Title of Rule: Revision to Case Management Redesign (CMRD) Case Management Agency and Waiver rules, Sections 8.400, 8.500 & 8.7000
Rule Number: MSB 24-05-30-A
Division / Contact / Phone: Office of Community Living / Tiffani Domokos / 303-866-5186

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 Office of Community Living is restructuring and revising certain rules to come into alignment with federal requirements for conflict free case management under Colorado's Case Management Redesign. These revised rules are codified at 10 C.C.R. 2505-10, Sections 8.7000-7500. Case Management Redesign (CMRD) refers to several initiatives aimed at simplifying access to long-term services and supports, creating stability for the case management system, increasing and standardizing quality requirements, ensuring accountability, and achieving federal compliance. Updates to rule language are necessary to mirror the policies created for CMRD and to be able to hold agencies accountable to the CMRD requirements outside of contracts. The purpose of these updates is to further update case management and waiver rules and remove references to rules that are now repealed.
2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 CFR § 441.301(c)(1)(vi)

4. State Authority for the Rule:

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

Sections 25.5-1-301-313; 25.5-5-305, 306(1); 25.5-6-401-411, 601-607, 701-706, 901, 13.01-13.04, 1701, et seq.; 27-10.5-101- 103, 401; and 27-10.5-102(11), C.R.S.

Title of Rule: Revision to Case Management Redesign (CMRD) Case Management Agency and Waiver rules, Sections 8.400, 8.500 & 8.7000
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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.

   All members who receive Home and Community Based Services (HCBS) will be affected by these rules, as will all HCBS providers and case management agencies. The Department believes these updates will positively impact all stakeholders by removing outdated, conflicting, or repetitive language and more clearly describing requirements for provider agencies and case management agencies.

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

   Stakeholders should experience a positive qualitative impact from these regulations. With the repeal of outdated conflicting and repetitive language, members, provider agencies and other stakeholders will find it easier to locate pertinent sections of the rules. There are no economic impacts from this rule.

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

   The proposed amendments will not result in any additional costs to the Department or any other agency.

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

   If the Department does not repeal the outdated conflicting and repetitive regulations, we will be unable to finalize the work of Case Management Redesign. The redesign of regulations was needed to mandate case management requirements that are outside the scope of contracts. Additionally, without the revisions to the regulations governing long-term care services, the Department would not meet its goals of simplifying access to long-term services and supports, creating stability for the case management system, increasing and standardizing quality requirements, ensuring accountability, and achieving federal compliance.

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

There are no less costly methods to achieving the purpose of this repeal and rule updates.

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.

   No other methods exist to repeal and update outdated regulations.

8.401 LEVEL OF CARE SCREEN

8.401.21 SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

.211 Specialized Services shall include the following requirements:

A. Community Mental Health Centers and Provider Agencies shall be authorized by the State to provide specialized services to individuals in Medicaid nursing facilities.

B. These services shall be reimbursed by the Medicaid program to the community mental health centers or ~~community centered boards~~Provider Agencies through The Department of Health Care Policy and Financing. The cost of these services shall not be reported on the Nursing Facility cost report.

C. Specialized services may be provided by agencies other than community mental health centers or ~~community centered boards~~Provider Agencies or other designated agencies on a fee for service basis, but the cost of these services shall not be included in the Medicaid cost report or the Medicaid rate paid to the nursing facility.

.212 Specialized Services for Individuals with Mental Illness shall be defined as services, specified by the State, which include:

A. Specified services combined with the services provided by the nursing facility, resulting in a program designed for the specific needs of eligible individuals who require the services.

B. An aggressive, consistent implementation of an individualized plan of care.

.213 Specialized services shall have the following characteristics:

A. The specialized services and treatment plan must be developed and supervised by an interdisciplinary team which includes a physician, a qualified mental health professional and other professionals, as appropriate.

B. Specific therapies, treatments and mental health interventions and activities, health services and other related services shall be prescribed for the treatment of individuals with mental illness who are experiencing an episode of serious mental illness which necessitates supervision by trained mental health personnel.

.214 The intent of these specialized services is to:

A. Reduce the applicant or resident's behavioral symptoms that would otherwise necessitate institutionalization.

B. Improve the individual's level of independent functioning.

C. Achieve a functioning level that permits reduction in the intensity of mental health services to below the level of specialized services at the earliest possible time.

.215 Levels of Mental Health services shall be provided, as defined by the State, including Enhanced and General Mental Health services.

.216 Specialized Services for Individuals with Intellectual or developmental disability shall be defined as a continuous program for each individual which includes the following:

A. An aggressive, consistent implementation of a program of specialized and generic training, specific therapies or treatments, activities, health services and related services, as identified in the plan of care.

B. The individual program plan includes the following:

1. The acquisition of the behaviors necessary for the individual to function with as much self determination and independence as possible; and

2. The prevention or deceleration of regression or loss of current optimal functional status.

8.401.183 Requirements for the PASRR Program

A. The Level of Care determination and the Level I screening reviews shall be required by the Utilization Review Contractor prior to admission to a Medicaid certified nursing facility.

B. The Utilization Review Contractor admission start date (the first date of care covered by Medicaid) shall be assigned after the required Level II PASRR evaluation is completed and the Utilization Review Contractor certifies the client is appropriate for nursing facility care. The admission start date for individuals who do not requiring a Level II evaluation shall be the date that the Initial Screening and Intake Form and Professional Medical Information pages from the ULTC 100.2 are faxed to the ~~Single Entry Point~~Case Management Agency.

C. Individuals other than Medicaid eligible recipients, who require a Level II evaluation, shall have the Level II evaluation prior to admission. The Level II contractor shall perform the evaluation. The Level II contractor can be a qualified mental health professional, a corporation that specializes in mental health, the community mental health center, or the ~~community centered board~~Case Management Agency.

D. The Level II contractor shall conduct a review and determination for individuals or clients found to be mentally ill or ~~retarded~~ developmentally delayed who have had a change in mental health or developmental ~~disabled~~ disability status.

E. PASRR findings, as related to care needs, shall be coordinated with the ~~nursing facility~~ federally prescribed, routine nursing facility Resident Assessments (Minimum Data Set) requirements. These requirements are described at 42 C.F.R. part 483.20 (October 1, 2000 edition), which is hereby incorporated by reference. The incorporation of 42 C.F.R. part 483.20 excludes later amendments to, or editions of, the referenced material. The Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

8.405 ADMISSION PROCEDURES: PROGRAMS FOR THE DEVELOPMENTALLY DISABLED

.10 PREADMISSION REVIEW

For admission to ICF/IID facilities clients must be evaluated by the ~~Community Centered Board (CCB)~~Case Management Agency in the area where the client resides. If services will be provided through an agency ~~CCB~~ in another area, the client shall be evaluated by that area's ~~CCB~~Case Management Agency.

The client shall be referred by the ~~CCB~~ Case Management Agency to the URC for admission review and to the appropriate County Department of Social/Human Services for determination of Medicaid eligibility. The URC shall not determine admission certification under Medicaid for any intellectually or developmentally disabled client in the absence of a referral from the ~~CCB~~ Case Management Agency except for emergency admissions to the Class I facilities.

.11 The ~~CCB~~ Case Management Agency evaluation must contain background information as well as currently valid assessments of functional, developmental, behavioral, social, health, and nutritional status to determine if the facility can provide for the client's needs and if the client is likely to benefit from placement in the facility.

.12 ~~CCB~~ Case Management Agency ~~ADVERSE RECOMMENDATION~~Adverse Recommendation

In cases where the ~~CCB~~ Case Management Agency declines to recommend placement of a client into an ICF/IID facility, the ~~CCB~~ Case Management Agency shall inform the client of the recommendation using the HCBS-DD-21 form. The ~~CCB~~ Case Management Agency shall also notify the client or the client's designated representative of the client's right to request a formal URC level of care review.

The client shall have thirty (30) days from the postmark date of the notice to request a formal URC review. If the client requests a formal URC level of care review, the ~~CCB~~ Case Management Agency shall submit the required documentation plus any new documentation submitted by the client to the URC. The URC shall review and make a level of care determination in accordance with the admission procedures below.

8.405.2 ADMISSION PROCEDURES FOR ICF/IID FACILITIES

.21 When ~~the client~~, based on ~~CCB~~ Case Management Agency review, the Member cannot reasonably be expected to make use of ICF/IID or HCBS-DD, the Case Management Agency~~CCB~~ shall notify the physician and the URC. The physician and the URC/ Case Management Agency~~Community Center Board (URC/CCB)~~ ~~agency~~ shall then proceed with the SNF or ICF placement under the provisions set forth at ~~10 CCR 2505-10~~ Section 8.402.10.

22 When the Case Management Agency~~CCB~~ determines that a client is not appropriately served through HCBS-DD services or, in accordance with provisions permitting the client or the client's designated representative to choose institutional services as an alternative to HCBS-DD services, the Case Management Agency~~CCB~~ shall recommend placement to an ICF/IID facility. The Case Management Agency~~CCB~~ shall seek the approval of the client's physician. The physician shall notify the URC/ Case Management Agency~~CCB~~ agency of the proposed placement. Based on information provided by the Case Management Agency~~CCB~~ and the client's physician, the URC~~/SEP agency~~ Case Management Agency may certify the client for long-term care prior to ICF/IID admission.

.23 The URC/ Case Management Agency~~CCB agency~~ shall advise the County Department of Social/Human Services of the certification to enable the County Department staff to assist with the placement arrangements.

24. The LOC Screen and other transfer documents concerning medical information as applicable must accompany the client to the facility.

.25 Following receipt of the fully completed LOC Screen, the URC/ Case Management Agency~~CCB~~ shall review the information and make a final certification decision. If certification is approved, the URC/ Case Management Agency~~CCB~~ shall assign an initial length of stay according to ~~10 CCR~~

~~2505-10~~ Section 8.404.1. If certification is denied, the decision of the URC/CCB may be appealed in accordance with the appeals process at ~~10 CCR 2505-10~~ Section 8.057.

