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8.7206-300 Case Managment Rule Revisions

8.7206 FUNCTIONS OF A CASE MANAGEMENT AGENCY

8.7206.1 Case Management Services Overview

Functions of the Case Manager

Ongoing Case Management and Targeted Case Management ~~[from 8.393.2.G.]~~

Case management services are provided for members and individuals accessing Home and Community Based services. Case Management services shall include, but not be limited to, the following tasks, activities, requirements and responsibilities:

8.7206.2 Intake, Screening, and Referral

A. The intake, screening and referral function of a {Case Management Agency} shall include, but not be limited to, the following activities:
    1. The {Case Management Agency} shall verify the individual's demographic information collected during the intake;
    2. The completion of the intake, screening and referral functions using the Department's IMS to determine applicant needs and eligibility for LTSS and non-LTSS services, information and referral assistance to LTSS and other services and supports, as needed;
    3. Level of care eligibility determination as applicable;
    4. Referring to and facilitation of the Medicaid financial eligibility application process.

B. The Case Management Agency must maintain, or have access to, information about public and private state and local services, supports and resources and shall make such information available to the Member, Client and/or persons inquiring upon their behalf.

C. The {Case Management Agency} shall coordinate the completion of the financial eligibility determination by:
    1. Verifying the individual's current financial eligibility status; or
    2. Referring the individual to the county department of social services of the individual's county of residence for application and support with completing an application in accordance with 8.100.3.A.7; or

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3. Providing the individual with financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides; and
4. Conducting and documenting follow-up activities to complete the functional eligibility determination and coordinate the completion of the financial eligibility determination.

D. In compliance with standards established by the Department, {Case Management Agencies} may ask referring agencies to complete and submit an intake and screening form to initiate the process.
   1. CMAs shall not delay the completion of an intake screen based on the use of this form.
   2. CMAs shall accept referrals for LTSS including but not limited to the following modalities:
      1. Intake Screen form
      2. Phone calls
      3. County DHS referrals and communication
      4. In person requests for LTSS
      5. Medical Assistance sites

E. A screening to determine whether a functional eligibility assessment is needed; {The individual shall be informed of the right to request an assessment if the individual disagrees with the case manager's decision} ~~[8.509.31]~~.

F. The identification of potential payment source(s), including the availability of private funding resources; including but not limited to trusts, third-party insurance, and/or private community funding.

G. The implementation of a {Case Management Agency} procedure for prioritizing urgent inquiries.

H. Referrals to the Regional Centers shall comply with the Regional Centers admission policy.
   1. When a person needs assistance with challenging behavior, including a person whose behavior is dangerous to himself, herself or others, or engages in behavior which results in significant property destruction, the program approved service agency in conjunction with the individual, their guardian or other legally authorized representative, and other members of member-identified team ~~[the person's interdisciplinary team]~~ shall complete a comprehensive review of the person's life situation including:

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2. The status of friendships, the degree to which the person has access to the community, and the person's satisfaction with his or her current job or housing situation;
3. The status of the family ties and involvement, the person's satisfaction with roommates or staff and other providers, and the person's level of freedom and opportunity to make and carry out decisions;
4. A review of the person's sense of belonging to any groups, organizations or programs for which they may have an interest, a review of the person's sense of personal security, and a review of the person's feeling of self-respect;
5. A review of other issues in the person's current life situation such as staff turnover, long travel times, relationship difficulties and immediate life crises, which may be negatively affecting the person;
6. A review of the person's medical situation which may be contributing to the challenging behavior; and,
7. A review of the person's Individualized Plan and any Individual Service and Support Plans to see if the services being provided are meeting the individual's needs and are addressing the challenging behavior using positive approaches.

I. If any aspects of this review suggests that the person's life situation could be or is adversely affecting his or her behavior, these circumstances shall be evaluated by the member identified team, and specific actions necessary to address those issues shall be included in the Individualized Plan and/or Individual Service and Support Plan, prior to the use of any Rights Modifications to manage the person's behavior.

J. Issues identified in this comprehensive review that cannot be addressed by the {member identified team} ~~[interdisciplinary team)~~ as led by the individual or their guardian or other legally authorized representative should be documented in the ~~[Individualized Plan or Individual Service and]~~ {Person Centered} Support Plan, and CMA, the community centered board or regional center administration should be notified of these issues and the present or potential effect they will have on the person involved.

8.7206.3 Nursing Facility Admission and Discharge

A. For individuals receiving services in HCBS Programs who are already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the {Case Management Agency} shall:

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1. \Provide options counseling on community-based services to the individual to identify if they desire to live in the community with additional support.\
2. Coordinate the admission date with the facility;
3. Complete the PASRR Level 1 Screen, and if there is an indication of a mental illness or developmental disability, submit to the Department or its agent to determine whether a PASRR Level 2 evaluation is required;
4. Maintain the Level 1 Screen in the individual's case file regardless of the outcome of the Level 1 Screen; and
5. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ULTC 100.2 is not six (6) months old or older.

B. The case manager and the nursing facility shall complete the following activities for discharges from nursing facilities:
   1. The nursing facility shall contact the {Case Management Agency} in the district where the nursing facility is located to inform the {Case Management Agency} of the discharge if placement into home- or community-based services is being considered.
   2. The nursing facility and the {Case Management Agency} case manager shall coordinate the discharge date.
   3. When placement into HCBS Programs is being considered, the {Case Management Agency} shall determine the remaining length of stay.
      a. If the end date for the nursing facility is indefinite, the {Case Management Agency} shall assign an end date not past one (1) year from the date of the most recent {Level of Care Screen}.
      b. If the {Level of Care Screen} is less than six (6) months old, the {Case Management Agency} shall generate a new certification page that reflects the end date that was assigned to the nursing facility.
      c. The {Case Management Agency} shall complete a new {Level of Care Screen} if the current completion date is six (6) months old or older. The assessment results shall be used to determine level of care and the new length of stay.
      d. The {Case Management Agency} shall send a copy of the {Level of Care Screen} certification page to the eligibility enrollment specialist at the county department of social services.

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e. Within 2 business days of financial approval, the {Case Management Agency} will outreach the member to review available service options.

f. The {Case Management Agency} shall submit the HCBS prior authorization request to the Department or its fiscal agent.

C. If the client is being discharged from a hospital or other institutional setting, the discharge planner shall contact the ~~[URC/SEP]~~ CM agency for assessment by emailing or faxing the initial intake and screening form.

D. The ~~[URC/SEP]~~ case manager shall view and document the current Personal Care Boarding Home license, if the client lives, or plans to live, in a congregate facility as defined at Section [8.485.50], in order to ensure compliance with Section [8.485.20].

E. A ~~[SEP]~~ case manager may determine that a client is eligible for a waiver while the client resides in a nursing facility when the client meets the eligibility criteria as established at Section [8.400, et seq.], the client requests transition services and the ~~[SEP]~~ CMA case manager includes transition services in the client's long-term care plan. If the client has been evaluated with the LOC Screen and has been assigned a length of stay that has not lapsed, the ~~[SEP]~~ CMA case manager shall not conduct another review when transition services is requested. [8.486.30]

8.7206.4 Determination of Developmental Delay and/or Disability

The \determination of developmental delay and/or disability shall be in accordance with [8.607.2 Sections 25.5-10-202(2), C.R.S.], in accordance with criteria as specified by the Department.\

8.7206.5 Level of Care Determination

A. {The Level of Care Screen shall be used to establish a member's Level of Care.} For additional guidance on the [~~ULTC 100.2~~] {Level of Care Screen} as well as the actual tool itself, see Section [8.401.1. GUIDELINES FOR LONG TERM CARE SERVICES]

B. \At the time of completing the (Level of Care Screen), unless the individual opposes community living, the case manager shall provide options counseling on community based services to the individual to identify if they desire to live in the community with additional support.\

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C. The {Case Management Agency} shall complete the ~~ULTC 100.2~~ {Level of Care Screen} within the following time frames:
   1. For an individual who is not being discharged from a hospital or a nursing facility, the individual assessment shall be completed {and documented in the Department prescribed technology system} within ten (10) working days after receiving confirmation that the Medicaid application has been received by the county department of social services, unless a different time frame specified below applies.
   2. the {Case Management Agency} shall complete and document the assessment within five (5) working days after notification by the nursing facility for a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the {Case Management Agency} shall complete and document the assessment within five (5) working days after notification by the nursing facility.
   3. For a resident who is being admitted to the nursing facility from the hospital, the {Case Management Agency} shall complete and document the assessment, including a PASRR Level 1 Screen within two (2) working days after notification.
      a. For PASRR Level 1 Screen regulations, [refer to 8.401.18, PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY]
   4. For an individual who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the {Case Management Agency} shall complete and document the assessment within five (5) working days after notification by the nursing facility.
   5. For an individual who is being transferred from a hospital to an HCBS program, the {Case Management Agency} shall complete and document the assessment within two (2) working days after notification from the hospital.

