Title of Rule: Revision to the Medical Assistance Rule concerning CHCBS Cost Containment Rule Revision, Section 8.506
Rule Number: MSB 21-06-04-A
Division / Contact / Phone: Case Management and Quality Performance / Karli Altman / 303-866-4032

STATEMENT OF BASIS AND PURPOSE

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

   The rules implementing the cost containment process, 10 C.C.R. 2505-10, Sections 8.506, are being updated to reflect the removal of the requirement for Case Managers to submit a Cost Containment Form to the Utilization Review Contractor (URC) when the cost of an individual's services increases or decreases by a Department prescribed amount. Additionally, the rules will be updated to add in the requirement for Case Managers to submit a review to the URC not only upon initial enrollment into the HCBS-CHCBS waiver, but also at annual certification to ensure the individual continues to meet targeting criteria for the waiver.

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

   Explain:

2. Federal authority for the Rule, if any:

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2021);

Initial Review **02/11/22** Final Adoption **03/11/22**
Proposed Effective Date **04/30/22** Emergency Adoption

DOCUMENT #01

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REGULATORY ANALYSIS

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

   No costs have been identified. Case managers and members will benefit from no longer having to complete the cost containment review process. The Department will realize cost savings from revising the CHCBS review process.

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

   The revision of these rules to remove the cost containment process is a result of policy changes will remove duplicative work being done by contracted vendors, creating a savings to the Department. It will also discontinue use of an outdated form and review process that provides little to no value to the department. Members will have a better experience and case managers will have less paperwork.

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

   There is no anticipated cost/impact; a cost savings will be realized.

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

   Continuing the status quo would result in payment to vendors to complete duplicative work, continuing to have members and case managers complete a form and process that does not result in any meaningful benefit or value to the member or department.

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

   This was the most cost effective and least intrusive method of resolving the duplication in cost containment reviews. This change will be less intrusive; information the department already has access to will no longer be requested directly from the member and information that is not used in a meaningful way will no longer be obtained from the member.

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

   The policy decision requiring this rule change was made following consideration of the option to continue the review process. That options were adopted because it would not result in savings to the department; did not decrease administrative burden to the case management agencies or did not improve quality of administration and oversight of the program.

8.506 CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM

8.506.1 Legal Basis:

The Children's Home and Community -based Services program in Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CHCBS program is also authorized under state law at Section 25.5-6-901, et seq. C.R.S.

8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.506.3.B and the additional operations specifically defined for this waiver in Section 8.506.4.B.

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8.552

8.506.3 General Definitions

A. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources. Case managers shall use the Department approved instrument to complete assessments.

B. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic reassessment of such individual's needs. Additional operations specifically defined for this waiver are described in Section 8.506.4.B.

C. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency.

D. Continued Stay Review means a reassessment by the case manager to determine the Client's continued eligibility and functional level of care.

E. Cost Containment means the determination that, on an average aggregate basis, the cost of providing care in the community is less than or the same as the cost of providing care in a hospital or skilled nursing facility.

F. County Department means the Department of Human or Social Services in the county where the resident resides.

G. Department means the Department of Health Care Policy and Financing.

H. Extraordinary Care means an activity that a parent or guardian would not normally provide as part of a normal household routine.

I. Functional Eligibility means that the Client meets the criteria for long-term care services as determined by the Department's prescribed instrument.

J. Institutional Placement means residing in an acute care hospital or nursing facility.

K. Intake/Screening/Referral means the initial contact with individuals by the Case Management Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

L. Performance and Quality Review means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by a Case Management Agency to ensure quality and compliance with all statutory and regulatory requirements.

M. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery and utilization of services.

M. Professional Medical Information Page (PMIP)Client means the medical information form signed by a licensed medical professional used to certify Level of Care.

N. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support planning informs the individual seeking or receiving services of his or her rights and responsibilities.

O. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1

P. Utilization Review Contractor (URC) means the ~~the~~ agency or agencies contracted with the Department to review the CHCBS waiver application for confirmation that functional eligibility and targeting criteria are met.

8.506.4 Benefits

8.506.4.A Home and Community-based Services under the CHCBS waiver shall be provided within Cost Containment, as demonstrated in Section 8.506.12.