8.405.30 ADMISSION PROCEDURES FOR HCBS-DD

.31 Case Management Agencies shall use evaluation and admission criteria at Sections 8.7100-8.7200 et seq.for HCBS-DD admissions ~~CCBs~~ Case Management Agencies may evaluate clients for HCBS-DD services if~~, in the judgment of the CCB,~~ such services represent a viable alternative to SNF, ICF, or ICF/IID services. The evaluation shall be carried out in accordance with the procedures set forth in 2 ~~CCR~~ C.C.R. Section 503-1.

.32 If the ~~CCB~~ Case Management Agency recommends HCBS-DD placement, then the URC~~/CCB will~~ shall approve certification for services for the developmentally disabled at the level of care recommended by the ~~CCB~~Case Management Agency. The ~~client~~ Member~~will~~shall be placed in alternative service.

Following receipt of the completed LOC Screen and any other supporting information, the URC~~/CCB will~~ Case Management Agency shall review the information and make a final certification determination.

If certification is approved, the URC~~/CCB~~ Case Management Agency shall assign an initial length of stay for HCBS-DD services.

If certification is denied, the decision of the URC/Case Management Agency ~~/CCB~~ may be appealed in accordance with Section 8.057.

8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

~~8.486.60 POST-ELIGIBILITY TREATMENT OF INCOME (PETI)~~

~~A. Definition~~

~~1. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the member's obligation (payment) for the payment of residential services.~~

~~B. Post Eligibility Treatment of Income Application~~

~~2. When a member has been determined eligible for Home and Community Based Services (HCBS) under the 300% income standard, according to Section 8.100, the Departmeyont may reduce the Medicaid payment for Alternative Care Facility services according to the procedures set forth in this section.~~

~~3.PETI is required for Medicaid members residing in Alternative Care Facilities under the Home and Community Based Services (HCBS) Elderly, Blind, and Disabled (EBD) waiver.~~

~~C. Case Management Responsibilities~~

~~1. For 300% eligible members who reside in an Alternative Care Facility (ACF) , the case manager shall complete a State-prescribed form, which calculates the member payment according to the following procedures:~~

~~a. The member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long-Term Care (LTC) Insurance amount.~~

~~b. The member's Room and Board amount shall be deducted from the gross income and paid to the provider.~~

~~c. The member's Personal Needs Allowance (PNA) amount is based upon a member's gross income, up to the maximum amount set by the Department.~~

~~d. For an individual with financial responsibility for only a spouse, the amount protected under Spousal Protection as defined in Section 8.100.7 K shall be deducted from the member's gross income.~~

~~e. If the member is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level less any income of the spouse and/or dependents (excluding pan-time employment earnings of dependent children as defined at Section 8.100.1) shall be deducted from the members gross income.~~

~~f. Amounts for incurred expenses for medical or remedial care for the member that are not covered by Medicare, Medicaid, or other third party, shall be deducted from the member's gross income as follows:~~

~~i. Health insurance premiums, deductibles or co-insurance charges if health insurance coverage is documented; and~~

~~ii. Necessary dental care not to exceed amounts equal to actual expenses incurred; and~~

~~iii. Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred; and~~

~~iv. Medications, with the following limitations:~~

~~1) The member has a prescription for the medication.~~

~~2)~~

~~3) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be allowed.~~

~~4) The full cost of brand-name medications shall not be allowed if a generic form is available at a lower price, unless the prescriber has specifically prescribed a name brand medication over the generic formula.~~

~~5)~~

~~g. Other necessary medical or remedial care or items shall be deducted from the member's gross income, with the following limitations:~~

~~i. The need for such care must be documented in writing by the attending physician. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and shall be renewed at least annually or whenever there is a change.~~

ii. Any service, supply or equipment that is available under the Medicaid State Plan, with or without prior authorization, shall not be allowed as a deduction.

h. Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

i. If the case manager cannot immediately determine whether a particular medical or remedial service, supply, equipment or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the case manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment or medication is a benefit of Medicaid, the deduction shall be discontinued.

j. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the member's gross income.

k. Any remaining income shall be applied to the cost of the Alternative Care Facility services, as defined at Section 8.495, and shall be paid by the member directly to the provider.

l. If there is still income remaining after the entire cost of Alternative Care Facility services is paid from the member's income, the remaining income shall be kept by the member and may be used at the member's discretion.

2. At the beginning of each support plan year and whenever there is a significant change to a member's payment obligation, the case managers shall inform the HCBS Alternative Care Facility member of their payment obligations in a manner prescribed by the Department.

a. Significant change is defined as fifty dollars ($50) or more.

3. Copies of member payment forms shall be kept in the member files at the case management agency. A copy of the form may be requested by the Department for monitoring purposes.

8.500 HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES(HCBS-DD) WAIVER

TH INTELLECTUAL OR DEVELOPMENTAL DISABILITIES(HCBS-DD) WAIVER

8.500.7 WAITING LIST PROTOCOL

8.500.7.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 The name of a person eligible for the HCBS-DD waiver program shall be placed on the waiting list by the community centered board making the eligibility determination.~~

~~8.500.7.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 The placement date used to establish a person's order on a waiting list shall be:~~

~~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 As openings become available in the HCBS-DD Waiver program in a designated service area, that community centered board shall report that opening to the Operating Agency.~~

~~8.500.7.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. 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.~~

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

~~t in 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.~~

~~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.~~

~~n the recommendation of a professional, the primary caregiver cannot provide sufficient supervision to ensure the person's health and welfare.~~

~~8.500.7.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 a requested to be placed in a community setting, and~~

~~3. Persons who are in an emergency situation.~~

~~8.500.7.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. 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.~~

~~1. 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.~~

~~2. 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.~~

~~8.500.102 SERVICE PLAN AUTHORIZATION LIMITS (SPAL)~~

~~8.500.102.A The service plan authorization limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a Client's ongoing service needs within one (1) service plan year.~~

~~8.500.102.B The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations, vehicle modifications, health maintenance activities available under the Consumer Directed Attendant Support Services (CDASS), home delivered meals, life skills training, peer mentorship, transition setup, individual job coaching, individual job development, job placement, workplace assistance, and benefits planning.~~

t Support Services (CDASS), home delivered meals, life skills training, peer mentorship, transition setup, individual job coaching, individual job development, job placement, workplace assistance, and benefits planning.

fits planning.

8.500.102.C The total of all HCBS-SLS services in one service plan shall not exceed the overall authorization limitation as set forth in the federally approved HCBS-SLS waiver.

8.500.102.D Each SPAL is assigned a specific dollar amount determined through an analysis of historical utilization of authorized waiver services, total reimbursement for services, and the spending authority for the HCBS-SLS waiver. Adjustments to the SPAL amount may be determined by the Department and Operating Agency as necessary to manage waiver costs.

o manage waiver costs.

8.500.102.E Each SPAL is associated with one of the six support levels determined by an algorithm which analyzes the level of support needed by a Client as determined by the SIS assessment, and additional factors, including whether a Client meets the definition of Public Safety Risk-Convicted, Public Safety Risk-Non Convicted, and Extreme Safety Risk to Self..

8.500.102.F The SPAL determination shall be implemented in a uniform manner statewide and the SPAL amount is not subject to appeal.

1. If a Client's HCBS waiver eligibility and/or services are adversely affected at any time, the Client will be sent their appeal rights as required at 8.612.4.E. and 8.057.2.A (10 C.C.R. 2505-10).

8.500.102.G The Department and/or Utilization Review Contractor (URC) shall implement an Exception Review to allow a Member's SPAL and/ or HCBS unit limitations to be exceeded in certain situations.

1. To be eligible for the Exception Review Process, the following shall be demonstrated:

a. The Client must be at risk for seeking an emergency Developmental Disability (DD) waiver enrollment because one or more of the following criteria such as listed below are not currently being met through other Long-Term Services and Supports (LTSS) and or State Plan services:

i. Medically fragile with skilled care needs;

ii. Behavioral and/or Mental Health needs;

iii. Criminal convictions and/or law enforcement involvement;

iv. Homelessness;

v. Mistreatment, Abuse, Neglect, Exploitation (MANE) reports with potential need to remove from home;

vi. Extreme danger to self/others;

vii. Caregiver capacity or;

viii. 1:1 supervision needed.

b. The Client must demonstrate that less than 10% of current SPAL remains; or

c. The Client must demonstrate that the current rate of utilization of Home and Community-Based Services (HCBS) will exhaust the number of approved units prior to the Client's regularly scheduled monitoring.

2. When a client is eligible for the Exception Review Process, the Case Manager (CM) shall send the following documentation to the URC for review:

a. "Request for Exception Review Process" form;

b. Service Plan;

c. PAR; and,

d. Any documentation from current providers that demonstrate need to exceed service limitation caps for additional planned services.

3. The URC shall review and approve or deny the Exception Review Process requests made.

a. Upon completion of the review, the URC shall notify the CM of the outcome.

i. The outcome letter shall include the reason for approval or denial, and/or any information on partial approvals or negotiated outcomes.

b. The URC shall compete the review in accordance with the timelines as identified in their contract.

4. The Exception Review Process shall not be used in place of a Support Level Review or request for a Support Intensity Scale (SIS) reassessment. Provider rates shall not be changed based on the outcome of the Exception Review Process.

5. The Exception Review Process shall be implemented in a uniform manner applied to Members statewide, but outcomes shall be based on individual needs and circumstances. The Exception Review Process outcome is not an adverse action subject to appeal.

a. If a Client's HCBS waiver eligibility and/or services are adversely affected at any time, the Client will be sent their appeal rights as required at 8.612.4.E. and 8.057.2.A (10 C.C.R. 2505-10).