D. Under no circumstances shall the start date for functional eligibility based on the [~~ULTC 100.2~~] {Level of Care Screen} be backdated by the [~~SEP~~] case manager. See Section 8.486.30, ASSESSMENT.

E. The {Case Management Agency} shall complete and document the [~~ULTC 100.2~~] {Level of Care Screen} for LTSS {and I/DD waiver} Programs, in accordance with Section [8.401.1]. Under no circumstances shall late PAR revisions be approved by the State or its agent.

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F. The {Case Management Agency} shall assess the individual's functional status face-to-face in the location where the person currently resides. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

G. The {Case Management Agency} shall conduct the following activities for a {Level of Care Screen} [~~comprehensive assessment]~~ of an individual seeking services:

1. Obtain diagnostic information through the Professional Medical Information Page (PMIP) form from the individual's medical provider for individuals in nursing facilities, ICF-IID, or HCBS waivers.
2. Determine the individual's functional capacity during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in [Section 8.401.1.]
3. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.15.
4. Determine the need for long-term services and supports on the [~~ULTC 100.2]~~ {Level of Care Screen} during the evaluation.
5. For HCBS Programs and admissions to nursing facilities from the community, the original [~~ULTC-100.2 copy shall be sent to the provider agencies]~~ {Level of Care Screen and {Person-Centered} Support Plan copy shall be sent to entities or persons of the member's choosing ~~}~~, [~~and a copy shall be placed in the individual's case record~~]. If there are changes in the individual's condition which significantly change the payment or services amount, a copy of the [ULTC-100.2] must be sent to the provider agency, and a copy is to be maintained.
6. When the [~~SEP Agency~~] {Case Management Agency} assesses the individual's functional capacity on the [~~ULTC-100.2~~], {Level of Care Screen}, it is not an adverse action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into an LTSS Program by the {Case Management Agency} based on the {Level of Care Screen} for functional eligibility. The appeal process is governed by the provisions of Section [8.057].

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8.7206.6 Needs Assessment

A. **\Needs Assessment**

1. The case manager shall continually identify individuals' strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of critical incidents.
2. The case manager shall complete a new {Level of Care Screen} during an in-person reassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the LTSS Program in which the individual is enrolled. Upon Department approval, reassessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

B. **\Reassessment** ~~**[from 8.393.2.D.]**~~

1. The case manager shall commence a regularly scheduled reassessment at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a reassessment of an individual receiving services within twelve (12) months of the initial individual assessment or the most recent reassessment. A reassessment shall be completed within 10 days if the individual's condition changes or if required by program criteria.
2. The case manager shall update the information provided at the previous {Level of Care Screen} \in the Department prescribed system within 5 business days of completion.\
3. Reassessment shall include, but not be limited to, the following activities:
    A. Assess the individual's functional status face-to-face, in the location where the person currently resides. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

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B. Review Support Plan, service agreements and provider contracts or agreements;
C. Evaluate effectiveness, appropriateness and quality of services and supports;
D. Verify continuing Medicaid eligibility, other financial and program eligibility;
E. Annually, or more often if indicated, complete a new Support Plan and service agreements;
F. Inform the individual's medical provider of any changes in the individual's needs;
G. Maintain appropriate documentation, including type and frequency of LTSS the individual is receiving for certification of continued program eligibility, if required by the program;
H. Refer the individual to community resources as needed and develop resources for the individual if the resource is not available within the individual's community; and
I. Submit appropriate documentation for authorization of services, in accordance with program requirements.
J. In order to assure quality of services and supports and the health and welfare of the individual, the case manager shall ask for permission from the individual to observe the individual's residence as part of the reassessment process, but this shall not be compulsory of the individual.

4. The {Case Management Agency} shall be responsible for completing reassessments of individuals receiving care in a nursing facility. A reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a reassessment or if the case manager assigns a definite end date. The nursing facility shall be responsible to send the [~~SEP Agency~~] {Case Management Agency} a referral for a new assessment as needed. \At the time of completing the reassessment, unless the individual opposes community living, the case manager shall provide options counseling on community based services to the individual to identify if they desire to live in the community with additional support.\

8.7206.7 Waitlist Management

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A. {There shall be one waiting list for persons eligible for the HCBS-DD waiver when the total capacity for enrollment or the total appropriation by the general assembly has been met. ~~[8.500.7.B]~~

B. The name of a person eligible for the HCBS-DD waiver program shall be placed on the waiting list by the CMA ~~community centered board~~ making the eligibility determination if the member meets DD waiver target criteria. ~~[8.500.7.C]~~

C. When an eligible person is placed on the waiting list for HCBS-DD waiver services, a written notice of action including information regarding Client rights and appeals shall be sent to the person or the person's legal guardian in accordance with the provisions of Section ~~[8.057 et seq. 8.500.7.D]~~

D. The placement date used to establish a person's order on a waiting list shall be: ~~[CODE OF COLORADO REGULATIONS 10 CCR 2505-10 8.500 Medical Services Board 16]~~

   1. The date on which the person was initially determined to have a developmental disability by the community centered board; or
   2. The fourteenth (14) birth date if a child is determined to have a developmental disability by the community centered board prior to the age of fourteen. ~~[8.500.7.E]~~

E. As openings become available in the HCBS-DD Waiver program in a designated service area, that Case Management Agency shall report that opening to the Operating Agency. ~~[8.500.7.F]~~

F. Persons whose name is on the waiting list shall be considered for enrollment to the HCBS-DD waiver in order of placement date on the waiting list. Exceptions to this requirement shall be limited to:

   1. An emergency situation where the health and safety of the person or others is endangered, and the emergency cannot be resolved in another way and if the person meets DD waiver target criteria. Persons at risk of experiencing an emergency are defined by the following criteria:
      a. Homeless: the person will imminently lose their housing as evidenced by an eviction notice; or whose primary residence during the night is a public or private facility that provides temporary living accommodations; or any other unstable or non-permanent situation; or is discharging from prison or jail; or is in the hospital and does not have a stable housing situation to go upon discharge.
      b. Abusive or neglectful situation: the person is experiencing ongoing physical, sexual or emotional abuse or neglect in

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the person's present living situation and the person's health, safety or well-being is in serious jeopardy.

c. Danger to others: the person's behavior or psychiatric condition is such that others in the home are at risk of being hurt by him/her. Sufficient supervision cannot be provided by the current caretaker to ensure safety of the person in the community.

d. Danger to self: a person's medical, psychiatric or behavioral challenges are such that the person is seriously injuring/harming self or is in imminent danger of doing so.

e. Loss or Incapacitation of Primary Caregiver: a person's primary caregiver is no longer in the person's primary residence to provide care; or the primary caregiver is experiencing a chronic, long-term, or life-threatening physical or psychiatric condition that significantly limits the ability to provide care; or the primary caregiver is age 65 years or older and continuing to provide care poses an imminent risk to the health and welfare of the person or primary caregiver; or, regardless of age and based on the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.

G. Enrollments may be reserved to meet statewide priorities that may include:

1. A person who is eligible for the HCBS-DD Waiver and is no longer eligible for services in the foster care system due to an age that exceeds the foster care system limits,
2. Persons who reside in long-term care institutional settings who are eligible for the HCBS DD Waiver and have requested to be placed in a community setting, and persons enrolled in CES, CHRP or CLLI waivers before their 18th birthday.
3. Persons who are in an emergency situation. ~~[CODE OF COLORADO REGULATIONS 10 CCR 2505-10 8.500 Medical Services Board 17 8.500.7.H]~~

H. Enrollments shall be authorized to persons based on the criteria set forth by the general assembly in appropriations when applicable. ~~[8. 500.7.I.]~~

1. A person shall accept or decline the offer of enrollment within thirty (30) calendar days from the date the enrollment was offered. Reasonable effort shall be made to contact the person, family, legal guardian, or other interested party.

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2. Upon a written request of the person, family, legal guardian, or other interested party an additional thirty (30) calendar days may be granted to accept or decline an enrollment offer. The delineation reason shall be recorded in the department prescribed system within 10 business days.
3. If a person does not respond to the offer of enrollment within the allotted time, the offer is considered declined and the person will maintain their order of placement date.
4. The CMA shall record all waiting list communications, enrollments, and declinations in the Department's prescribed system within 10 business days.
5. The CMA shall record annual waiting list review within the Department's prescribed system within 10 business days.}

8.7206.8 Telehealth and Delivery

A. Members eligible to use HCBS Telehealth are those enrolled in the waivers and services as defined in this rule at [Section 8.615.2.] ~~[CODE OF COLORADO REGULATIONS 10 CCR 2505-10 8.600 Medical Services Board 95]~~
B. The {Case Management Agency} shall ensure the use of HCBS Telehealth is the choice of the Member through the Support Planning process by indicating the Member's choice to receive HCBS Telehealth in the Department prescribed IT system.
C. Through the Support Planning process, the {Case Management Agency} shall identify and address the benefits and possible detriments to Members choosing to use HCBS Telehealth for service delivery.
D. HCBS Telehealth delivery must be prior authorized and documented in the Member's Support Plan.
E. Telehealth as a service delivery method for authorized HCBS waiver services, shall not interfere with any client rights or be used as any part of a Rights Modification plan.

