Activities), and E (Health and Safety Activities) (ABE) from the SIS-A,
            (b) Total scores from Section 1A: Exceptional Medial Support Needs score from the SIS-A,
            (c) Total scores from Section 1B: Exceptional Behavioral Support Needs score from the SIS-A, and
            (d) Whether the Member presents as a safety risk, defined in Section 8.7100.A Definitions, as follows:
                (i) In HCBS-DD, Extreme Safety Risk to Others or Extreme Safety Risk to Self.
                (ii) In HCBS-SLS, Extreme Safety Risk to Others.
        iii) Supports Intensity Scale (SIS-A) Assessment Algorithm Formula Table

SIS-A Support Level/Subgroup
SIS-A Support Level 1
Subgroup 1A: ∑ 2ABE ≤ 25; 1A ≤ 1 AND 1B ≤ 2
Subgroup 1B: ∑ 2ABE ≤ 25; 1A ≤ 2 AND 1B 3-5
Subgroup 1C: ∑ 2ABE ≤ 25; 1A 3-4 AND 1B 3-5

SIS-A Support Level 2
Subgroup 2A: ∑ 2ABE 26-30; 1A ≤ 1 AND 1B ≤ 2
Subgroup 2B: ∑ 2ABE 26-30; 1A ≤ 2 AND 1B 3-5
Subgroup 2C: ∑ 2ABE 26-30; 1A 3-4 AND 1B 3-5
Subgroup 1D: ∑ 2ABE ≤ 25; 1A 5-6
Subgroup 1G: ∑ 2ABE ≤ 25; 1B 6-9
Subgroup 2D: ∑ 2ABE 26-30; 1A 5-6
Subgroup 2G: ∑ 2ABE 26-30; 1B 6-9
Subgroup 3A: ∑ 2ABE 31-33; 1A ≤ 1 AND 1B ≤ 2
Subgroup 3B: ∑ 2ABE 31-33 1A ≤ 2 AND 1B 3-5
SIS-A Support Level 3
Subgroup 1H: ∑ 2ABE ≤ 25; 1B 10-13
Subgroup 2H: ∑ 2ABE 26-30; 1B 10-13
Subgroup 3C: ∑ 2ABE 31-33; 1A 3-4 AND 1B 3-5
Subgroup 3D: ∑ 2ABE 31-33; 1A 3-6
Subgroup 3G: ∑ 2ABE 31-33; 1B 6-9
Subgroup 4A: ∑ 2ABE ≥ 34; 1A ≤ 1 AND 1B ≤ 2
Subgroup 4B: ∑ 2ABE ≥ 34 1A ≤ 2 AND 1B 3-5
SIS-A Support Level 4
Subgroup 1E: ∑ 2ABE ≤ 25; 1A 7-8
Subgroup 1F: ∑ 2ABE ≤ 25; 1A ≥ 9
Subgroup 1I: ∑ 2ABE ≤ 25; 1B 14-15
Subgroup 1J: ∑ 2ABE ≤ 25; 1B ≥ 16
Subgroup 2E: ∑ 2ABE 26-30; 1A 7-8
Subgroup 2I: ∑ 2ABE 26-30; 1B 14-15
Subgroup 2J: ∑ 2ABE 26-30; 1B ≥ 16
Subgroup 3E: ∑ 2ABE 31-33; 1A 7-8
Subgroup 3H: ∑ 2ABE 31-33; 1B 10-13
Subgroup 4C: ∑ 2ABE ≥ 34; 1A 3-4 AND 1B 3-5
Subgroup 4G: ∑ 2ABE ≥ 34; 1B 6-9
SIS-A Support Level 5
Subgroup 2F: ∑ 2ABE 26-30; 1A ≥ 9
Subgroup 3I: ∑ 2ABE 31-33; 1B 14-15
Subgroup 3J: ∑ 2ABE 31-33; 1B ≥ 16
Subgroup 4D: ∑ 2ABE ≥ 34; 1A 3-6
Subgroup 4E: ∑ 2ABE ≥ 34; 1A 7-8