8.500.103 RETROSPECTIVE REVIEW PROCESS

8.500.103.A Services provided to a Client are subject to a retrospective review by the Department and the Operating Agency. This retrospective review shall ensure that services:

1. Identified in the PCSP are based on the Client's identified needs as stated in the LOC Screen.

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

3. Provided to a Client are in accordance with the PCSP and

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

8.500.103.B When the retrospective review identifies areas of non compliance, the case management agency or provider shall be required to submit a plan of correction that is monitored for completion by the Department and the Operating Agency.

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

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

ension of payments, or termination of provider status

8.504 HOME AND COMMUNITY BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESS WAIVER

8.504.8 PRIOR AUTHORIZATION REQUESTS

8.504.8.A. The SEP case manager shall complete and submit a PAR form within one calendar month of determination of eligibility for the HCBS-CLLI waiver.

8.504.8.B. All units of service requested shall be listed on the Support Planning form.

8.504.8.C. The first date for which services may 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 Department approved assessment tool.

3. The date, on which the Client's parent(s) and/or legal guardian signs the Support Planning form or Intake form, as prescribed by the Department, agreeing to receive services.

8.504.8.D. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Department approved assessment tool.

8.504.8.E. The SEP case manager shall submit a revised PAR if a change in the Support Planning results in a change in services.

8.504.8.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.

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

~~8.504.8.H. If services are decreased without the Client's parent(s) and/or legal guardian agreement, the SEP case manager shall notify the Client's parent(s) and/or legal guardian of the adverse action and appeal rights using the LTC 803 form in accordance with the 10 day advance notice period.~~

~~8.504.9 REIMBURSEMENT~~

~~8.504.9.A. Providers shall be reimbursed at the lower of:~~

~~1. Submitted charges; or~~

~~2. A fee schedule as determined by the Department.~~

~~8.517 HOME AND COMMUNITY-BASED SERVICES FOR THE COMPLEMENTARY AND INTEGRATIVE HEALTH WAIVER~~

~~8.517.9 PRIOR AUTHORIZATION OF SERVICES~~

~~8.517.9.A. All Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH) waiver services must be prior authorized by the Department or its agent.~~

~~8.517.9.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by case managers in compliance with all applicable regulations.~~

~~8.517.9.C. Claims for services are not reimbursable if:~~

~~1. Services are not consistent with the Client's documented medical condition and functional capacity;~~

~~2. Services are not medically necessary or are not reasonable in amount, scope, frequency, and duration;~~

~~3. Services are duplicative of other services included in the Client's Support Plan;~~

~~4. The Client is receiving funds to purchase services; or~~

~~5. Services total more than 24 hours per day of care.~~

~~8.517.9.D. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.~~

~~8.517.9.E. Payment for HCBS-CIH waiver services is also conditional upon:~~

~~a. The Client's eligibility for HCBS-CIH waiver services;~~

~~b. The provider's certification status; and~~

~~c. The submission of claims in accordance with proper billing procedures.~~

~~8.517.9.F. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulation and necessary to meet the Client's needs.~~

~~8.517.9.G. Services requested on the PAR shall be supported by information on the Long-term Care Support Plan and written documentation from the income maintenance technician of the Client's current monthly income.~~

~~8.517.9.H. The PAR start date shall not precede the start date of HCBS-CIH eligibility in accordance with Section 8.517.7.~~

~~8.517.9.I. The PAR end date shall not exceed the end date of the HCBS-CIH eligibility certification period.~~

~~8.519 Case Management~~

~~8.519.1 Definitions~~

~~A. Adverse Action means a denial, reduction, termination, or suspension from a long-term service and support program or service.~~

~~B. Algorithm means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Clients into one of six support levels in the Home and Community-based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services- Supported Living Services (HCBS-SLS) waivers.~~

~~C. Assessment means as defined in Section 8.390.1 DEFINITIONS.~~

~~D. Authorized Representative means an individual designated by a Client or by the parent or guardian of the Client, if appropriate, to assist the Client in acquiring or utilizing services and supports, this does not include the duties associated with an Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as defined in Section 8.510.1.~~

~~E. Business Day means any day in which the state is open and conducting business, but shall not include Saturday, Sunday, or any day in which the state observes on of the holidays listed in Section 24-11-101(1), C.R.S.~~

~~he state observes on of the holidays listed in Section 24-11-101(1), C.R.S.~~

~~F. Case Manager means a person who provides case management services and meets all regulatory requirements for Case Managers.~~

~~G. Case Management means as defined in Section 8.390.1 DEFINITIONS.~~

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

I. Certification means the process by which an agency is approved by the Department to provide case management which includes the submission and approval of a Medicaid Provider Agreement along with submission of verification that the agency meets the qualifications as set forth in Section 8.519.

h includes the submission and approval of a Medicaid Provider Agreement along with submission of verification that the agency meets the qualifications as set forth in Section 8.519.

J. Client means an individual who meets long-term services and supports eligibility requirements and has been approved for and agreed to receive Home and Community-Based Services (HCBS).

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

ent to speak for or act on the Client's behalf.

L. Community Centered Board means a private corporation, for-profit or not-for-profit that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

.R.S., responsible for, but not limited to conducting Developmental Disability determinations, waiting list management Level of Care Evaluations for Home and Community-Based Service waivers specific to individuals with intellectual and developmental disabilities, and management of State Funded programs for individuals with intellectual and developmental disabilities.

M. Conflict-Free Case Management means, pursuant to 42 CFR § 441.301(c)(1)(vi), case management services provided to a Client enrolled in a Home and Community-Based Services waiver that are provided by a Case Management Agency that is not the same agency that provides services and supports to that person.

me and Community-Based Services waiver that are provided by a Case Management Agency that is not the same agency that provides services and supports to that person.

N. Corrective Action Plan shall be as defined at Section 8.390.1.DEFINITIONS.

O. Critical Incident means incidents or allegations involving Clients receiving services to include mistreatment, abuse, neglect, exploitation, illness/injury, death, damage to consumer's property/theft, medication management issues, criminal activity, unsafe housing/displacement, and missing persons.

P. Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.

Q. Developmental Delay means as defined in Section 8.600.4.

R. Developmental Disability means as defined in Section 8.600.4.

S. Executive Director means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

T. Financial Eligibility means the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources, if applicable.

U. Guardian means an individual at least twenty-one years of age, resident or non-resident, who has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or by the court. The term includes a limited, emergency, and temporary substitute guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.

-102 (4), C.R.S.

V. Guardian ad litem or GAL means a person appointed by a court to act in the best interests of a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set forth in article 33 of title 22, C.R.S.

W. Home and Community-based Services (HCBS) waivers means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a Level of Care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

X. Incident means an injury to a person receiving services; lost or missing persons receiving services; medical emergencies involving persons receiving services; hospitalizations of persons receiving services; death of persons receiving services; errors in medication administration; incidents or reports of actions by persons receiving services that are unusual and require review; allegations of abuse, mistreatment, neglect, or exploitation; use of safety control procedures; use of emergency control procedures; and stolen personal property belonging to a person receiving services.

ent, neglect, or exploitation; use of safety control procedures; use of emergency control procedures; and stolen personal property belonging to a person receiving services.

es; and stolen personal property belonging to a person receiving services.

Y. Information Management System (IMS) means as defined in Section 8.390.1 DEFINITIONS.

Z. Interdisciplinary Team (IDT) means a group of people convened by a certified Case Management Agency that includes the person receiving services, the parent or guardian of a minor, guardian or an authorized representative, as appropriate, the person who coordinates the provision of services and supports, and others as chosen by the person receiving services, who are assembled to work in a cooperative manner to develop or review the PCSP.

or review the PCSP.

AA. Legally Responsible Persons means the parent of a minor child, or the Client's spouse,

BB. Level of Care Eligibility Determination means as defined in Section 8.390.1 DEFINITIONS.

CC. Level of Care Eligibility Determination Screen means as defined in Section 8.390.1 DEFINITIONS.

~~DD. Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.~~

~~EE. Medicaid Eligible means an Applicant or Client meets the criteria for Medicaid benefits based on the Applicant's financial determination and disability determination when applicable.~~

~~FF. Organized Health Care Delivery System (OHCDS) means a public or privately managed service organization that is designated as a Community Centered Board and contracts with other qualified providers to furnish services authorized in the Home and Community-based Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.~~

~~), HCBS-Supported Living Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.~~

~~GG. Parent means the biological or adoptive parent.~~

~~HH. Performance and Quality Review means a review conducted by the Department or its contractor at any time but no less than the frequency as specified in the approved waiver application. To include a review of required case management services performed by the agency to ensure quality and compliance with all requirements. The agency shall provide all requested information and documents as requested by the Department or by its contractor.~~

~~II.. Person-Centered Support Plan (PCSP) means as defined in Section 8.390.1 DEFINITIONS.~~

~~8.390.1 DEFINITIONS.~~

~~JJ. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.~~

~~KK. Prior Authorization Requests (PAR) means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.~~

~~LL. Professional Medical Information Page (PMIP) means as defined in Section 8.390.1 DEFINITIONS.~~

~~MM Provider for the purpose of this section means any person, group or entity approved to render services or provide items to a Client enrolled in an HCBS waiver program.~~

~~NN. Regional Center means a facility or program operated directly by the Department of Human Services which provides services and supports to Clients with intellectual and developmental disabilities.~~

~~OO. Retrospective Review means the Department or the Department's contractor's review after services and supports are provided to ensure the Client received services according to the PCSP and that the Case Management Agency complied with the requirements set forth in statute, waiver, and regulations.~~

~~PP. Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Client's ongoing needs. Purchase of services not~~

subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level, and projected utilization.

QQ. Supports Intensity Scale (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with intellectual and developmental disabilities.

ensity Scale (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with intellectual and developmental disabilities.

RR. Support Level means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.