8.7206.9 Utilization Review ~~[and Cost Containment]~~

A. \The case manager shall complete a utilization review at quarterly monitoring or as needed.\
B. The Case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or mis-

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utilization of any public assistance benefit, and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services Income Maintenance Rules at 9 C.C.R. 2503-8, Section 3.810 and Section 8.076.

~~C. [Cost Containment (from 8.393.2.F.)~~

~~1. If the case manager expects that the cost of services required to support the individual will exceed the Department-determined Cost Containment Review Amount, the Department or its agent will review the Support Plan to determine whether the individual's request for services is appropriate and justifiable based on the individual's condition and quality of life and, if it is, will sign the Prior Authorization Request.~~

~~a. The individual may request of the case manager that existing services remain intact during this review process.~~

~~b. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:~~

~~i. The individual's appeal rights pursuant to Section 8.057; and~~

~~ii. Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.~~

~~D. The case manager shall determine whether the individual meets the cost containment criteria of Section 8.485.50.J by using a State-prescribed PAR form to:~~

~~1. Determine the maximum authorized costs for all waiver services and long-term home health services for the period of time covered by the care plan and compute the average cost per day by dividing by the number of days in the care plan period; and~~

~~2. Determine that this average cost per day is less than or equivalent to the individual cost containment amount, which is calculated as follows:~~

~~a. Enter (in the designated space on the PAR form) the monthly cost of institutional care for the individual; and~~

~~b. Subtract from that amount the individual's gross monthly income; and~~

~~c. Subtract from that amount the individual's monthly Home Care Allowance authorized amount, if any, and~~

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~~d. Convert the remaining amount into a daily amount by dividing by 30.42 days. This amount is the daily individual cost containment amount.~~

~~3. An individual client whose service needs exceed the amount allowed under the client's individual cost containment amount may choose to purchase additional services with personal income, but no client shall be required to do so. (8.486.80)]~~

8.7206.10 Person Centered Support Coordination

A. \Service and support coordination shall be the responsibility of the [~~community centered boards and regional center]~~ Case Management Agencies. Service and support coordination shall be provided in partnership with the person receiving services, the parents of a minor, legal guardians and public and private agencies to the extent such partnership is requested by these individuals. Persons receiving services who are their own guardians may also request their family or others to participate in this partnership.

B. Service and support coordination shall assist the eligible person to ensure:
   1. A ~~Individualized Plan~~ Person Centered Support Plan is developed, utilizing necessary information for the preparation of the ~~Individualized Plan~~ Person Centered Support Plan and using the Interdisciplinary Team process;
   2. Facilitating access to and provision of services and supports identified in the Person Centered Support Plan ~~Individualized Plan~~;
   3. The coordination of services and supports identified in the Person Centered Support Plan for continuity of service provision; and
   4. The Person Centered Support Plan ~~Individualized Plan~~ is reviewed periodically, as needed, to determine the results achieved, if the needs of the person receiving services are accurately reflected in the Person Centered Support Plan ~~Individualized Plan~~, whether the services and supports identified in the Person Centered Support Plan ~~Individualized Plan~~ are appropriate to meet the person's needs and what actions are necessary for the plan to be achieved.
   5. The Case Management Agency shall develop the Person Centered Support Plan for individuals not residing in nursing facilities. within fifteen (15) business days after determination of program eligibility.\

C. Support Plan Development

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1. The case manager shall work with individuals to design and update Support Plans that address individuals' goals and assessed needs and preferences;

D. Remediation
   1. The case manager shall identify, resolve, and to the extent possible, establish strategies to prevent Critical Incidents and problems with the delivery of services and supports.

E. The {case manager} shall develop the {Person-Centered} Support Plan (PCSP) for individuals not residing in nursing facilities within fifteen (15) working days after determination of program eligibility.

F. The {case manager} shall:
   1. Address the functional needs identified through the individual assessment in the support plan;
   2. Offer informed choices to the individual regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but that may not be available;
   3. \Support members in provider selection to the degree and depth that the member or family requests or requires for successful placement with a direct service provider;\
   4. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;
   5. Reflect cultural considerations of the individual and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency;
   6. Formalize the Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;
   7. Contain prior authorization for services, in accordance with program directives, ~~[including cost containment requirements]~~;
   8. Contain prior authorization of Adult Long-Term Home Health Services, pursuant to Sections [8.520-8.527];
   9. Include a method for the individual to request updates to the plan as needed;
   10. Include an explanation to the individual of grievance and complaint procedures for CMA and providers;

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11. Include an explanation to the individual of critical incident procedures; and
12. Explain the appeals process to the individual.

G. The case manager shall provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and shall ensure that the development of the Support Plan:
   1. Occurs at a time and location convenient to the individual receiving services;
   2. Is led by the individual, the individual's parent's (if the individual is a minor), and/or the individual's authorized representative;
   3. Includes people chosen by the individual;
   4. Addresses the goals, needs and preferences identified by the individual throughout the planning process;
   5. Includes the arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the individual regarding service provision and formalizing provider agreements in accordance with program rules; and
   6. Includes referral to community resources as needed and development of resources for the individual if a resource is not available within the individual's community.

H. Prudent purchase of services:
   1. The case manager shall arrange services and supports using the most cost-effective methods available in light of the individual's needs and preferences.
   2. When family, friends, volunteers or others are available, willing and able to support the individual at no cost, these supports shall be utilized before the purchase of services, providing these services adequately meet the individual's needs.
   3. When public dollars must be used to purchase services, the case manager shall encourage the individual to select the lowest-cost provider of service when quality of service is comparable.
   4. The case manager shall assure there is no duplication in services provided by LTSS programs and any other publicly or privately funded services.

I. In order to assure quality of services and supports and health and welfare of the individual, the case manager shall {ask for permission from the member to} observe the individual's residence prior to completing and submitting the individual's Support Plan, {but this shall not be compulsory of the individual

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member.} Upon Department approval, observation may be completed using virtual technology methods may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

J. Clients and/or their guardians and authorized representatives, as appropriate, who enroll in HCBS waiver services shall have the freedom to choose from qualified provider agencies in accordance with Section 8.603, as applicable.

K. Case Managers shall follow all documented rules, regulations, policies and operational guidance in these rules and set forth by the Department for case management and home and community based services.

L. Case Managers shall support members in identifying qualified providers and assist them in determining the best fit for their needs and service plan approvals, including but not limited to: setting up tours, communicating with potential providers about the member's needs or soliciting entrance to programs on behalf of the member, depending on member preferences and needs.

M. Case Managers shall follow all documented policy and operational guidance from the Department for case management services and all other long term services and supports including but not limited to:

1. Home modification
2. Vehicle modification
3. Organized Health Care Delivery System
4. Consumer Directed Attendant Supports and Services
5. In Home Supports and Services
6. Nursing Facilities
7. Transition Services
8. Long Term Home Health
9. Private Duty Nursing

8.7206.11 Monitoring

{Case Management Agencies} shall be responsible to monitor the overall provision of services and supports authorized by case managers to ensure the rights, health, safety and welfare of members, quality services, and that service provision practices promote member's ability to engage in self-determination, self-representation, and self-advocacy. Monitoring is required for all waivers in accordance with rules XXX Title of the section.

A. {The case manager shall complete monitoring activities to ensure the rights, health, safety and welfare of members and that members are provided quality services as authorized in their {Person-Centered} Support Plan in a manner that promotes self-

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determination, self-representation, and self-advocacy and are person-centered. Monitoring activities shall include but not be limited to the following:}

1. Case managers shall monitor service providers and the delivery of services and supports identified within the Support Plan and the Prior Authorization Request (PAR) for potential rights violations, risks to health, safety and welfare; changed needs, issues with utilization or provision of services, quality of service deliver, or issues with statutory or regulatory compliance. This may include, but is not limited to:
    i. Reviewing and following up on incident reports, ISSPs, rights modifications, and other provider documentation
    ii. Observing the environment(s) where services are being provided.
    iii. Contacting service agency staff about service provision and member satisfaction
    iv. Contacting members and/or their legally authorized representative about service provision and member satisfaction
2. The case manager shall contact service provider(s) /at a minimum of every 6 months/,
3. The case manager shall perform quarterly monitoring contacts with the member, as defined by the member's certification period start and end dates.
    i. At a minimum, member monitoring contacts shall include the following:
        1. A review of the member's LOC Screen, Needs Assessment and Person-Centered Support Plan, with the member, to determine whether their level of care or needs have changed, or needs are not being met.
        2. A review of their service utilization to determine whether services are being delivered/utilized as outlined in the PCSP/PAR.
        3. An evaluation of the member's satisfaction with services, to include whether service provision practices promote self-determination, self-representation, and self-advocacy and are person-centered.
        4. An evaluation of the member's health, safety and welfare, to include their rights being respected.
        5. A review of the member's goals, choices and preferences
    ii. An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period {not to include the annual LTSS Level of Care reassessment}. The case manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services.
        1. Upon Department approval in advance, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods.
        2. Such approval may be granted for situations in which in- person face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

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iii. The case manager shall perform three additional monitoring contacts Each certification period either in-person, on the phone, or through other technological modality based on the member preference of engagement.
   1. Contacts shall be directly with the member and/or their legally authorized representative.
   2. Contacts shall be bidirectional, i.e., questions and responses, conversation between the case manager and the member and/or their legally authorized representative; letters, emails or voicemails to the member and/or their authorized representative shall not constitute a monitoring contact for purposes of this requirement.