Subgroup 4H: ∑ 2ABE ≥ 34; 1B 10-13
Subgroup 4I: ∑ 2ABE ≥ 34; 1B 14-15
Group 5A: Extreme Safety Risk to Others AND 1b ≤ 11
SIS-A Support Level 6
Subgroup 4J: ∑ 2ABE ≥ 34; 1B ≥ 16
Subgroup 3F: ∑ 2ABE 31-33; 1A ≥ 9
Subgroup 4F: ∑ 2ABE ≥ 34; 1A ≥ 9
Group 6A: Extreme Safety Risk to Self AND Extreme Safety Risk to Others AND 1b ≥ 12
Group 6B: Extreme Safety Risk to Others AND 1b ≥ 12
Extreme Safety Risk to Self – this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 3, level 2 increases to level 4, level 3 increases to level 4, level 4 increases to level 5. Subgroup 6A outlines the conditions in which level 5 may increase to level 6.
Extreme Safety Risk to Others – this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 5, level 2 increases to level 5, level 3 increases to level 5, and level 4 increases to level 6. Subgroup 6B outlines the conditions in which level 5 may increase to level 6.

iv) The Interim Support Level Assessment (ISLA) converts subscale raw scores for into scale scores for each section, which are used in the Algorithm for Interim Support Level Assessment (ISLA) Support Levels.

v) Interim Support Level Assessment (ISLA) Algorithm factors:
   (1) Functioning (ADLs and IADLs), and
   (2) Health (Medical), and,
   (3) Psychosocial (Behavior and Mental Health), and,
   (4) Memory and Cognitive, and,
   (5) Social Environment and Safety; and,
   (6) Whether the Member presents as a safety risk, defined in Section 8.7100.A Definitions, as follows:
      (a) In the HCBS-SLS waiver, Extreme Safety Risk to Others.
      (b) In the HCBS-DD waiver, Extreme Safety Risk to Others or Extreme Safety Risk to Self.

vi) Interim Support Level Assessment (ISLA) Algorithm Formula Table is posted on the Department's website and can be found at (link).

vii) The results of the Algorithm are used to assign Members to Support Levels one through six; with a Support Level one indicating a minimal need for supports and a Support Level six indicating a significantly higher need for supports.
   (1) In HCBS-DD, the Department may assign a Support Level seven (7) reimbursement rate for Residential Habilitation and/or Day Habilitation services provided to a Member with extraordinary overall needs.
   (2) These Support Level seven (7) requests must be initiated by the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, and submitted by the Case Management Agency to the Department for review.

viii) For HCBS-SLS, the Support Level will determine the Service Plan Authorization Limit (SPAL), defined at Section 8.7200.B, and the rate of reimbursement for Day Habilitation and Supported Employment Service.
    (1) The HCBS-SLS SPAL will remain in place for already established Support Plan certifications that end after July 1, 2025.
        (a) The HCBS-SLS SPAL shall not apply to Support Plan Continued Stay Reviews held after July 1, 2025.
    (2) For Members newly enrolling in HCBS-SLS and Community First Choice (CFC) on or after July 1, 2025, the SPAL shall not apply.
    (3) The SPAL is posted on the Department's webpage.

ix) For HCBS-DD, Support Level determines the rate of reimbursement for Supported Employment Services, Day Habilitation, and Residential Habilitation Services.