SS. Targeted Case Management (TCM) means case management services provided to Clients enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities Assessment and periodic Reassessment, development and periodic revision of a PCSP, referral and related activities, and monitoring.

ver services and coordinating with other non-waiver resources, including, but not limited to medical, social, educational and other resources to ensure non-duplication of waiver services and the monitoring of effective and efficient provision of waiver services across multiple funding sources. Targeted case management includes the following activities Assessment and periodic Reassessment, development and periodic revision of a PCSP, referral and related activities, and monitoring.

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TT. Waiver Services means those optional Medicaid services defined in the current federally approved HCBS waiver document and do not include Medicaid state plan services.

8.519.2 Case Management Agency Qualifications

8.519.2.A. A CMA must meet the following qualifications:

1. Have a physical location in Colorado and provide all required case management activities for the counties in which the agency elects to serve.

2. Be a public or private not for profit or for profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services pursuant to Section 25.5-10-209.5, C.R.S. Case management agencies that are

~~private not for profit must have certification from the state of Colorado or a letter from the Department of the Treasury, internal revenue service classifying the agency as a private not for profit agency.~~

~~rtment of the Treasury, internal revenue service classifying the agency as a private not for profit agency.~~

~~3. Provide proof that the agency staff meets all Case Manager qualifications.~~

~~4. As an agency, have a minimum of two years of agency experience in assisting high-risk, low income individuals, to obtain medical, social, educational and/or other services. Case Management Agencies who were previously affiliated with an agency providing HCBS case management prior to August 30, 2019 are exempt from this requirement.~~

~~5.. Demonstrate the agency does not have any fiduciary relationship with an agency who provides HCBS waiver services. Agencies providing HCBS case management prior to August 30, 2019 are exempt from this requirement.~~

~~0, 2019 are exempt from this requirement.~~

~~6.. Provide case management to Clients who select the agency as long as the Client reside in the county for which the agency has elected to provide case management services~~

~~7. Possess the administrative capacity to deliver case management services in accordance with state and federal requirements.~~

~~8. Have established community referral systems and demonstrate linkages and the ability to make community referrals for services with other agencies.~~

~~9. Demonstrate ability to meet all state and federal requirements governing the participation of case management agencies in the state Medicaid program, including but not limited to the ability to meet state and federal requirements for documentation, billing and auditing.~~

~~10. Have one-month reserve financial capacity to maintain operations. HCBS case management agencies providing case management services in Colorado prior to August 30,2019 are exempt from this requirement.~~

~~11. Demonstrate that the agency has financial reserves for one month of expenditures to cover costs associated with the number of Clients expected through their catchment area, including reserves to cover salaries and costs for Case Managers, and Clients. All agencies are required to submit an audited financial statement to the Department for review annually. Agencies providing HCBS case management services in Colorado prior to August 30, 2019 are exempt from this one-month financial requirement.~~

~~ncial statement to the Department for review annually. Agencies providing HCBS case management services in Colorado prior to August 30, 2019 are exempt from this one-month financial requirement.~~

~~12. Possess and maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements.~~

13. Shall not be an approved provider agency providing direct services to individuals who are enrolled in HCBS waivers. Agencies providing HCBS case management prior to August 30, 2019 are exempt from this requirement

8.519.3 Functions of all Case Management Agencies

8.519.3.A Case Management Agencies must:

1. Maintain sufficient documentation of case management activities performed and to support claims.

2. Not provide guardianship services for any Client enrolled in an HCBS waiver.

3. 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 Client and/or persons inquiring upon their behalf.

4. Be separate from the delivery of services and supports for the same individual, unless otherwise approved as an exception by the Centers for Medicare and Medicaid services (CMS) in the approved waiver application. Agencies providing HCBS case management services prior to August 30, 2019 shall comply with the timelines set forth at Sections 25.5-10-211.5(3)(f)-(g), C.R.S.

ll comply with the timelines set forth at Sections 25.5-10-211.5(3)(f)-(g), C.R.S.

5. Assign one (1) primary person who ensures case management services are provided on behalf of the Client across all programs, professionals within the agency. Reasonable efforts shall be made to include the Client's preference in this assignment.

6. Ensure that services are available on Business Days.

7. Maintain records for seven (7) years after the date a Client discharges from a waiver program, including all documents, records, communications, notes and other materials related to services provided and work performed.

8. Possess appropriate financial management capacity and systems to document and track services and costs in accordance with state and federal requirements.

9. Maintain and update records of persons determined to be eligible for services and supports and who are receiving case management services in accordance with the Departments requirements.

10. Establish and maintain working relationships with community-based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the Clients' needs.

11. Have a system for recruiting, hiring, evaluating, and terminating employees, and maintain employment policies and practices that comply with federal and state laws.

12. Maintain current written job descriptions for all positions.

13. Maintain a website that at a minimum contains contact information for the agency, the ability for electronic communication, hours of operation, available resources, program options, and services provided.

14. Ensure staff have access to statutes and regulations relevant to the provision of authorized services.

15. Provide case management services for Clients without discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression or disability.

16. Provide information and reports as required by the Department including, but not limited to, data and records necessary for the Department to conduct operations.

17. 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.

18. If the Case Management Agency is unable to continue providing case management services, the agency must submit a written notice to the Department at least 90 days prior to terminating services. The written notice shall include the effective date of termination.

e written notice shall include the effective date of termination.

19. As part of the application process to be an approved Case Management Agency, the agency shall submit a Closeout Plan that describes all requirements, steps, timelines, and milestones necessary to fully transition the services provided by the agency to another Case Management Agency. The Closeout Plan shall designate an individual to act as a closeout coordinator who will ensure that all requirements, steps, timelines, and milestones contained in the Closeout Plan are completed and work with the Department and any other agency to minimize the impact of the transition on Clients and the Department. The Closeout Plan shall include, but is not limited to, all of the following:

ined in the Closeout Plan are completed and work with the Department and any other agency to minimize the impact of the transition on Clients and the Department. The Closeout Plan shall include, but is not limited to, all of the following:

nt and any other agency to minimize the impact of the transition on Clients and the Department. The Closeout Plan shall include, but is not limited to, all of the following:

a. Notification and communication of agency closure to the Department, Clients and providers;

b. Transfer of Clients;

c. Transfer of documentation to include all electronic and physical documentation;

d Transfer of all Client records through the Department Case Management System; and

e. Transfer of Case Management Services.

20. Case Management Agencies are responsible for ensuring persons who are employed by the agency meet the requirement of these regulations

21. Maintain verification of Case Managers who are employed meet minimum requirements and qualifications

8.519.4 Staffing

8.519.4.A. The case management agency shall provide staff for the following functions: receptionist/clerical, administrative/supervisory, and case management.

1. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, and assisting case management agency staff with clerical duties.

2. The administrative/supervisory function shall include, but not be limited to, supervision of staff, training and development of agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, resource development, marketing liaison with the Department, and, as needed, providing case management services in lieu of the case manager.

the Department, and, as needed, providing case management services in lieu of the case manager.

8.519.5. Qualifications of Case Managers

8.519.5.A. All Home and Community-Based (HCBS) case managers must be employed by a certified Case Management Agency.

1. CMAs must maintain verification that employed case managers meet the qualifications set forth in these regulations.

8.519.5.B. minimum qualifications for HCBS Case Managers hired on or after October 8th, 2021 are:

1. A bachelor's degree; or

2. Five (5) years of relevant experience in the field of LTSS, which includes Developmental Disabilities; or

3. Some combination of education and relevant experience appropriate to the requirements of the position.

4. Relevant experience is defined as:

a. 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 non-profit 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,

ing filled; and,

b. 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.

rk 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.C. Case Managers may not:

1. Be related by blood or marriage to the Client.

2. Be related by blood or marriage to any paid caregiver of the Client.

3. Be financially responsible for the Client.

4. Be the Client's legal guardian, authorized representative, or be empowered to make decisions on the Client's behalf through a power of attorney.

5. 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.

8.519.5.D. Case Managers must complete the Department prescribed attestation form.

8.519.5.E. Case Managers must complete and document the following trainings within 120 days from the date of hire and prior to providing case management services independently:

1. Department prescribed assessment tool;

2. Service plan development and revision;

3. Referral for services, to include Medicaid and non-Medicaid;

4. Monitoring;

5. Case documentation;

6. Level of Care determination process;

7. Notices and appeals;

8. Incident and critical incident reporting;

9. Waiver requirements and services;

10. Person-centered approaches to planning and practice;

11. Interviewing and assessment skills; and

12. Regulations and state statutes for the LTSS program.

13. Department IMS Documentation

14. Mandatory Reporting

15. Participant Directed Training

16. Disability and Cultural Competency

17. Any Case Management training required by contract

8.519.5.F. Case Managers must demonstrate and document competency in the following areas:

1. Knowledge and experience working with populations served by the Case Management Agency;

2. Knowledge of the statutes, regulations, policies and procedures regarding public assistance programs and the American with Disabilities Act;

3. Knowledge of LTSS and other community resources;

4. Negotiation, conflict resolution, intervention, cultural and linguistic training, disability cultural competency, and interpersonal communication skills; and

5. Knowledge of consumer direction philosophy and programs.

8.519.5.G. Case Managers shall attend any mandatory training required by the Department.

8.519.5.H. Case Manager supervisors shall meet the minimum requirements for education and/or experience for Case Managers and shall have one year of competency in pertinent case management knowledge and skills.

8.519.5.I. Background checks.

1. Prior to employment, all case management staff must have the following minimal background checks and screenings:

a. Criminal;

b. Medicaid or other federal health programs exclusion list;

c. Sex offender registry; and

d. Adult protective services data system.

2. Background checks must be repeated at minimum every five (5) years with the exception of the adult protective services data system.