B. The case manager shall take appropriate action to remediate any risks or issues regarding the rights, health, safety and welfare of the member or service provision or utilization identified during monitoring activities.
   1. The identified issue(s) shall be documented in the IMS.
   2. The action(s) taken to remediate identified issue(s) shall be documented in the IMS.

C. The following criteria may be used by the case manager to determine the individual's level of case management involvement needed:
   1. Member preference;
   2. Availability and level of involvement of family, volunteers, or other supports;
   3. Overall level of physical capabilities;
   4. Mental status or cognitive capabilities;
   5. Duration of disabilities or conditions;
   6. Length of time supports have been in place;
   7. Stability of providers/unpaid supports;
   8. Whether the member is in a crisis or acute situation;
   9. The member's perception of need for services;
   10. The member's familiarity with navigating the system/services;
   11. The member's move to a new housing alternative; and
   12. Whether the individual was discharged from a hospital or Nursing Facility

8.7206.12 Critical Incident Reporting

A. Case Managers shall report critical incidents within 24 hours of notification within the State Approved IMS.

B. Critical Incident reporting is required when the following occurs.
   1. Injury/Illness;
   2. Missing Person;
   3. Criminal Activity;
   4. Unsafe Housing/Displacement;
   5. Death;
   6. Medication Management Issues;

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7. Other High-Risk Issues;
8. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;
9. Damage to the Consumer's Property/Theft.

C. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the Agency administrator or designee.

D. Case Managers shall comply with mandatory reporting requirements set forth at Section [18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102, C.R.S.]

E. Each Critical Incident Report must include:

1. incident type
    a. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at [Section 19-1-103, 26-3.1-101, 16-22-102 (9), and 25.5-10-202 C.R.S.]
    b. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, other high risk issues.
2. Date and time of incident;
3. Location of incident, including name of facility, if applicable;
4. Individuals involved;
5. Description of incident, and
6. Resolution of incident, if applicable.

F. The Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.

G. The {Case Management Agency}'s case manager shall be responsible to report suspected crimes against a member to protective services ~~[from 8.323.2.A.]~~. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of mistreatment, abuse, neglect, exploitation or a harmful act, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence and/or the local law enforcement agency. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, [Section 19-13-304, C.R.S., (Colorado Children's Code), Section 18-6.5-108, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Section 26-3.1-102, C.R.S., (Human Services Code - Protective Services)], to

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report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

8.7206.13 Case Management Agency Transfers

A. {Case Management Agencies} shall complete the following procedures in the event an individual receiving services transfers from one {Case Management Agency} \defined service area\ to another {Case Management Agency} \defined service area\:

B. {Transfer activities shall include, at minimum,
   1. Initial contact to the Case Management Agency in the designated service area of the member.
   2. Determination of transfer date.
      a. Determination of transfer date shall not be delayed based on receipt of mailed, electronic, or paper records.
   3. Necessary permissions in all appropriate Department prescribed systems.
   4. Both agencies, sending and receiving, must verify and document transfer request sent and transfer request received.
   5. All transfer activities shall be documented and recorded in the Department's prescribed system.}
   6. The transferring {Case Management Agency} shall notify the original county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and eligibility enrollment specialist shall follow rules described in Section 8.100.3.C. The receiving {Case Management Agency} shall coordinate the transfer with the eligibility enrollment specialist of the new county.

C. \The transferring {Case Management Agency} shall contact the receiving {Case Management Agency} by telephone and give notification that the individual is planning to transfer, negotiate a transfer date and provide all necessary information.

D. Both agencies, sending and receiving, must verify and document transfer request sent and transfer request received.

E. The transferring {Case Management Agency} shall notify the original county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and eligibility enrollment specialist shall follow rules described in Section 8.100.3.C. The receiving {Case Management Agency} shall coordinate the transfer with the eligibility enrollment specialist of the new county.

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F. The transferring {Case Management Agency} shall make available in the IMS the individual's case records to the receiving {Case Management Agency} prior to the relocation.\

G. If the individual is moving from one {Case Management Agency} \defined service area\ to another {Case Management Agency} \defined service area\ to enter an ACF or NF, the transferring {Case Management Agency} shall forward copies of the individual's records to the facility prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

H. To ensure continuity of services and supports, the transferring {Case Management Agency} and the receiving {Case Management Agency} shall coordinate the arrangement of services prior to the individual's relocation to the receiving {Case Management Agency's} \defined service area\ and within ten (10) working days after notification of the individual's relocation. Case Management Agencies shall work collaboratively to ensure a smooth transfer of services is completed.

I. Case Management Agencies shall be subject to Payment Liability as outlined in 10 CCR 2505-10 8.519.10.B if a failure of Case Management Agency transfer results in a break in payment authorization.

J. The receiving {Case Management Agency} shall complete a face-to-face meeting with the individual in the individual's residence and a case summary update within ten (10) working days after the individual's relocation, in accordance with assessment procedures for individuals served by {Case Management Agencies}. Upon Department approval, meeting may be completed using virtual technology methods or may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.)

K. The receiving {Case Management Agency} shall review the Support Plan and the {Level of Care Screen} and change or coordinate services and providers as necessary. The transferring CMA shall not close out the case until face to face contact is verified.

L. \If indicated by changes in the {Person-Centered} Support Plan\, The receiving {Case Management Agency} shall revise the {Person-Centered} Support Plan and prior authorization forms {as identified during the review.} [required by the publicly funded program necessary based on the]

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M. Within thirty (30) calendar days of the individual's relocation, the receiving {Case Management Agency} shall forward to the Department, or its fiscal agent, revised forms as required by the publicly funded program.

8.7206.14 Case Management Agency Member Choice Process

1. {Members may request to be served by a Case Management Agency outside of their defined service area with the approval of THE CASE MANAGEMENT AGENCY OUTSIDE THEIR DEFINED SERVICE AREA and Department oversight.

2. The CMA shall be willing and able to incur all costs to meet all regulatory and contractual requirements for the members served outside their defined service areas. The Department does not provide additional funding for any travel costs incurred by a Case Management Agencies that is serving a Member in any HCBS Waiver or State General Fund (SGF) programs outside of the agency's approved defined service area.

3. The Case Management Agency must be able and willing to provide health and safety checks in the same manner and frequency as required for a member within the defined service area. THE DEPARTMENT WILL NOT ALLOW AN EXCEPTION TO IN-PERSON ASSESSMENTS OR MONITORING VISIT REQUIREMENTS BASED SOLELY ON TRAVEL TIME.

4. CMA processes must outline how they plan to ensure all regulatory and contractual requirements can be met for members served outside their defined service area for case management.

5. The Case Management Agency shall follow the reporting requirements set forth by the Department FOR MEMBERS BEING SERVED OUTSIDE THEIR DEFINED SERVICE AREA.

6. If a person requires a transfer to a new CMA for any reason , both CMAs must follow the transfer process in rules XXXX or necessary procedures to maintain member eligibility and services.