x) Specific scores from the Member's Support Level Assessment shall be used in addition to Risk Factor scores to calculate the Member's Support Level in HCBS-DD and HCBS-SLS.
    (1) The Case Management Agency in consultation with the Member Identified Team shall make a determination whether a Member meets the definition of Extreme Safety Risk to Others or Extreme Safety Risk to Self through the following process:
        (a) The Case Manager shall:
            (i) Document the Member Identified Team discussion of the Rights Modification identifying the line-of-sight supervision and/or secured, controlled setting justification, in the Member's record on the Department prescribed Information Management System; and,
            (ii) Follow the Rights Modification process outlined in Section 8.7001.B.4.
        (b) The Case Manager Supervisor shall:
            (i) Verify the Member meets safety risk criteria,
            (ii) Verify the signed Informed Consent for the Rights Modification is in the Member's record on the Department prescribed Information Management System; and,
            (iii) Document that the Member meets the Extreme Safety Risk to Others or Extreme Safety Risk to Self definition(s) in the Department prescribed Information Management System.
            (iv) The Case Management Agency shall review the status of the Member's Safety Risk Factors at least annually or when significant changes occur, to ensure that the Member continues to meet the definition(s).
        (c) At the point a Member no longer meets the definition(s) of Extreme Safety Risk to Others or Extreme Safety Risk to Self, their status must be changed in the Department prescribed Information Management System which will auto-calculate to the Member's current Algorithm Support Level and the Member's Person-Centered Support Plan shall be updated to reflect the removal of the Risk Factor and any changes in related, identified support needs within 10 business days of the definition(s) no longer being met or, in cases where Section 8.7202.AA.C(xiii)(4)(b)(i-iii), applies, within 10 business days of

receipt of approval or denial of the Support Level Review request.

(d) For cases in which a Member's behavior does not satisfy a Safety Risk Factor definition but the Member's needs continue to be substantially higher than those typical of their assigned Support Level (without adjustments for risk factors) and a Rights Modification continues to be in place, the Member Identified Team may consider a Support Level Review request, as outlined in Section 8.7202.5, as a part of the person-centered support planning and Rights Modification processes.

(i) If the Member Identified Team determines a Support Level Review request is needed, the Case Management Agency shall submit a Support Level Review request with input from the Member Identified Team which includes, but is not limited to, detailed information from the Person-Centered Support Plan describing the extensive supports needed and the Rights Modification(s), to include all requirements outlined in Section 8.7001.B.

(ii) The Department shall review the Support Level Review request as outlined in Section 8.7202.5.

(iii) Rights shall be restored as soon as circumstances justify.

1. When rights are restored prior to the end date of the Support Level Review approval period, the Case Management Agency shall notify the Department of the change in support needs in a manner determined by the Department.
2. When rights are restored, the Department shall adjust the Support Level override in the Department prescribed Information Management System to the original assessed Algorithm Support Level.
3. The Case Management Agency shall make any necessary Person-Centered Support Plan and Prior Authorization (PAR) revisions resulting from the Support Level changes within 10 business days of the affected Support Level change.

d) The Case Management Agency shall inform each Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, of their Support Level at the time of the initial or Continued Stay Review (CSR) Person-Centered Support Plan meeting or when the Support Level changes for any reason.

i) Notification to the Member of a Support Level change shall occur within 20 business days of the date of the Support Level change.

ii) Pursuant to the Department's rules in Section 8.057.2.A, Section 8.7202.R, and Section 8.7202.S.1(c), the Member shall be notified when a waiver service is changed, reduced, or denied. At any time, the Member may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3.A.

3) Support Level Assessment Complaint Process

a) The Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, may file a complaint regarding the administration of the Support Level Assessment up to 30 calendar days after the Member's receipt of the Support Level Assessment document.
b) The complaint shall be filed verbally or in writing with the Member's Case Management Agency. Additional information to support the complaint may be submitted at that time. If the complaint has been filed verbally the Case Management Agency shall document in the Member's record on the Department-prescribed Information Management System the time, date and details surrounding the complaint.
c) The Case Management Agency shall make efforts to resolve the complaint and provide the complainant with a written response within 10 business days after receipt of the complaint.
d) When a resolution cannot be reached, the Case Management Agency shall inform the complainant that they may submit the complaint to the Department through the Department's Complaint Form within 30 calendar days after receipt of the Case Management Agency response.
e) The Department shall provide a written response to the complainant within 15 business days after receipt of the complaint.