3. Proof of checks and screenings must be maintained and made available.

8.519.7 Functions of Case Management Agencies for HCBS-CES, HCBS-CHRP, HCBS-DD, and HCBS-SLS

~~8.519.7.A. Case Management Agencies shall comply with the regulations at Sections 8.500 et seq., 8.503 et seq., 8.600 et seq. and 8.760 et seq.~~

~~8.519.7.B. The Case Management Agency chosen by the Client is responsible for providing case management services.~~

~~8.519.7.C. Case Management Agencies shall establish agency written procedures sufficient to execute case management services according to the provisions of these regulations. Such procedures shall include, but are not limited to:~~

~~1. Comprehensive assessment and periodic reassessment of a Client's needs;~~

~~2. Development and periodic revision of Client Service Plans;~~

~~3. Referral and related activities;~~

~~4. Monitoring;~~

~~5, The authorization and purchase of services and supports;~~

~~6. Services and support coordination;~~

~~7. Any safeguards necessary to prevent conflict of interest between case management and direct services provision; and~~

~~8. Denial and discontinuation of services.~~

~~8.519.7.D. Case Management Agencies shall have written procedures concerning the exercise and protection of Client rights pursuant to Sections 25.5-10-218 through 231, C.R.S.~~

~~8.519.7.E. Case Management Agencies shall have written procedures for Clients to dispute agency decisions, adverse actions, or actions of the agency's employees or contractors. Disputes may be filed by the Client, or parent of a minor Client, the Client's guardian, advocate, or the Client's authorized representative if within the scope of his/her duties. Agency procedures shall meet the requirements of Section 8.605.5. The agency shall offer and provide interpretation or translation services in languages other than English, and through such other modes of communication as may be necessary.~~

~~of his/her duties. Agency procedures shall meet the requirements of Section 8.605.5. The agency shall offer and provide interpretation or translation services in languages other than English, and through such other modes of communication as may be necessary.~~

~~her than English, and through such other modes of communication as may be necessary.~~

~~8.519.8 Compliance~~

~~8.519.8.A. Pursuant to Section 25.5-10-208 (4), C.R.S., upon a determination by the executive director or designee that services and supports have not been provided in accordance with the program or financial administration standards contained in these rules, the executive director or designee may reduce, suspend, or withhold payment to a Case Management Agency from which the Department purchases services or supports directly.~~

~~8.519.8.B. Prior to initiating action to reduce, suspend, or withhold payment to a Case Management Agency for failure to comply with Department regulations, the executive director or designee shall~~

provide written notice which must specify the reasons for the action and the actions necessary to achieve compliance.

a Case Management Agency for failure to comply with Department regulations, the executive director or designee shall provide written notice which must specify the reasons for the action and the actions necessary to achieve compliance.

8.519.8.C. The executive director or designees may revoke the Case Management Agency's certification upon a finding that the agency is in violation of provisions of Section 25.5-10-209.5, C.R.S, other state or federal laws, or these rules.

8.519.9 Payment for Case Management Services

8.519.9.A. Targeted case management services are only reimbursed for Clients enrolled in the HCBS-CES, HCBS-CHRP, HCBS-DD, HCBS-SLS waivers, and only if the services are in compliance with the requirements set forth at Section 8.760 et seq.

8.519.10 Case Management Payment Liability

8.519.10.A. 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 denial of reimbursement for services authorized retroactive to first date of service. The Case Management Agency and/or providers may not seek reimbursement for these services from the Client receiving services.

B. 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.

uthorization, 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.

8.519.11 Case Management Services

8.519.11.A. Clients must be determined eligible for an HCBS waiver specific for individuals with Intellectual or Developmental Disabilities by a Community Centered Board prior to receiving case management services.

8.519.11.B. Case management services include the following:

1. Assessment: comprehensive assessment and periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support. Assessment activities include:

   a. Obtaining Client history;

   b. Identifying the Client's needs, completing related documentation, and gathering information from other sources such as family members, medical providers, social workers and educators, as necessary to form a complete assessment of the Client.

2. Service plan development and revision occurs no less than annually or as a warranted by the Client's needs or change in condition, at a time and location convenient for the Client with the Client and others chosen by the Client. The Case Manager shall complete and review a service plan for each Client enrolled in the HCBS-CES, HCBS-DD, and HCBS-SLS waivers.

a. The service plan at minimum shall:

i. Identify needs, personal goals, preferences, unique strengths, abilities, desires, health and safety, and risk factors;

ii. Be in accordance with the Department's regulations, policies and procedures;

iii. Identify the specific services and supports appropriate to meet the needs of the eligible Client, and family, as applicable;

iv. Document decisions made through the service planning process including, but not limited to, rights suspension/modifications, the existence of appropriate services and supports and the actions necessary for the plan to be achieved;

v. Document the authorized services and supports funded by the Department and the date authorized services begin or the projected date of initiation;

vi. Identify a contingency plan for how necessary supports will be provided in the event that the Client's family, caregiver, or direct HCBS waiver provider is unavailable due to an emergency situation or unforeseen circumstances;

vii. Have a listing of the service plan participants and their relationship to the Client;

viii. Contain a statement of agreement with the plan signed, physical or digital signature, by the Client or other such person legally authorized to sign on the Client's behalf; and

ix. Be in effect for a period not to exceed one year without review and be reviewed and amended as determined by the Case Manager, Client, and others as applicable.

b. The service plan shall document that the Client has been offered a choice:

i. In the Home and Community-based Services or institutional care,

ii. Of waiver services, including service delivery options, and

iii. Of qualified providers.

c. The service plan shall contain documentation that the Client is aware of the conflict of interest in situations where the Case Management Agency is the only agency able to provide direct HCBS waiver services, as approved in the waiver

application, and that the Client has been provided a complaint and grievance procedure.

d. The service plan development shall occur at times and locations chosen by the Client to include but not limited to the Client's place of residence, place of service, or other appropriate setting as determined by the Client's needs or preferences.

ate setting as determined by the Client's needs or preferences.

e. Others chosen by the Client shall be provided notification at least ten (10) days prior to the service plan meeting, if possible.

f. Copies of the service plan shall be disseminated to all persons and providers involved in implementing the service plan including the Client, their legal guardian, authorized representative and parent(s) of a minor, and others as applicable. If requested, copies shall be made available prior to the provision of services or supports, or within a reasonable period of time not to exceed thirty (30) days from the development of the service plan and in accordance with these rules;

3. Referral: the Case Manager shall assist Clients to obtain needed HCBS waiver services or other programs and services, to include non-Medicaid services, which include making referrals to providers, scheduling appointments, and assisting with access to transportation as needed or requested by the Client.

r shall assist Clients to obtain needed HCBS waiver services or other programs and services, to include non-Medicaid services, which include making referrals to providers, scheduling appointments, and assisting with access to transportation as needed or requested by the Client.

4. Monitoring: the Case Manager shall ensure that Clients receive services in accordance with their Service Plan and monitor the quality of the services and supports provided to the Clients.

a. The frequency and level of monitoring shall meet the requirements of the waiver in which the Client is enrolled. At a minimum, monitoring shall occur at least once per quarter, face-to-face, in a place where services are delivered, and review the following for each Client:

i. The delivery and quality of services and supports identified in the service plan including ensuring that services are delivered in accordance with the scope, frequency, and duration documented in the service plan;

ii. The health, safety and welfare of Clients, including the provider agencies' procedures to address the Client's needs;

iii. The satisfaction with services and choice in providers;

iv. Services are being delivered in a way that promote a Client's ability to engage in self-determination, self- representation and self-advocacy;

v. Concerns or issues as they relate to provider agencies. The Case Manager shall contact the provider agency to coordinate, arrange, or adjust services to address and resolve quality issues or concerns;

vi. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or misutilization of any public assistance benefit and shall cooperate with the appropriate agency in any subsequent recovery process.

b. Upon Department approval, monitoring 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.).

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5. Remediation: the Case Manager shall identify and implement strategies to prevent and resolve problems with the delivery of services and supports.

8.519.12 Case Documentation

8.519.12.A. The Case Management Agency shall complete and maintain all required records in the state approved IMS and shall maintain individual case records at the agency level for any additional documents associated with the individual enrolled in a HCBS waiver.

1. The case records shall include:

a. Identifying information, including the Client's state identification (Medicaid) number, date of birth (DOB) social security number (SSN), address and phone number;

b. Department required forms specific to the program in which the Client is enrolled; and

c. Documentation of all case management activity.

2. Case management documentation shall meet all of the following standards:

a. Be objective and understandable;

b. Occur at the time of the activity or no later than five (5) business days from the time of the activity;

c. Dated according to the date of the activity, including the year;

d. Entered into the Department's IMS;

e. Identify the person creating the documentation;

f. Entries must be concise and include all pertinent information;

g. Information must be kept together, in a logical organized sequence, for easy access and review;

h. 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 judgement or conclusion;

i. All persons and agencies referenced in the documentation must be identified by name and by relationship to the individual;

j. All forms prescribed by the Department shall be completely and accurately filled out by the Case Manager; and,

k. 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.

3. These circumstances shall be taken into consideration when monitoring the Case Management Agency's performance.

8.519.13 Choice of provider agency for authorized HCBS waiver services

8.519.13.A. 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.

8.519.13.B. Case Management Agencies shall provide Clients, and/or their guardian, and authorized representatives, as appropriate, informed choice on all provider agencies qualified to provide the authorized HCBS waiver services.

1. When the Client or guardian, or authorized representative when applicable, knows which qualified provider agency(ies) they want to provide the authorized HCBS waiver service(s), the Client shall inform the Case Manager of their choice.

a. The Case Manager shall contact the selected provider agency(ies) regarding the Client's needs, the services authorized, and the scope, frequency, and duration of services.

b. If the provider agency(ies) are willing to provide the authorized HCBS waiver service(s), the Case Manager shall create the Prior Authorization Request in accordance with Section 8.519.14.

c. If the provider agency(ies) are not willing to provide the authorized HCBS waiver service(s), the Case Manager shall inform the Client and discuss options for additional provider selection as outlined in Section 8.519.13.B(2).