7. CMAs shall have a policy and procedure to grant members choice of case manager at their agency.}

8.7206.15 State General Fund Transfers

A. When an individual enrolled in, or on the waiting list for, State General Fund (SGF) programs wishes to transfer State General Fund services, the following procedure shall be followed:

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B. {All transfer activities outlined in} [XXXX] {shall apply to SGF Programs.}

1. The originating ~~[CCB]~~ {Case Management Agency} will send the SGF Individual Support Plan to the receiving ~~[CCB]~~ {Case Management Agency}, where {the receiving ~~[CCB]~~ {Case Management Agency} will determine if appropriate SGF funding is available or if the individual will need to be placed on a waiting list {by reviewing the SGF Individual Support Plan in the Department's prescribed system.} The receiving ~~[CCB]~~ {Case Management Agency} decision of service availability will be communicated in the following way:
2. The receiving ~~[CCB]~~ {Case Management Agency} will notify the individual seeking transfer of its decision by the individual's preferred method, no later than ten (10) business days from the date of the request; and
3. The receiving ~~[CCB]~~ {Case Management Agency} will notify the originating CMA of its decision by U.S. Mail, phone call or email of its decision no later than ten (10) business days from the date of the request.
    a. The decision shall clearly state the outcome of the decision including:
        i. The basis of the decision; and
        ii. The contact information of the assigned Case Manager or waiting list manager.\
    b. The originating ~~[CCB]~~ {Case Management Agency} shall contact the individual requesting the transfer no more than 5 days from the date the decision was received to:
        i. Ensure the individual understands the decision; and
        ii. Support the individual in making a final decision about the transfer.
4. If the transfer is approved, there shall be a transfer meeting in-person when possible, or by phone if geographic location or time does not permit, within in fifteen (15) business days of when the notification of service determination is sent out by the receiving ~~[CCB]~~ {Case Management Agency}. The transfer meeting must include but is not limited to the transferring individual and the receiving case manager. Any additional attendees must be approved by the transferring individual.
5. The receiving ~~[CCB]~~ {Case Management Agency} must ensure that:
    a. the transferring individual meets his or her primary contact of the receiving ~~[CCB]~~ {Case Management Agency}.
    b. The individual is informed of the date when Services and Supports will be transferred, when Services and Supports will be available, and the length of time the Supports and Services will be available.

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c. The receiving ~~[CCB]~~ {Case Management Agency} case manager shall have an in-person face to face meeting with the Client to review and update the State-SLS Individual Support Plan, prior to the Supports and Services being authorized. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.).

8.7206.16 Informed Consent for Rights Modifications

A. {The {Case Management Agency}'s case manager is responsible for following the HCBS Settings Final Rule, as codified at [8.484], and ensuring that Informed Consents for Rights Modifications are obtained, maintained, and distributed per Department requirements as set forth in rule, other issuances, and trainings.
B. The case manager shall arrange for meetings to discuss proposed Rights Modifications consistent with the timelines in 8.484.5.G and H.
C. Before requesting or obtaining Informed Consent, the case manager shall make the offers required under 8.484.5.D and record the responses in the Department prescribed IMS.}
D. The {Case Management Agency}'s case manager is responsible for obtaining Informed Consent and other documentation supporting any Rights Modifications, maintaining these materials in the prescribed Department system as a part of the Person-Centered Support Plan, and distributing them to any providers implementing the Rights Modifications.

8.7206.17 Human Rights Committees ~~[8.608.5]~~

A. Each ~~[community centered board, CMA, and regional center]~~ {Case Management Agency} shall establish at least one Human Rights Committee (HRC) as a third party mechanism to safeguard the rights of persons receiving services. The Human Rights Committee is an advisory and review body to the administration of each ~~[community centered board, CMA, and regional center]~~ {Case Management Agency}.
B. ~~Such~~ The Human Rights committee shall be constituted as required by section 25.5-10-209(2)h, C.R.S.
C. If a consultant to the {Case Management Agency} ~~[community centered board]~~, regional center, or service agency serves on the Human Rights Committee, procedures shall be developed ~~[by the community centered board or regional center and the Human Rights Committee]~~ related to potential conflicts of interest.

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D. The ~~[community centered board and regional center]~~ {Case Management Agency} shall orient members regarding the duties and responsibilities of the Human Rights Committee.

E. The ~~[community centered board and regional center]~~ {Case Management Agency} shall provide the Human Rights Committee with the necessary staff support to facilitate its functions.

F. Each program approved service agency shall make referrals as required in rules and regulations for review by the Human Rights Committee(s) in the manner required by the ~~[community centered board and regional center]~~ {Department}/

G. The recommendations of the Human Rights Committee shall become a part of the ~~[community centered board and regional center]~~ {Case Management Agency's} record as well as a part of the individual's master record.

H. The Human Rights Committee shall develop operating procedures which include, but are not limited to, Human Rights Committee responsibilities for the committee's organization, {Department required universal documents}, the review process, and provisions for recording dissenting opinions of committee members in the committee's recommendations.

I. The Human Rights Committee shall establish and implement operating and review procedures to determine that the practices of the {Case Management Agency} ~~[community centered board, service agencies and regional centers]~~ are in compliance with section [25.5-10, C.R.S.], are consistent with the mission, goals and policies of the Department~~, [community centered board or regional center,~~ and {Case Management Agency} and ensure that:

1. Informed consent is obtained when required from the person receiving services, the parent of a minor, or the guardian {or other legally authorized representative} as appropriate;[]
2. ~~Suspension of rights~~ Modifications of the rights of persons receiving services occurs only within procedural safeguards as stipulated in section [8.604.3 and 8.484] and that continued ~~[suspension]~~ {modification} of such rights is reviewed by the {individual, their guardian or other legally authorized representative, and the rest of the member-identified} ~~interdisciplinary~~ team at a frequency decided by the team, but not less than every six months;
3. Psychotropic medications ~~and other medications~~ and other prescribed medications used for the purpose of modifying the behavior of ~~persons receiving comprehensive services~~ members receiving services through the DD waiver are used in accordance with the requirements of section [8.609.6.D.7 and 8], and are monitored by the Human Rights Committee on a regular basis; and,

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4. Allegations of mistreatment, abuse, neglect and exploitation are investigated, and the investigation report reviewed.

8.7206.18 Denials/Discontinuations/Adverse Actions

A. Individuals seeking or receiving services shall be denied or discontinued from services under publicly funded programs served by the {Case Management Agency} if they are determined ineligible for any of the reasons below. Individuals shall be notified of any of the adverse actions and appeal rights as follows:
   1. Financial Eligibility
      a. The eligibility enrollment specialist from the county department of social services shall notify the individual of denial or discontinuation for reasons of financial eligibility and shall inform the individual of appeal rights in accordance with Section [8.057].
      b. If the individual is found to be financially ineligible for {HCBS or} LTSS programs, the {Case Management Agency} shall notify the individual of the adverse action and inform the individual of their appeal rights in accordance with Section [8.057]. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the Department.
   2. Functional Eligibility and Target Group
      a. The {Case Management Agency} shall notify the individual of the denial or discontinuation and appeal rights by sending the [~~Notice of Services Status~~] {Long-Term Care Waiver Program Notice of Action} (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:
         A. The individual does not meet the functional eligibility threshold for {HCBS and} LTSS Programs or nursing facility admissions; or
         B. The individual does not meet the target group criteria as specified by the HCBS Program.
   3. Receipt of Services
      a. The {Case Management Agency} shall notify the individual of the denial or discontinuation and appeal rights by sending the [~~Notice of Services Status~~] {Long-Term Care Waiver Program Notice of Action} (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

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A. The individual has not received long-term services or supports for one month;
B. The individual has two (2) times in a one month consecutive period refused to schedule an appointment for assessment, or monitoring required by these regulations;
C. The individual has failed to keep three scheduled assessment appointments within a thirty-day consecutive period.
~~D. [The SEP Agency does not receive the completed Professional Medical Information Page (PMIP) form, when required.]~~

4. Institutional Status
   a. The {Case Management Agency} shall notify the individual of denial or discontinuation by sending the ~~[Notice of Services Status]~~ {Long-Term Care Waiver Program Notice of Action} (LTC-803) when the case manager determines that the individual does not meet the following program eligibility requirements.
      A. The individual is not eligible to receive HCBS services while a resident of a nursing facility, hospital, or other institution; or
      B. The individual who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.

B. The Long-Term Care Waiver Program Notice of Action (LTC-803) shall be completed in the IMS for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, and at the time of discontinuation.
C. In the event the individual appeals a denial or discontinuation action, except for reasons related to financial eligibility, the case manager shall attend the appeal hearing to defend the denial or discontinuation action.
D. The {Case Management Agency} shall provide the long-term care notice of action form to applicants and Clients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 et seq. when:
   1. The Client or applicant is determined to not have a developmental disability,
   2. The Client or applicant is found eligible or ineligible for LTSS,
   3. The Client or applicant is determined eligible or ineligible for placement on a waiting list for LTSS,
   4. An adverse action occurs that affects the Client's or applicant's waiver enrollment status,

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E. The {Case Management Agency} shall appear and defend its decision at the Office of Administrative Courts as described in Section [8.057 et seq.] when the {Case Management Agency} has made a denial or adverse action against a Client.

F. The {Case Management Agency} shall notify the {Case Management Agency} in the Client's service plan within one (1) business day of the adverse action.

G. The case manager shall notify all providers on the Support Plan {prior to discontinuation and no later than} within one (1) working day of discontinuation.

H. The case manager shall follow procedures to close the individual's case in the IMS within one (1) working day of discontinuation for all HCBS Programs.

I. The {Case Management Agency} shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business day of an adverse action that affects Medicaid financial eligibility.