8.506.4.B Case Management:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at Section 26-1-114, C.R.S.

2. Case Management Agencies will complete all administrative functions of a Client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

   a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of Client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible. 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.

b. At the time of making the initial face-to-face contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective. 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.

c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

d. Verify that the child meets the eligibility requirements outlined in Client Eligibility, Section 8.506.6.

e. Submit the assessment and documentation ~~of the enrollment application~~ to the URC to ensure the targeting criteria and functional eligibility criteria are met. Minimum documents required:

~~i. Initial Enrollment Form~~

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the approved ~~initial enrollment form~~ certification to the County Department for activation of a Medicaid State Identification Number.

g. Develop the Support Planning document in accordance with Section 8.506.4.B.7.

~~h. Develop a Cost Containment Record in accordance with Section 8.506.12 at the time that the Support Planning is completed.~~

i. Following issuance of a Medicaid ID, submit a Prior Authorization Request in accordance with Section 8.506.10.

4. Continued Stay Review

a. Complete a new Assessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved ~~by the URC~~. 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 documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

b. Submit the assessment and documentation to the URC to ensure the targeting criteria and functional eligibility criteria are met.

c. Review and revise the Support Planning document in accordance with Section 8.506.4.B.7.

~~c. Calculate expected costs to the Medicaid Program, as set forth in Section 8.506.12, for the redetermination period.~~

d. Notify the county technician of the renewed Long-term Care certification.

5. Discharge/Withdrawal

a. At the time that the Client no longer meets all of the eligibility criteria outlined in Section 8.506.6 or chooses to voluntarily withdraw, the case management agency will:

i. Provide the child and their parent/guardian with a notice of action, on the Department designated form, within ten (10) calendar days before the effective date of discharge.

~~ii. Submit a Department designated Discharge form to the URC.~~

iii. Submit PAR termination to the Department's Fiscal Agent.

iv. Notify County Department of termination.

v. Notify agencies providing services to the Client that the child has been discharged from the waiver.

6. Transfers

a. Sending agency responsibilities:

i. Contact the receiving case management agency by telephone and provide notification that:

1) The child is planning to transfer, per the parent(s) or guardian choice.

2) Negotiate an appropriate transfer date.

3) Forward the case file, and other pertinent records and forms, to the receiving case management agency within five (5) working days of the child's transfer.

ii. Using a State designated form, notify the URC of the transfer within thirty (30) calendar days that includes the effective date of transfer, and the receiving case management agency.

iii. If the transfer is inter-county, notify the income maintenance technician to follow inter-county transfer procedures in accordance with the Colorado Department of Human Services, Income Maintenance Staff Manual 9 CCR 2503-5 Section 3.560 Case Transfers.

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, ~~Sectino~~Section 3.560 is available at Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

b. Receiving agency responsibilities

i. Conduct a fact-to-face visit with the child within ten (10) working days of the child's transfer. 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.)., and

ii. Review and revise the Support Planning document ~~and the Prior Approval Cost Containment Record~~ and change or coordinate services and providers as necessary.

7. Support Planning

a. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community-based services. A signature from the parent(s) or guardian is required on this state designated form.

b. Documentation that the Client 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

b. On a monthly basis, evaluate the effectiveness of the Support Planning document by monitoring services provided to the child. This monitoring may include:

i. Conducting child, parent(s) or guardian, and provider interviews.

ii. Reviewing ~~cost~~ utilization data.

iii. Reviewing any written reports received.

8. Performance and Quality Review

a. The Department shall conduct a Performance and Quality Review of the Children's Home and Community-based Services program to ensure that the Case Management Agency is in compliance with all statutory and regulatory requirements.

b. A Case Management Agency found to be out of compliance shall be required to develop a Corrective Action Plan, upon written notification from the Department. A Corrective Action Plan must be submitted to the Department within ten (10) business days of the date of the written request from the Department. A Corrective Action Plan shall include, but not limited to:

i. A detailed description of the actions to be taken to remedy the deficiencies noted on the Performance and Quality Review, including any supporting documentation;

ii. A detailed timeframe for completing the actions to be taken;

iii. The employee(s) responsible for implementing the actions; and

iv. The estimated date of completion.