2. If the Client or guardian (as appropriate) does not know which provider agency(ies) the Client wants to select, the Case Manager shall provide informed choice to the Client which may include, but is not limited to:

a. Providing a list of qualified provider agencies;

b. Providing the Department's webpage address and information on how to search for a qualified provider agency;

c. Providing resources for accessing information about provider agency quality, such as survey information, that is available to the public;

d. Providing information regarding qualified provider agencies based on the Client's preferences;

e. Contacting all qualified provider agencies, with information regarding the requested and authorized service(s) including the scope, frequency, level of support necessary, and duration of the services for the purpose of receiving responses from qualified service agencies who can serve the Client to not include Support Level information unless requested by the Client family and/or guardian; or

f. In addition to other assistance as requested or needed by the Client.

3. The case manager shall document the Client's choice of provider agency(ies) and the method by which the choice was made in the Service Plan and in the Department's prescribed system.

4. Case Managers shall contact all requested providers within five (5) business days of the Client's selection.

8.519.14 Prior Authorization Requests (PAR)

8.519.14.A. The Case Manager shall submit a PAR in compliance with all applicable regulations and ensure requested services are:

1. Consistent with the Client's documented medical condition and needs assessment;

2. Adequate in amount, frequency, scope and duration in order to meet the Client's needs and within the limitations set forth in the current federally approved waiver; and

3. Not duplicative of another service, including but not limited to services provided through:

a. Medicaid state plan benefits,

b. Third party resources,

c. Natural supports,

d. Charitable organizations, or

e. Other public assistance programs.

4. Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency pursuant to Section 8.058.4.

8.519.15 Regional Center Referral Process

8.519.15.A. Referrals to the Regional Centers shall comply with the Regional Centers admission policy located on the Colorado Department of Human Services website.

8.519.16 Critical Incident Reporting

8.519.16.A. Case Management Agencies shall have a written policy and procedure for the recording, reviewing, and reporting of critical incidents. 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;

7. Other High Risk Issues ;

8. Allegations of abuse, mistreatment, neglect, or exploitation;

9. Damage to Consumer's Property/Theft.

8.519.16.B. 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, Case Management Agency, and to the CCB

1. 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.

8.519.16.C. Case Managers shall report critical incidents in the State-Approved IMS within 24 hours of notification. Each report must include:

a. Incident type

i. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, C.R.S, Section 26-3.1-101, C.R.S, Section 16-22-102 (9) C.R.S, and Section 25.5-10-202 C.R.S.

ii. 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.

b. Date and time of incident;

c. Location of incident, including name of facility, if applicable;

d. Individuals involved.

e. Description of incident, and

f. Resolution of incident, if applicable.

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

8.519.16.D. Incident reports submitted to by a provider to the CCB or, Case Management Agency will be reviewed by the case manager, documented into the state IMS and entered as a critical incident if the incident meets critical incident reporting criteria. Incident reports are to be made available to the Department upon request.

8.519.17 Client Responsibilities

8.519.17.A. A Client, when provided with appropriate and necessary accommodations, or guardian is responsible to:

1. Provide accurate information regarding the Client's ability to complete activities of daily living;

2. Assist in promoting the Client's independence;

3. Cooperate in the determination of financial eligibility for Medicaid;

4. Notify the Case Manager within thirty (30) days after:

a. Changes in the Client's support system, medical, physical or psychological condition, or living situation including any hospitalizations, emergency room admissions, placement in a nursing home or Intermediate Care Facility for Individuals with Intellectual Disability (ICF-IID)

b. The Client has not received an HCBS waiver service during one (1) calendar month;

c. Changes in the Client's care needs;

d. Problems with receiving HCBS waiver services for which the Client would like the Case Manager's assistance to resolve; and

e. Changes that may affect Medicaid financial eligibility, including promptly reporting changes in income or assets;

f. Client will notify the Case Manager when withdrawing from services.

5. Cooperate with Case Management Agency requirements for the functions of case management outlined in Section 8.519 et seq.

8.519.18 Use of an Authorized Representative

8.519.18.A. Clients who are eligible for services and supports, the parent or guardian of a minor, or legal guardian of an adult, shall be informed at the time of enrollment and at each annual review of the service plan that they may designate an authorized representative. The designation of an authorized representative must occur with informed consent of the Client, or the parent or guardian of a minor, or legal guardian of an adult.

8.519.18.B. A designation of an authorized representative shall be in writing and specify the extent of the authorized representative's involvement in assisting the Client receiving services, in acquiring or utilizing services or supports available, and in safeguarding the Client's rights.

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8.519.18.C. The written designation of an authorized representative shall be maintained in the Client's record and shall be reviewed annually.

8.519.18.D. The Client may withdraw their designation of an authorized representative at any time and must notify the Case Manager of the withdrawal.

8.519.19 Petitions for Declaratory Orders

8.519.19.A. Disposition of petitions for declaratory orders

1. The executive director of the Department or designee may entertain petitions for declaratory orders in accordance with Section 24-4-105 (11), C.R.S., when a controversy or uncertainty exists as to the applicability of any statutory or regulation of the Department to a party. A petition may be filled when a process for resolving the controversy or uncertainty is not otherwise provided in these rules.

8.519.19.B. Any petition filled pursuant to this rule shall set forth the following:

1. The name and address of the petitioner;

2. The statute, rule or order to which the petition relates;

3. A concise statement of all of the facts necessary to show the nature of the controversy of uncertainty; and.

4. All parties directly involved in the subject matter of the petition known to the petitioner.

8.519.19.C. If the executive director or designee decides to rule on the petition, the following procedure shall apply:

1. The executive director or designee shall provide notice of the petition and an opportunity to respond to the petition to all parties noted by the petitioner or otherwise known to the Department to be directly interested in the petition.

2. The executive director or designee may rule upon the petition based solely upon the facts presented in the petition and response. In such a case any ruling of the Department will apply only to the extent of the facts presented in the petition and the response.

3. The executive director or designee may request the petitioner or any involved party to submit additional information, or file a written brief, memorandum, or statement of position.

4. The executive director or designee may rule upon the petition without a hearing or may set the petition for hearing, upon due notice to all parties to obtain additional facts or information.

5. The ruling of the Department shall be Final Agency Action subject to judicial review.

8.519.20 Grievance/Complaint process

8.519.20.A. Case Management Agencies shall have procedures setting forth a process for the timely resolution of grievances or complaints. Use of the grievance procedure shall not prejudice the future provision of appropriate services or supports.

8.519.20.B. The grievance procedure shall be provided, orally and in writing, to all Clients receiving services, the parents of a minor, guardian and/or authorized representative, as applicable, at the time of submission and at any time that changes to the procedure occur.

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8.519.20.C. The grievance procedure shall, at a minimum, including the following:

1. Contact information for a person within the CMA who will receive grievances.

2. Identification of support person(s) who can assist the Client in submitting a grievance.

3. An opportunity to find a mutually acceptable solution. This could include the use of mediation if both parties voluntarily agree.

4. Timelines for resolving the grievance.

5. Consideration by the agency director or designee if the grievance cannot be resolved at a lower level.

6. Assurances that no Client shall be coerced, intimidated, threatened or retaliated against because the Client has exercised his or her right to file a grievance or has participated in the grievance process.

8.519.21 Termination from services and supports

8.519.21.A. A Client shall be terminated from services and supports if the CCB or Case Management Agency determines that the Client no longer meets the eligibility criteria.

8.519.21.B. A Client shall be discontinued from a service or support upon determination, made pursuant to the service planning process, that the services or supports are no longer appropriate or necessary to meet the Client's needs.

8.519.21.C. A Client receiving services may notify a service agency, verbally or in writing, that he or she no longer wishes to receive services from the provider agency. If the Client is a minor, has a legal guardian, authorized representative or is under court jurisdiction, the Client's parent(s), guardian or authorized representative shall be notified immediately after the Client notifies the service agency of the desire to discontinue services. The parent(s) of a minor or legal guardian shall be provided the option to exercise their decision-making authority on behalf of the Client receiving service, unless otherwise ordered by a court.

e Client's parent(s), guardian or authorized representative shall be notified immediately after the Client notifies the service agency of the desire to discontinue services. The parent(s) of a minor or legal

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8.519.22 Notice and Appeal Rights

8.519.22.A. The Case Management Agency shall provide the long-term care notice of action form to Clients within eleven (11) business days regarding their appeal rights in accordance with Section 8.057 *et seq*, when:

1. An adverse action occurs that affects the provision of the Client's waiver services, or:

8.519.22.B. The Case Management Agency shall notify all providers in the Client's service plan within one (1) business day of the adverse action.

1. The Case Management Agency shall notify the county Department of Human/Social services income maintenance technician within ten (10) business days of an adverse action that may affect financial eligibility for HCBS waiver services.

8.519.22.C. The applicant or Client shall be provided a notice of adverse action if the applicant or Client is determined to be ineligible as set forth in the waiver specific Client eligibility criteria and the following:

1. The Client cannot be served safely within the cost containment as identified in the HCBS waiver;

2. The Client is placed in an institution for treatment for more than thirty (30) consecutive days;

3. The Client is detained or resides in a correctional facility; or

4. The Client enters an institute for mental health for more than thirty (30) consecutive days.

8.519.22.D. The Client shall be notified, pursuant to Section 8.057.2.A., when the following results in an adverse action that does not relate to waiver Client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the needs assessment;

2. A service plan or waiver service exceeds the limits set forth in the federally approved waiver;

3. The Client is being terminated from HCBS due to a failure to attend a Level of Care assessment appointment after three (3) attempts to schedule by the Case Manager within a thirty (30) day consecutive period.

4. The Client is being terminated from HCBS due to a failure to attend a Service Plan appointment after three (3) attempts to schedule by the Case Manager within a thirty (30) day consecutive period.

5. The Client enrolls in a different LTSS program, or

6. Benefits are terminated because the Client moves out of state.

A. A Client who leaves the state on a temporary basis, with intent to return to Colorado, pursuant to Section 8.100.3.B.4, shall not be terminated unless one or more of the other Client eligibility criteria are no longer met.