J. The {Case Management Agency} shall notify the county eligibility enrollment specialist of the appropriate county department of social services:

   1. At the same time, it notifies the individual seeking or receiving services of the adverse action;
   2. When the individual has filed a written appeal with the {Case Management Agency}; and
   3. When the individual has withdrawn the appeal or a final Agency decision has been entered.

K. The applicant or Client shall be informed of an adverse action if the Client or applicant is determined ineligible and the following:

   1. The Client or applicant is detained or resides in a correctional facility, or
   2. The Client or applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

L. The CMA shall refer clients to the Medicaid Buy-In program who do not qualify for waivers due to financial eligibility.

8.7206.19 Support to Members and Families Receiving Services Related to Dispute Resolution with Providers

A. Every {Case Management Agency} [~~community centered board, regional center and program approved service agency~~] shall have procedures which comply with requirements as set forth in these rules and section 25.5-10- 212, C.R.S., for resolution of the following disputes involving individuals:

   1. The applicant is not eligible for services or supports;
   2. The person is no longer eligible for services or supports;
   3. Services or supports are to be terminated; or,

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4. Services set forth in the {person-centered support plan} [~~IP~~] are to be changed or reduced, or denied.

B. The procedure shall contain an explanation of the process to be used by persons receiving services or applicants for services or parents of a minor, guardians and/or authorized representatives in the event that they are dissatisfied with the decision or action of the community centered board, regional center or program approved service agency.

C. The dispute resolution procedure shall be stated in writing, in English. Interpretation in native languages other than English and through such modes of communication as may be necessary shall be made available upon request.

1. The procedure shall be provided, orally and in writing, to all persons receiving services or applicants for services and parents of a minor, guardian, and/or authorized representative at the time of application, at the time the individualized plan is developed, any time changes in the plan are contemplated, and upon request by the above named persons.
2. The procedure shall state that use of the dispute resolution procedure shall not prejudice the future provision of appropriate services or supports to the individual in need of and/or receiving services.
3. The procedure shall state that an individual shall not be coerced, intimidated, threatened or retaliated against because that individual has exercised his or her right to file a complaint or has participated in the dispute resolution process.

D. The procedure of the community centered board, regional center or the program approved service agency shall stipulate that notice of action proposed as defined in section 8.600.4 shall be provided to the person receiving services/applicant, and to the person's parents if a minor, guardian and authorized representative at least fifteen (15) days prior to the date actions enumerated in section 8.605.2.A become effective. CODE OF COLORADO REGULATIONS 10 CCR 2505-10 8.600 Medical Services Board 32 The above named persons may dispute such action(s) by filing a complaint with the agency initiating the action. Upon such complaint, the procedures set forth in section 8.605.2.E and the following provisions shall be initiated.

E. The procedure of the community centered board, regional center and program approved service agency shall provide the opportunity for resolution of any dispute through an informal negotiation process which may be waived only by mutual consent. Mediation could be considered as one means to informal negotiation if both parties voluntarily agree to this process.

F. The opportunity for resolution of a dispute through informal negotiation shall include the scheduling of a meeting of all parties or their representatives within fifteen (15) days of the receipt of the complaint.

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G. After opportunities for informal negotiation of the dispute have been attempted or mutually waived, either party may request that the dispute resolution process set forth in section 8.605.2.H and the following provisions shall be initiated. Parent(s) or guardian of a minor, age birth to three years, may utilize the dispute resolution process specified under the requirements of the Procedural Safeguards for early intervention services pursuant to the Individuals with Disabilities Education Act.

H. The dispute resolution procedures of the community centered board, regional center or program approved service agency shall, at a minimum, afford due process by providing for:

1. The opportunity of the parties to present information and evidence in support of their positions to an impartial decision maker. The impartial decision maker may be the director of the agency taking the action or their designee. The impartial decision maker shall not have been directly involved in the specific decision at issue;
2. Timely notification of the meeting (at least ten days prior) to all parties unless waived by the objecting parties;
3. Representation by counsel, authorized representative, or another individual if the objecting party desires;
4. The opportunity to respond to or question the opposing position;
5. Recording of the proceeding by electronic device or reporter;
6. Written decision within fifteen (15) days of the meeting setting forth the reasons therefore;
7. Notification that if the dispute is not resolved, the objecting party may request that the Executive Director of the Department or designee review the decision; and,
8. Notification to the Department by the community centered board, regional center or program approved service agency of all disputes proceeding according to section 8.605.2.H and the determination made thereon.

I. The dispute resolution procedure of the Department shall be as follows:

1. A request to the Executive Director of the Department to review the outcome of the dispute resolution process shall be submitted to the Department within fifteen (15) working days from which the written decision was postmarked; CODE OF COLORADO REGULATIONS 10 CCR 2505-10 8.600 Medical Services Board 33
2. The request for review shall also contain a statement of the matters in dispute and all information or evidence which is deemed relevant to a thorough review of the matter. The community centered board, regional center or the program approved service agency or other party shall be afforded the opportunity likewise to respond within fifteen (15) working days;

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3. The Executive Director of the Department or designee shall have the right to additional information and may request oral argument or a hearing if deemed necessary by the Executive Director or designee to render a decision;
4. The Executive Director of the Department or designee shall provide a de novo review of the dispute and shall render a decision within ten (10) working days of the submission of all relevant information; and,
5. The decision of the Executive Director of the Department shall constitute final agency action on the dispute.

J. No person receiving services may be terminated from services or supports during the dispute resolution process unless the Department determines an emergency situation, as meeting the criteria set forth in section 8.605.4 exists.

8.7206.20 \Disputes between Department and Case Management Agency\

~~[Pursuant to section 25.5-10-208(2)(c), C.R.S.]~~ The following shall apply in the event that the terms of ~~a contract between the Department and a [community centered board or program approved service agency]~~ { the Case Management Agency requirements and responsibilities in these rules for Targeted Case Management activities} are disputed by either party:

A. The ~~[community centered board or program approved service agency]~~{Case Management Agency} shall notify the ~~[Manager]~~ {Director} of the Office of Community Living of the circumstances of the dispute.
B. The parties shall informally meet at a mutually agreeable time to attempt resolution.
C. If the dispute cannot be resolved through this informal process, then the formal process at section 8.7204.3.A.4 shall be used.
D. The {Case Management Agency} ~~[community centered board or program approved service agency]~~ shall submit a written request for formal dispute resolution to the Department.
    i. The request shall state the specific grounds for the dispute.
    ii. It shall include all available exhibits, evidence, arguments, and documents believed to substantiate the protest, and the relief requested.
E. The Department may request additional information deemed necessary to resolve the dispute.
F. Within fifteen (15) working days following the receipt of written materials and additional requested information, the Department shall respond to the request by issuing a written decision, which shall be inclusive of the reasons for the decision.

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G. A copy of the documentation presented or considered, the decision made and the contract shall be maintained in the files of the Department. CODE OF COLORADO REGULATIONS 10 CCR 2505-10 8.600 Medical Services Board 34

H. The Department's decision shall represent final agency action on the disputed issue.

8.7206.2 Notwithstanding the dispute, the {Case Management Agency} ~~[community centered board or program approved service agency]~~ shall honor all contractual obligations entered into in its contract with the Department. No agency shall have its contract terminated pending resolution of a contractual dispute, unless necessary for the preservation of public health, safety or welfare, as determined pursuant to section 8.605.4.

8.7206.3 Nothing in this procedure shall prohibit the Department from {initiating corrective action} ~~[revoke designation of a community centered board or program approval of a service agency]~~ based on evidence presented in the request for Departmental intervention or during its review.

8.7206.4 \Disputes related to administrative case management activities must follow the process outlined in the Case Management Agency contract.\

8.7206.21 Continuous Quality Improvement

A. \To ensure the Case Management Agency is completing case management activities according to requirements, the Department conducts performance reviews or evaluations of the Case Management Agency.

B. The Department may work with the Case Management Agency in the completion of any performance reviews or evaluations, or the Department may complete any or all performance reviews or evaluations independently, at the Department's sole discretion.

C. The Case Management Agency shall provide all information necessary for the Department to complete all performance reviews or evaluations, as determined by the Department, upon the Department's request.

D. The Department may make the results of any performance reviews or evaluations available to the public or may publicly post the results of any performance reviews or evaluations.

E. The Department may recoup funding as a result of any performance review or evaluation where payment was rendered for services not complete or not in alignment with federal and/or state regulations or Contract.

F. A Case Management Agency may be placed on corrective action requiring remediation based on the result of any performance review or evaluation.\

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G. Case Management Agencies shall allow access by authorized personnel of the Department, or its contractors, for the purpose of reviewing documents and systems relevant to the provision of case management services and supports funded by the Department and shall cooperate with the Department in the evaluation of such services and supports.