4) Support Level Review Process
    a) The Case Management Agency shall request a review of the Support Level assigned on behalf of the Member, their Legal Guardian, or their Legally Authorized Representative when they have reason to believe it does not meet the Member's needs.
    b) When a Support Level Review is requested, the Case Management Agency shall complete the request with input from the Member Identified Team in a manner determined by the Department on the Department's prescribed request form.
    c) Support Level Review requests must be initiated by the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, and submitted by the Case Management Agency to the Department for review.
    d) Once the request form is completed, the Case Management Agency shall provide an opportunity for the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable, to review the request and provide additional information prior to submission to the Department for review.
    e) The Case Management Agency shall submit the Support Level Review request form to the Department within 30 calendar days of the receipt of all necessary information.
    f) The Department shall convene a review panel to examine Support Level Review requests monthly or as needed.
        i) The review panel shall be comprised of the following:
            (1) A minimum of three members designated by the Department.
            (2) Members shall include staff from the Department with extensive knowledge and experience with the assessments used to determine Support Levels, Case Management, and HCBS waiver services.
        ii) The review panel:
            (1) Shall examine all of the information submitted by the Case Management Agency and identify any significant factors not included in the Support Level calculation, which may cause the Member to have substantially higher support needs than those in the established Support Level.
            (2) In cases where the panel finds that the Member does have substantially higher support needs than those in the established Support Level, the panel may assign the Member to a Support Level that is a closer representation of the Member's overall support needs.

(a) A Member who has been assigned to a higher Support Level shall have this assignment re-examined by the review panel at a frequency determined by the Department.
(i) The Case Management Agency shall submit a Support Level Review request to have the Member's Support Level re-examined no later than 30 calendar days prior to the end date determined by the Department of the increased Support Level.
(ii) The panel may determine that the Member's condition necessitating a higher Support Level is unlikely to improve and, therefore, does not require a re-examination and, therefore, does not have an end date.

g) The Department shall provide the Case Management Agency with the written decision regarding the requested review of the Member's Support Level within 15 business days after the panel meeting. The written decision notification shall include the date of the Support Level Review request, the Support Level determination, the effective date, and the end date of the increased Support Level and, if denied, the reason for denial of an increased Support Level.

h) The Case Management Agency shall provide the written decision to the Member, their Legal Guardian, or their Legally Authorized Representative, if applicable.
i) The results of the panel review for a Member enrolled in HCBS-DD are conclusive.
ii) If a Member enrolled in HCBS-SLS, their Legal Guardian, or their Legally Authorized Representative, if applicable, disagrees with the decision provided by the panel, the Member, their Legal Guardian, or their Legally Authorized Representative may request a review by the Department's Executive Director or their designee, within 15 business days after the receipt of the decision.
(1) The Department's Executive Director, or their designee, shall review the request and provide a written decision within 15 business days of receipt of the requested review.
(2) The decision of the Department's Executive Director, or their designee, shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.

i) The Case Management Agency shall make any necessary Person-Centered Support Plan and Prior Authorization Request (PAR) revisions resulting from the Support Level changes within 10 business days of receipt of approval or denial of the Support Level Review request.

j) The Member shall be notified, pursuant to the Department's rules in Section 8.057.2.A, Section 8.7202.R, and Section 8.7202.S.1(c) when a waiver service is changed, reduced, or denied. At any time, the Member may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3.A.

5) Annual Support Level Assessment Overview
a) The Case Manager shall provide an overview of the results of the most recent Support Level Assessment during the Continued Stay Review (CSR) Person-Centered Support Plan (PSCP) meeting.
b) For SIS-A, this overview shall include discussion of:
i) The Exceptional Medical and/or Behavioral Support Needs identified in Section 1 of the SIS-A,
ii) The areas of priority support needs identified in Section 2 of the SIS-A,
iii) The resulting Support Level, and
iv) The services necessary to meet these priority areas.

c) For ISLA, the overview shall include discussion of:
    i) The Exceptional Medical/Health and/or Psychosocial Support Needs identified in the ISLA,
    ii) The areas of priority support needs identified in the Activities of Daily Living and Instrumental Activities of Daily Living scale,
    iii) The resulting Support Level, and
    iv) The services necessary to meet these priority areas.
d) If upon review of the results of the Support Level Assessment there is a significant change in the Member's condition or circumstances, the Case Manager should refer to Section 8.7202.AA.5 Support Level Review Process.