7. The Client voluntarily withdraws from the waiver. The Client shall be terminated from the waiver effective upon the day after the date on which the Client's request is documented.

A. The Case Manager shall review with the Client their decision to voluntarily withdraw from the waiver. The Case Manager shall not send a notice of action, upon confirmation of withdraw.

8.519.22.E. The case management agency shall not send the LTC notice of action form when the basis for termination is death of the Client, but shall document the event in the Client record. The date of action shall be the day after the date of death.

8.519.22.F. The case management agency shall appear and defend their decision at the Office of Administrative Courts when the case management agency has made a denial or adverse action against a Client.

1. When the Office of Administrative Courts rules in favor of the appellant, the Case Management Agency shall file exceptions when appropriate.

8.519.23 Retrospective review process

8.519.23.A. Services provided to a Client are subject to a retrospective review which includes but is not limited to a performance and quality review by the Department. The retrospective review shall ensure that services:

1. Identified in the service plan are based on the Client's assessed needs;

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

3. Provided to a Client are in accordance with the service plan, and;

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

8.519.23.B When the retrospective review identifies areas of noncompliance, the case management agency shall be required to submit a corrective action plan that is monitored for completion by the Department.

8.519;23.C. The inability of the case management agency to implement a plan of correction within the timeframes identified in the plan of correction may result in temporary suspension of claims payment or termination of the provider agreement.

8.519.23.D. When the provider has received reimbursement for services and the review by the Department identifies that it is not in compliance with requirements, the amount identified is subject to recovery pursuant to Section 8.076.

8.607 CASE MANAGEMENT SERVICES

8.607.2 DETERMINATION OF DEVELOPMENTAL DISABILITY

A. Any person, his/her legal guardian, parent(s) of a minor or such person(s) authorized by law may submit a written request for a determination of whether the applicant has a developmental disability.

B. A determination of developmental disability does not constitute a determination of eligibility for services or supports. The ~~Community Centered Boards~~ Case Management Agencies shall determine whether a person has a developmental disability and therefore may be eligible to receive services and supports pursuant to Sections 25.5-10-202(2) and 211, C.R.S., in accordance with criteria as specified by the Department.

Eligibility for Medicaid funded programs specific to persons with developmental disabilities shall be determined pursuant to ~~the Colorado Department of Health Care Policy and Financing's~~ Medical ~~Assistance~~ Services Board rules ~~(10 C.C.R. 2505-10).~~

C. The developmental disability determination shall be made according to Department procedures, which shall identify the qualifications of person(s) making such a determination.

D. A request for determination of developmental disability shall be submitted to the ~~Community Centered Board~~ Case Management Agency in the designated service area where the person resides, including temporary residence such as incarceration or hospitalization.

E. At the time of request, the ~~Community Centered Board~~ Case Management Agency shall:

1. Provide the applicant any required forms and a list of the minimum required documents and information necessary for the determination of developmental disability; and,

2. Provide the applicant with information on where to obtain testing for the level of intellectual functioning and adaptive behavior, if requested. The responsibility for obtaining such assessments shall be with the applicant and/or legal guardian.

F. The applicant and/or legal guardian shall provide all documentation and information necessary for the determination of developmental disability within ~~ninety (~~90~~)~~ calendar days of the request.

1. The ~~Community Centered Board~~ Case Management Agency may request additional documentation and/or information, as needed, to complete the determination of developmental disability.

2. The applicant and/or legal guardian may have additional assessments completed and submitted to the ~~Community Centered Board~~ Case Management Agency for consideration.

G. If the applicant and/or legal guardian has not provided the documentation and information necessary for the determination within ~~ninety (~~90~~)~~ calendar days of the request, the ~~Community Centered Board~~ Case Management Agency shall:

1. Close the request and notify the applicant in writing according to the procedures established at Section 8.607.2.L.4; or,

2. The ~~Community Centered Board~~ Case Management Agency may, at the request of the applicant and/or legal guardian, extend the deadline for providing the necessary documentation and information by up to an additional ninety (90) calendar days.

   a. In no case shall the deadline for providing the necessary documentation and information exceed one hundred eighty (180) calendar days.

b. The ~~Community Centered Board~~ Case Management Agency shall provide a written update to the applicant no less than every ninety (90) calendar days until a determination of developmental disability is completed or the request is closed.

c. If the extended deadline for providing the necessary documentation and information has expired and there is still insufficient information to make a determination of developmental disability, the ~~Community Centered Board~~ Case Management Agency shall close the request and notify the applicant and/or legal guardian in writing according to the procedures established at Section 8.607.2.L.4.

H. For all applicants, the ~~Community Centered Board~~ Case Management Agency shall enter into the Department's designated data system and shall permanently maintain a written and/or electronic record of the developmental disability determination on a Department prescribed form. The record, at a minimum, shall include:

1. The name of the applicant;

2. The applicant's date of birth;

3. The date of the determination of developmental disability;

4. A description of the rationale for the developmental disability determination including, at minimum, assessment scores and diagnoses;

5. The name(s) and title(s) of the person(s) involved in making the determination.

I. All information and assessments used to determine a developmental disability shall be current so as to accurately represent the applicant's abilities at the time of determination.

1. Assessments of adaptive behavior shall have been completed within three (3) years of the request.

2. Assessments of intellectual functioning shall have been completed as follows:

a. If an individual is between five ~~(5)~~ and ~~eighteen (~~18~~)~~ years of age, at least one intellectual assessment shall have been completed to determine the individual's impairment of general intellectual functioning; or,

b. If an individual is ~~eighteen (~~18~~)~~ years of age or older and there is only one intellectual assessment available to determine the individual's impairment of general intellectual functioning, the assessment shall have been completed when the individual was at least ~~eighteen (~~18~~)~~ years of age and shall have been completed within ~~ten (~~10~~)~~ years of the request; or,

c. If there is historical pattern of consistent scores, based on two ~~(2)~~ or more intellectual assessments, that demonstrates an impairment of general intellectual functioning, the assessments may be used regardless of the individual's age at the time of determination.

3. An established neurological condition shall be documented as follows:

a. A diagnosed neurological condition shall be determined by a licensed medical professional practicing within the scope of ~~his/her~~their license; or,

b. If a specific diagnosis is not possible, a written statement from a licensed medical professional, practicing within the scope of ~~his/her~~their license, or a licensed psychologist may be used as long as there is a documented effort to determine a diagnosis and the available assessment information reasonably supports a conclusion that a neurological impairment is present.

4. The effects of mental illness or physical or sensory impairment must be considered to determine the extent to which such impairments are the sole contributing factor to the impairment of general intellectual functioning or limitations to adaptive behavior.

J. Prior to July 1, 2015, the ~~Community Centered Board~~Case Management Agency shall make the determination of developmental disability within ~~ninety (~~90~~)~~ calendar days of the receipt of all necessary information. On or after July 1, 2015, the ~~Community Centered Board~~ Case Management Agency shall make the determination of developmental disability within ~~thirty (~~30~~)~~ calendar days of the receipt of all necessary information.

K. The date of the developmental disability determination shall be the date that the Department prescribed form and all documentation and information necessary for the determination of developmental disability was received by the ~~Community Centered Board~~ Case Management Agency.

If a delay to the determination of developmental disability is due to the actions or inactions of the ~~Community Centered Board~~ Case Management Agency, the original date of request shall be used.

L. The ~~Community Centered Board~~ Case Management Agency making the developmental disability determination shall, in writing, notify the applicant or legal guardian, and the authorized person requesting the determination, if other than the applicant or legal guardian, and other such persons as designated by the applicant, of the decision. Such notification shall:

1. Be mailed to the person within seven ~~(7)~~ calendar days of the date of determination;

2. Be provided in such alternative means of communication as to reasonably ensure that the information has been communicated in an understandable form; and,

3. For persons determined to have a developmental disability, contain an explanation of the process that will occur and notice that, at a minimum, an Individualized Plan shall be developed upon enrollment into a developmental disability service;

4. ~~For persons determined not to have a developmental disability or persons whose request is closed without the determination of a developmental disability, state the reasons for the determination or closure, and provide a written~~ For persons determined not to have a developmental disability or persons whose request is closed without the determination of a developmental disability, state the reasons for the determination or closure, and provide a written Long-Term Care Notice of Action form in accordance with the provisions of Section 8.057 regarding the applicant's right to appeal the decision to the Office of Administrative Courts.

M. Applicants determined not to have a developmental disability may request a new determination of developmental disability at any time upon receipt of new or missing required information, and a new request date shall be established.

N. A determination of developmental disability shall be accepted by other ~~Community Centered Boards~~ Case Management Agencies, service agencies and Rregional Centers.

O. A determination of developmental disability shall be permanent and shall not require renewal or review unless:

1. The ~~interdisciplinary~~ member-identified team determines that developmental disability services are no longer needed due to improvement in a person's condition and recommends a redetermination; or,

2. Information from a new evaluation becomes available which demonstrates sufficient improvement in a person's condition such that the determination should be reviewed.

8.608 SERVICE AND SUPPORT PLANNING, SUPPORTING PEOPLE WITH CHALLENGING BEHAVIOR, AND PROTECTIONS

~~**8.608.7 RESEARCH**~~

~~A. Any experimental research performed by or under the supervision of the community centered board, service agency or regional center shall be governed by policies/procedures which shall:~~

~~1. Require adherence to ethical and design standards in the conduct of research;~~

~~2. Require review by the Human Rights Committee;~~

~~3. Address the adequacy of the research design;~~

~~4. Address the qualifications of the individuals responsible for coordinating the project;~~

~~5. Address the benefits of the research in general;~~

~~6. Address the benefits and risks to the participants;~~

~~7. Address the benefits to the agency;~~

~~8. Address the possible disruptive effects of the project on agency operations;~~

~~9. Require obtaining informed consent from participants, their guardians or the parents of a minor. Such consent may be given only after consultation with:~~

~~a. The interdisciplinary team; and,~~

~~b. A developmental disabilities professional not affiliated with the service agency from which the person receives services; and~~

~~10. Require procedures for dealing with any potentially harmful effects that may occur in the course of the research activities.~~

~~B. No person shall be subjected to experimental research or hazardous treatment procedures if the person implicitly or expressly objects to such procedures or such procedures are prohibited.~~

8.612 SUPPORTS INTENSITY SCALE ASSESSMENT AND SUPPORT LEVELS

Definitions

Definitions pertaining to this section shall be found at 8.7001, 8.7100, 8.7200 in addition to the below:

A. Algorithm means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Members into one of six support levels in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.