H. **{Case Management Agency} Satisfaction Survey**

1. At least annually, the {Case Management Agency} shall survey a random sample of individuals receiving services to determine their level of satisfaction with services provided by the agency. The {Case Management Agency} shall have a written policy and procedure for completing the member satisfaction survey.
2. The random sample of individuals shall constitute forty (40) individuals or ten percent (10%) of the {Case Management Agency}'s average monthly caseload, whichever is higher.
3. The individual satisfaction survey shall conform to guidelines provided by the Department, including multiple survey formats and meet ADA compliance.
4. The results of the individual satisfaction survey shall be made available to the Department and shall be utilized for the {Case Management Agency}'s quality assurance and resource development efforts.
5. The {Case Management Agency} shall assure that consumer information regarding HCBS waiver programs is available for all individuals at the local level.
6. \The Survey results shall be provided to the Community Advisory Committee for advisement regarding follow up and community engagement.
7. The Survey results shall be provided to the Department upon request.\

8.7206.22 Provision of State Program Services

\The {Case Management Agency} is responsible for the administration of state plan LTSS programs including: state Supported Living Services, OBRA, and Family Support Services Program in accordance with XXXXX rules, regulations and contract. and all the requirements associated with these programs including, but not limited to: Family Support Council development and maintenance, rates for state SLS and monitoring of services, PASSR and other requirements.\

A. \Family Support Program

1. Case management for state general fund program support is the coordination of services provided for individuals with an IDD or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education, and other services to ensure

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nonduplication of services, and monitor the effective and efficient provision of services across multiple funding sources.

2. At minimum, the case manager is responsible for:
   a. Determining initial and ongoing eligibility for the FSSP;
   b. Development, application assistance, and annual re-evaluation of the Family Support Plan (FSP); and
   c. Ensuring service delivery in accordance with the FSP.
   d. Coordinate with the Family Support Council as needed.

B. OBRA-SS State General Fund Program
   1. Case Management Agencies shall follow all contractual obligations, rules and regulations regarding OBRA-SS. \

C. Supported Living Services State General Fund Program
   1. The CMA case manager shall coordinate, authorize and monitor services based on the approved State-SLS Individual Support Plan. a. The case manager shall have, based on the Client's preference, a in person or telephone contact once per quarter with the Client. CODE OF COLORADO REGULATIONS 10 CCR 2505-10 8.500 Medical Services Board 86
   2. The CMA Case Manager shall assist Clients to gain access to other resources for which they are eligible and to ensure Clients secure long-term support as efficiently as possible.
   3. The CMA Case Manager shall provide all State-SLS documentation upon the request from the Department.
   4. Referrals to the State-SLS program shall be made through the CMA in the defined service area the Client or Applicant resides in.

D. \Home Care Allowance program
   1. \Case Management Agencies shall contract with the Colorado Department of Human Services to administer the Home Care Allowance program.
   2. Case Managers shall complete all requirements for Home Care Allowance in accordance with all applicable rules, regulations and contracts as defined in [9 CCR 2503-5 (3.570.1)].\

8.7206.23 Organized Health Care Delivery System (8.503.110)

A. The Organized Health Care Delivery System (OHCDS) for waivers is the {Case Management Agency} as designated by the Department in accordance with Section 25.5 -10-209, C.R.S.

B. The Organized Health Care Delivery System is the Medicaid provider of record for a Member whose services are delivered through the Organized Health Care Delivery System.

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C. The Organized Health Care Delivery System shall maintain a Medicaid provider agreement with the Department to deliver waiver services according to the current federally approved waiver.

D. The Organized Health Care Delivery System may contract or employ for delivery of approved waiver services for Organized Health Care Delivery System.

E. {The Organized Health Care Delivery System shall:

1. Ensure that the contractor or employee meets minimum provider qualifications as set forth in the HCBS waiver;
2. Ensure that services are delivered according to the HCBS waiver definitions and as identified in the Member's Service Plan;
3. Ensure the contractor maintains sufficient documentation to Support the claims submitted; and
4. Monitor the health and safety of HCBS waiver Members receiving services from a subcontractor.

F. The Organized Health Care Delivery System is authorized to subcontract and negotiate reimbursement rates with providers in compliance with all federal and state regulations regarding administrative, claim payment and rate setting requirements. The Organized Health Care Delivery System shall:

1. Establish reimbursement rates that are consistent with efficiency, economy and quality of care;
2. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers;
3. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to Clients ;
4. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and the Department's procedures:
    a. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.
5. Collect and maintain the data used to develop provider rates and ensure data includes costs for the services to address the Client's needs, that are allowable activities within the HCBS-CES waiver service definition and that Supports the established rate;
6. Maintain documentation of provider reimbursement rates and make it available to the Department, its Operating Agency and Centers for Medicare and Medicaid Services (CMS); and

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7. Report by August 31 of each year, the names, rates and total payment made to the contract}

8.7206.24 Member and Client Documentation and Recordkeeping

A. Documentation includes:
   1. Documentation of the ~~[client's]~~ {member's} choice of ~~[HCBS-EBD]~~ services, providers, nursing home placement, or other services, including a signed statement of choice from the member;
   2. Documentation that the client or member was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the client understands his/her right to change providers;
   3. Except when a client or member is residing in an alternative care facility, documentation to include a process, developed in coordination with the ~~[client]~~ {member}, the ~~[client's]~~ {member's} family or guardian and the member's physician, by which the ~~[client]~~ {member}may receive necessary care if the ~~[client's]~~ {member's} family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The client and the client's family or guardian shall be duly informed of these alternative care provisions at the time the ~~[case]~~ {service} plan is initiated. ~~[8.486.50]~~

B. Case Managers shall support members in determining their PETI: Case managers shall inform ~~[HCBS-EBD]~~ Alternative Care Facility clients of their client payment obligation on a form prescribed by the state at the time of the first assessment visit; by the end of each plan period; or within ten (10) working days whenever there is a significant change in the diem payment amount.
   1. Significant change is defined as fifty dollars ($50) or more.
   2. Copies of client payment forms shall be kept in the client files at the single entry point agency, and shall not be mailed to the State of its agent except as required for a prior authorization request, according to [10 CCR 2505-10 section 8.509.31(G)], or if requested by the state for monitoring purposes~~.~~ ~~[8.486.60 C]~~

C. All Case management documentation shall meet all of the following standards:
   1. Be objective and understandable;
   2. Occur at the time of the activity or no later than five (5) business days from the time of the activity;
   3. Dated according to the date of the activity, including the year;
   4. Entered into the Department's IMS;
   5. Identify the person creating the documentation;
   6. Entries must be concise and include all pertinent information;

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7. Information must be kept together, in a logical organized sequence, for easy access and review;
8. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact or is a someone's judgment or conclusion; \
9. All persons and agencies referenced in the documentation must be identified by name and by relationship to the individual;
10. All forms prescribed by the Department shall be completely and accurately filled out by the Case Manager; and,
11. If the Case Manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the case management agency's control, the circumstances shall be documented in the case record.

D. **Documentation of Contacts and Case Management Activities in the Department-Prescribed IMS**

1. All case documentation must be entered into the Department's IMS within five (5) business days from the date of activity.
2. The case manager shall use the Department-prescribed IMS for purposes of documentation of all case management activities, monitoring of service delivery, and service effectiveness. If applicable, the individual's legally authorized ~~designated~~ representative or LTSS Representative or both (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation.
3. The {Case Management Agency} may accept physical or digital signatures on Department forms. If the individual is unable to sign a form requiring his/her signature because of a medical condition, any mark the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a guardian or authorized representative will be accepted.

8.7206.25 Communication ~~[from 8.393.4.]~~

A. \The Case Management Agency's case manager shall be responsible for ensuring materials, documents, and information used to conduct case management activities are adapted to the cultural background, language, ethnic origin and means of communication used by the individual.\

B. In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

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1. The case manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of an individual receiving services in {Case Management Agency}-served programs, including changes in income, within one (1) working day after the case manager learns of the change. The case manager shall provide the eligibility enrollment specialist with copies of the certification page of the approved {Level of Care Screen} form.
2. If the individual has an open adult protective services (APS) {or child protective services (CPS)} case at the county department of social services, the case manager shall keep the individual's APS {or CPS} worker informed of the individual's status and shall participate in mutual staffing of the individual's case.
3. The case manager shall inform the individual's physician of any significant changes in the individual's condition or needs.
4. The case manager shall report to the Colorado Department of Public Health and Environment (CDPHE) any congregate facility which is not licensed.
5. The case manager shall inform all Alternative Care Facility clients of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider. ~~[8.486.4]~~
6. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent, the case manager shall provide copies to all the HCBS providers in the person-centered support plan. ~~[8.486.4]~~
7. The case manager shall coordinate with the Regional Accountable Entity and Behavioral Health Administration along with other community partners involved with the members' services and supports.
8. The case manager shall notify the URC, on a form prescribed by the Department, within thirty (30) calendar days, of the outcome of all non-diversions, as defined at Section [8.485.50.] ~~[8.486.4]~~
9. {Case Managers shall maintain communication with members, family members, providers and other necessary parties within minimum standards for returned communication as described in contract.}

8.7206.26 {Targeted Case Management Activity} Billing and Payment Liability

A. **Billing**

1. Claims are reimbursable only when supported by the following documentation:
    a. The name of the Client;
    b. The date of the activity;

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c. The nature of the activity including whether it is direct or indirect contact with the Client;
d. The content of the activity including the relevant observations, assessments, findings;
e. Outcomes achieved, and as appropriate, follow up action;
f. For HCBS waiver programs, documentation required under [Sections 8.519 and 8.760.]