c. The Case Management Agency shall notify the Department in writing, within three (3) business days if it will not be able to present the Corrective Action Plan by the due date. The Case Management Agency shall explain the reason for the delay and the Department may grant an extension, in writing, of the deadline for the submission of the Corrective Action Plan.

i. Upon receipt of the proposed Corrective Action Plan, the Department will notify the Case Management Agency in writing whether the Corrective Action Plan has been accepted, modified, or rejected.

ii. In the event that the Corrective Action Plan is rejected, the Case Management Agency shall re-write the Corrective Action Plan and resubmit along with the requested documentation to the Department for review within five (5) business days.

iii. The Case Management Agency shall begin implementing the Corrective Action Plan upon acceptance by the Department.

iv. If the Corrective Action Plan is not implemented within the timeframe specified therein, funds may be withheld or suspended.

8.506.4.C In Home Support Services:

1. IHSS for CHCBS Clients shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.

2. Family members of a Client can only be reimbursed for extraordinary care.

8.506.4.D CHCBS Clients are eligible for all other Medicaid state plan benefits.

8.506.5 Non-Benefit

8.506.5.A Tasks defined as Personal Care or Homemaker in Section 8.552 are not benefits of this waiver.

8.506.6 Client Eligibility

8.506.6.A An eligible Client shall meet the following requirements:

1. Targeting Criteria:

a. Not have reached his/her eighteenth (18th) birthday.

b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Functional Eligibility:

a. The URC certifies, through the Case Management Agency completed assessment, that the child meets the Department's established minimum criteria for hospital or skilled nursing facility levels of care.

3. Enrollment of a child is cost effective to the Medicaid Program, as determined by the State as outlined in section 8.506.12.

4. Receive a waiver benefit, as defined in 8.506.2, on a monthly basis.

8.506.6.B Financial Eligibility

1. Parental income and/or resources will result in the child being ineligible for Medicaid benefits.

2. The income and resources of the child do not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance

3. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, Long-Term Care Medical Assistance Eligibility, Consideration of Trusts in Determining Medicaid Eligibility, Section 8.100.7.E.

8.506.6.C Roles of the County Department

1. Processing the Disability Determination Application through the contracted entity determined by the Department.

2. Certify that the child's income and/or resources does not exceed 300% of SSI.

3. Ensure that the parent(s) or guardian is in contact with a case management agency.

4. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility within five (5) workings days of determination.

8.506.7 Waiting List

8.506.7.A The number of Clients who may be served through the CHCBS waiver during a fiscal year shall be limited by the federally approved waiver.

8.506.7.B Individuals who meet eligibility criteria for the CHCBS waiver and cannot be served within the federally approved waiver capacity limits shall be eligible for placement on a waiting list.

8.506.7.C The waiting list shall be maintained by the URC.

8.506.7.D The date that the Case Manager determines a child has met all eligibility requirements as set forth in Sections 8.506.6.A and 8.506.6.B is the date the URC will use for the individual's placement on the waiting list.

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the URC will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the URC that an opening for the CHCBS waiver is available the Case Management Agency shall:

1. Reassess the individual for functional level of care using the Department's prescribed instrument if more than six months has elapsed since the previous assessment.

2. Update the existing functional level of care assessment in the official Client record.

3. Reassess for eligibility criteria as set forth at 8.506.6.

4. Notify the URC of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.8 Provider Eligibility

8.506.8.A Providers shall enter into an agreement with the Department to conform to all federal and state established standards for the specific service they provide under the HCBS-CHCBS waiver.

8.506.8.B Providers must comply with the requirements of Section 8.130.

8.506.8.C Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure statute and regulations.

8.506.8.D IHSS providers shall comply with IHSS Rules in Section 8.552.

8.506.9 Provider Responsibilities

8.506.9.A CHCBS providers shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining, and terminating employees;

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to Section 19-3-307 C.R.S.

8.506.9.B CHCBS Providers shall:

1. Ensure a Client is not discontinued or refused services unless documented reasonable efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure Client records and documentation of services are made available at the request of the case manager, Department, or URC.