2. {Claims are subject to a retrospective review by the Department. If the Department identifies a claim reimbursement not in compliance with requirements, the amount reimbursed shall be subject to reversal of claims, recovery of the amount reimbursed, or suspension of payments.} [8.500.13]
3. Targeted Case Management services ~~{for Persons with Developmental Disabilities]~~ consist of facilitating enrollment; locating, coordinating, and monitoring needed {LTSS} ~~[developmental disabilities]~~ services; and coordinating with other non-~~[developmental]~~ disabilities funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources.

4. TCM for ~~[HCBS-DD, HCBS-CES, HCBS-CHRP and HCBS-SLS)~~ {HCBS waiver programs} are to be reimbursed based on the Department's TCM Fee Schedule. ~~[8.761.5]~~
5. TCM providers shall record what documentation exists in the log notes and enter it into the Department prescribed system as required by the Department.
    a. {Case Management Agencies} shall document all targeted case management services and meet the following criteria:
        1. All targeted case management services must be documented in the Department's system within 10 business days of the activity and prior to submitting a claim for reimbursement.
        2. Documentation must be specific to the Member and clearly and concisely detail the activity completed.
        3. Documentation must specify the Member's preference for in-person or virtual for monitoring contacts in adherence with Department direction and requirements.
        4. The use of mass email communication, robotic and/or automatic voice messages cannot be used to replace the {Case Management Agencies} required case management services or any billable targeted case management service.

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6. Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at [42 C.F.R. § 447.205] and shall be based upon a market-based.~~[CODE OF COLORADO REGULATIONS 10 CCR 2505-10 8.700 Medical Services Board 68]~~
7. TCM services may not be claimed prior to the first day of enrollment into an eligible program nor prior to the actual date of eligibility for Medicaid benefits.

B. **Exclusions**

1. Case management services provided to any individuals enrolled in the following programs are not billable as Targeted Case Management services ~~[for persons with developmental disabilities]~~ as specified in Section [8.760]:
    a. Persons enrolled in a Home and Community Based Services waiver not included as an eligible HCBS service as described in Section [8.761.21.c].
    b. Persons residing in a Class I nursing facility.
    c. Persons residing in an Intermediate Care Facility for the Intellectually Disabled (ICF-ID).

C. **Payment Liability**

1. Failure to prepare the service plan and prior authorization or failure to submit the service plan forms in accordance with Department policies and procedures shall result in the {reversal and recovery} of reimbursement for services authorized retroactive to the first date of service. The {Case Management Agency} and/or providers may not seek reimbursement for these services from the Client receiving services.
2. If the {Case Management Agency} causes a Client enrolled in HCBS waiver services to have a break in payment authorization, the agency will ensure that all services continue and will be solely financially responsible for any losses incurred by service providers until payment authorization is reinstated.

8.7206.27 PCBA and Resource Development [place holder for PCBA]

8.7207 {Case Manager Requirements and Responsibilities}

8.7207.1 The {Case Management Agency} case manager(s) hired on or after October 8, 2021 shall meet minimum standards for HCBS case managers required and shall be able to demonstrate competency in pertinent case management knowledge and skills.

8.7207.2 All Home and Community-Based (HCBS) case managers must be employed by a ~~[certified]~~ {contracted Case Management Agency}. {Case Management Agencies} must

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maintain verification that employed case managers meet the qualifications set forth in these regulations. ~~(8.519.5)~~

8.7207.3 The minimum qualifications for HCBS Case Managers hired on or after October 8, 2021 are:

A. A bachelor's degree; or
B. Five (5) years of relevant experience in the field of LTSS, which includes Developmental Disabilities; or
C. Some combination of education and relevant experience appropriate to the requirements of the position.
D. Relevant experience is defined as:
    1. Experience in one of the following areas: long-term care services and supports, gerontology, physical rehabilitation, disability services, children with special health care needs, behavioral science, special education, public health or nonprofit administration, or health/medical services, including working directly with persons with physical, intellectual or developmental disabilities, mental illness, or other vulnerable populations as appropriate to the position being filled; and,
    2. Completed coursework and/or experience related to the type of administrative duties performed by case managers may qualify for up to two (2) years of required relevant experience. ~~[8.519.5]~~

8.7207.4 Case Managers may not:

A. Be related by blood or marriage to the Client.
B. Be related by blood or marriage to any paid caregiver of the Client.
C. Be financially responsible for the Client.
D. Be the Client's legal guardian, authorized representative, or be empowered to make decisions on the Client's behalf through a power of attorney.
E. Be a provider for the Client, have an interest in, or be employed by a provider for the same Client. Case Managers employed by a {Case Management Agency} that is operating under an exception approved by the Centers for Medicare and Medicaid Services (CMS) in the approved waiver application are exempt from this requirement.
F. Be related by blood or marriage to the owner or managing employee of a provider.

8.7207.5 Case management agency staff must pass competency-based training requirements as defined and enforced by the Department through contractual agreements.

8.7207.6 The {Case Management Agency} supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of HCBS case management.

8.7208 {Functions of the Case Management Agency Supervisor ~~[8.393.1.N]~~

8.7208.1. **Supervision of Case Managers}**

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A. {Case Management Agencies} shall provide adequate supervisory staff who shall be responsible for:
   1. Supervisory conferences with case managers on a regular basis related to their caseload and members' needs;
   2. Approval of indefinite lengths of stay in nursing facilities, pursuant to [8.402.15];
   3. Regular, systematic review and remediation of case records and other case management documentation, on at least a sample basis;
   4. Communication with the Department when technical assistance is required by case managers and the supervisor is unable to provide answers after reviewing the regulations and other departmental publications;
   5. Allocation and monitoring of staff to assure that all standards and time frames are met; and
   6. Assumption of case management duties when necessary.

8.7208.2. **{Training of Case Management Agency Staff}** **~~[from 8.393.1.L.]~~**

A. {Case Management Agency} staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for {Case Management Agencies}.
B. Prior to start-up, the {Case Management Agency} staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:
   1. Background information on the development and implementation of the {Case Management Agency} system;
   2. Mission, goals, and objectives of the {Case Management Agency} system;
   3. Regulatory requirements and changes or modifications in federal and state programs;
   4. Contracting guidelines, quality assurance mechanisms, and certification requirements; and
   5. Federal and state requirements for the {Case Management Agency}.
C. The {Case Management Agency} is responsible for tracking completion of required {Case Management Agency} training and staff development of program knowledge. Staff who require retraining or additional training will receive training through available Department training and the {Case Management Agency} internal training processes.
D. Case management agency staff must pass competency-based training requirements as defined by the Department including but not limited to disability/cultural competency, person centeredness, soft skills, as well as program specific knowledge and skills.
E. {Case Management Agencies} are responsible for providing quality oversight of their staff work product. At least quarterly, the {Case Management Agency} will audit case records to evaluate case management performance. The {Case Management Agency} will audit ten percent (10%) of the {Case Management Agency} average monthly caseload size or ten individual case records, whichever is higher.

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1. The audit form utilized will be issued by the Department for {Case Management Agency} completion.
2. Each case manager employed by the {Case Management Agency} must receive one case audit per year.
3. The results of the audit shall be made available to the Department and shall be utilized for the {Case Management Agency} quality assurance efforts.

8.7300. Community Centered Board ~~[CCB definitions: From 8.601.1 and CRS 25.5-10-209, which is being repealed and CCB will be referenced in 25.5-10-206]~~

8.7301. Community Centered Boards (CCB) are the agencies responsible for leveraging local and regional resources to meet unmet needs for individuals with Intellectual and Developmental Disabilities (IDD) and their families.

8.7302. \At each Case Management Agency contract period or every ten years, whichever is longer, beginning in 2024, not for profits who have held a previous Community Centered Board designation and are seeking designation as a Community Centered Board for the next 10 year cycle, shall submit an application for designation to the Department.

A. Applications shall be submitted in a form and manner specified by the Department which shall be made available to applicants upon request.
B. The Department shall notify all applicants by email to the CCB Executive Director of the designation or non-designation.
C. The designation shall cover up to a ten-year period.
D. Designation of a Community Centered Board shall be based on the following factor only:
    1. Prior Community Centered Board designation.
E. If no agency requests the Community Centered Board designation in a defined service area, CCB designation for that area will be heretofore dropped from that defined service area.\