3. Ensure that adequate records are maintained.

a. Client records shall contain:

i. Name, address, phone number and other identifying information for the Client and the Client's parent(s) and/or legal guardian(s).

ii. Name, address and phone number of child's Case Manager.

iii. Name, address and phone number of the Client's primary physician.

iv. Special health needs or conditions of the Client.

v. Documentation of the specific services provided, including:

a. Name of individual provider.

b. The location for the delivery of services.

c. Units of service.

d. The date, month and year of services and, if applicable, the beginning and ending time of day.

x. Documentation of any changes in the Client's condition or needs, as well as documentation of action taken as a result of the changes.

xi. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.2.

xii. Documentation of communication with the Client's case manager.

xiii. Documentation of communication/coordination with any additional providers.

b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.506.

v. A copy of the employee's job description.

4. Ensure all care provided is coordinated with any other services the Client is receiving.

8.506.9.C Responsibilities specific to IHSS Provider Agencies

1. Eligible IHSS Agencies will conform to all certification standards set forth at 10 C.C.R 2505-10, Section 8.552.5

2. IHSS Agencies will adhere to all responsibilities outlined at 10 C.C.R. 2505.10, Section 8.552.6

3. Ensure that only Health Maintenance Activities are delivered to CHCBS Clients through the IHSS benefit.

8.506.9.D Responsibilities Specific to Case Management Agencies

1. Case Management Agencies will obtain a specific authorization to provide CHCBS case management benefits to Clients as set forth in Provider Enrollment Section 8.487.

2. Verify that the IHSS care plan developed by IHSS providers is in accordance with both Sections 8.506.4.C and 8.552 of this volume.

3. Case Management Agencies must submit all documentation requested by the Department to complete a Performance and Quality Review within the timeframe specified by the Department.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the Support Planning document.

8.506.10.C The first date for which services can be authorized is the latest date of the following:

1. The financial eligibility start date, as determined by the financial eligibility site.

2. The assigned start date on the certification page of the Assessment.

3. The date, on which the Client's parent(s) and/or legal guardian signs the Support Planning document or Intake form, as prescribed by the Department, agreeing to receive services.8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Assessment.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Support Planning document results in a change in services.

8.506.10.F The revised Support Planning document shall list the service being changed and state the reason for the change. Services on the revised Support Planning document, plus all services on the original document, shall be entered on the revised PAR.

8.506.10.G Revisions to the Support Planning document requested by providers after the end date on a PAR shall be disapproved.

8.506.10.H The Long-Term Care Notice of Action Form (LTC-803) shall be completed in the Information Management System (IMS) (as defined at 8.519.1.Z) 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, or at the time of discontinuation.

8.506.11 Reimbursement

8.506.11.A Providers shall be reimbursed at the lower of:

1. Submitted charges; or

2. A fee schedule as determined by the Department.

8.506.12 Cost Containment

8.506.12.A The Department is responsible for ensuring that, on average, services delivered to the child are within the Department's cost containment requirements for the respective level of institutional care. Cost Containment includes;

1. Waiver benefit services and units, as defined at 8.506.2.

2. State Plan benefit services and units.

8.506.12.B The case manager must ~~identify costs~~ensure cost effectiveness as part of the Support Planning ~~document~~process. ~~This Cost Containment Record shall be on a Department prescribed form and include all estimated:~~

~~1. Waiver benefit services and units, as defined at 8.506.2.~~

~~2. State Plan benefit services and units.~~

8.506.12.C The costs of the benefit services ~~identified in the Cost Containment Record~~ shall be totaled and divided by the number of days remaining before the end of the child's current enrollment period.

8.506.12.D The cost per day for the child shall be compared against the Department designated cost per day of institutional care to determine cost effectiveness.

~~8.506.12.E The Case Manager will revise the child's Cost Containment Record anytime that a significant change in the Support Planning document results in an increase or change in the services to be provided.~~

~~8.506.12.F The Case Manager will submit the Cost Containment Record to the URC for approval at the time of the child's initial enrollment onto the CHCBS waiver, or any time that a revision to the Cost Containment Record increases by a Department prescribed amount.~~

~~8.506.12.G Approval of the Cost Containment Record by the Department only ensures that the cost of the services does not exceed the equivalent cost of the appropriate institutional care.~~

~~8.506.12.H Approval of the Cost Containment Record form does not constitute approval of Medicaid reimbursement for authorized services identified within the record.~~