B. Authorized Representative means as defined in Section 8.7001.A.7.

C. Case Management Agency is as defined in Section 8.7100.A.8.

C. Developmental Delay means as defined in Section 8.7100.A.21.

D. Developmental Disability means as defined in Section 8.7100.A.23.

E. Executive Director means the Executive Director of the Colorado Department of Health Care Policy and Financing unless otherwise indicated.

F. Extreme Safety Risk to Self means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a Member's support level. This factor shall be identified when a Member:

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

2. Has a Rights Modification in accordance with Section 8.7001.A.6 or has a court order that imposes line of sight supervision unless the Member is in a controlled environment that limits the ability of the Member to harm himself or herself.

G. Home and Community Based Services (HCBS) means as defined in 8.7201.B.4

H. Member has the same meaning as the terms "Member" as defined in Sections 8.7001.A.8-A.

I. Person Centered Support Plan (PCSP) means as defined in Section 8.7200.B.

J. Prior Authorization Request (PAR) means as defined in Section 8.7200.B

K. Public Safety Risk-Convicted means a factor in addition to specific SIS scores that is considered in the calculation of a Member's support level. This factor shall be identified when a Member has:

1. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,

2. A Rights Modification in accordance with Section 8.7001.A.6 or through parole or probation, or a court order that imposes line of sight supervision unless the Member is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

L. Public Safety Risk-Not Convicted means a factor in addition to specific SIS scores that is considered in the calculation of a Member support level. This factor shall be identified when a Member has:

1. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,

2. A Rights Modification in accordance with Section 8.7001.A.6 or through parole or probation, or a court order that imposes line of sight supervision unless the Member is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

M. Respondent means a person participating in the SIS assessment who has known the Member for at least three months and has knowledge of the Member's skills and abilities. The respondent must have recently observed the Member directly in one or more places such as home, work, or in the community.

N. SIS Interviewer means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department approved trainer using the Department approved curriculum. SIS Interviewers must maintain a standard for conducting SIS assessments as measured through periodic interviewer reliability reviews.

O. Supports Intensity Scale (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Member well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.

P. Support Level means a numeric value determined using an algorithm that places Members into groups with other Members who have similar overall support needs.

8.612.1 Supports Intensity Scale (SIS) Assessment [Eff. 2/1/12]

A. Completion of a Supports Intensity Scale (SIS) Assessment is a requirement for a Member to participate in the Home and Community Based Services-Supported Living Services (HCBS-SLS) or the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) waiver. A Member, their legal guardian, or their legally authorized representative refusing to have a SIS assessment shall not be enrolled in the HCBS-SLS or HCBS-DD waivers.

B. Specific scores from the Member's SIS assessment shall be used in addition to Risk Factor scores to obtain the Member's Support Level in the HCBS-DD and HCBS-SLS waivers.

C. The Case Management Agency (CMA) shall conduct a SIS assessment for a Member at the time of enrollment. Reassessments shall be conducted upon approval by the Department.

D. The CMA shall:

1. Notify the Member, their legal guardian, or their legally authorized representative of the requirement for and the right to participate in the SIS assessment.

2. Support and encourage the Member to participate in the SIS assessment. If the Member chooses not to participate in the SIS assessment, the CMA shall document their choice in the Member record on the Department required data system.

3. Schedule a SIS Interviewer to conduct the assessment. If the Member, their legal guardian, or their legally authorized representative objects to the assigned SIS Interviewer, they shall be offered a choice of a different SIS Interviewer.

4. Assist the Member or other ~~interdisciplinary team (IDT)~~Member Identified Team members to identify at least two people who know the Member well enough to act as respondents for the SIS assessment. If at least two respondents cannot be identified, the CMA shall

document the efforts to find two respondents and the reasons this could not be done and proceed with the assessment using the information available.

5. To facilitate person centered practices, the SIS assessment may be completed by the SIS Interviewer at an alternate location, via the telephone or using virtual technology methods. When practicable the Member's preference of engagement shall be accommodated.

E. A qualified SIS Interviewer shall conduct the assessment. A SIS Interviewer shall not act as the respondent for a SIS assessment.

F. The CMA shall inform the Member, their legal guardian, or their legally authorized representative of the purpose of the SIS, the SIS Complaint Process, and the Support Level Review (SLR) Process. The CMA shall document that this information was provided and received on the SIS and Support Level disclosure form. The CMA shall inform the Member that they will receive a copy of the completed SIS assessment within 30 days of the SIS interview date. The CMA shall document provision of a copy of the SIS assessment to the Member, their guardian, or their legally authorized representative in the Department prescribed system.

1. The CMA case manager will provide an overview of the results of the most recent SIS assessment during the initial or continued stay review (CSR) person-centered support planning process. This overview shall include discussion of:

   a. The Exceptional Medical and/or Behavioral Support Needs identified in Section 1 of the SIS assessment;

   b. The areas of priority support needs identified in Section 2 of the SIS assessment;

   c. The resulting Support Level; and,

   d. The services necessary to meet these priority areas.

2. If, upon review of the results of the SIS assessment at the initial or CSR planning meeting, there is a significant change in the Member's condition or circumstances, they should refer to G. below for the SIS reassessment process or Section 8.612.4 Support Level Review Process

G. After the initial SIS assessment has been completed, the CMA shall conduct a SIS reassessment for the Member only when approved by the Department through the following process:

1. Prior to a SIS reassessment being conducted, the CMA shall submit a request to the Department for approval in the format prescribed by the Department.

2. The Department shall provide the CMA with a written decision regarding the request to conduct a SIS reassessment within ~~fifteen (~~15~~)~~ business days after the date the request was received.

3. Upon receiving approval to conduct a SIS reassessment, the CMA shall coordinate with a SIS Interviewer to complete the SIS reassessment.

4. If the Member, their legal guardian, or their legally authorized representative disagrees with a decision to deny the SIS reassessment request, then a request for review of the decision may be submitted to the Executive Director of the Department, or their designee, within ~~fifteen (~~15~~)~~ business days after the date the decision was received.

5. The Department's Executive Director, or their designee, shall review the request for conducting a SIS reassessment and provide a written decision within ~~fifteen (~~15~~)~~ business days of the receipt of the request for the Executive Director review.

6. The decision of the Department's Executive Director, or their designee, shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.

H. A SIS reassessment shall be conducted only when approved by the Department and when:

1. There has been a change in the Member's life circumstances or condition resulting in a significant change to the amount of services and supports needed to keep the Member safe;

2. The Member, their legal guardian, or their legally authorized representative, family member or case manager, as appropriate, has reason to believe the results of the most recent SIS assessment do not accurately reflect the Member's current support needs; or,

3. The Member, their legal guardian, or their legally authorized representative file a complaint, as outlined in Section 8.612.2, regarding the administration of the SIS assessment.

I. Administration of the SIS assessments shall be reviewed by the Department for the purpose of quality assurance.

J. When the Department identifies SIS Interviewer practices that result in inaccurate SIS assessments:

1. Remediation efforts by the Department may occur to ensure that the SIS Interviewer performs assessments according to Department standards. The SIS Interviewer(s) who conducted the inaccurate SIS assessment(s) may be deemed no longer qualified to conduct SIS assessments.

2. Payments made for the administration of the inaccurate SIS assessments may be recovered through a repayment agreement; by offsetting the amount owed against current and future SIS determination payments; or, by any other appropriate action within the Department's legal authority.

3. The Member shall receive another SIS assessment conducted by a SIS Interviewer designated by the Department.

4. The Member's Support Level and Service Plan Authorization Limit will be adjusted as necessary and effective on the date determined by the Department.

8.612.2 SIS Complaint Process [Eff. 2/1/12]

A. The Member, their legal guardian, or their legally authorized representative may file a complaint regarding the administration of the SIS assessment up to ~~thirty (~~30~~)~~ calendar days after the SIS assessment is conducted.

B. The complaint shall be filed verbally or in writing with the Member's CMA. Additional information to support the complaint may be submitted at that time. If the complaint has been filed verbally the CMA shall document in the Member's record on the Department required data system the time, date and details surrounding the complaint.

C. When the complainant requests that another SIS assessment be completed, the CMA shall submit a request for approval to conduct another SIS assessment, pursuant to the process identified in Section 8.612.1.G.

D. The CMA shall make efforts to resolve the complaint and provide the complainant with a written response within ~~ten (~~10~~)~~ business days after receipt of the complaint.

E. When a resolution cannot be reached, the CMA shall inform the complainant that they may submit the complaint to the Department within ~~thirty (~~30~~)~~ calendar days after receipt of the CMA response.

F. The Department shall provide a written response to the complainant within ~~fifteen (~~15~~)~~ business days after receipt of the complaint.

8.612.3 Support Levels [Eff. 2/1/12]

A. A Member is assigned into one of six Support Levels according to their overall support needs and based upon the standardized algorithm for the HCBS-DD or HCBS-SLS waivers. The SIS-A Assessment converts subscale raw scores for each section into standard scores for each section, which are used in the algorithm for support levels.

B. The structure of the algorithm, defined at Section 8.600.4 definitions, includes the following:

1. Algorithm factors:

   a. Standard scores from Section 2: Parts A (Home Living Activities), B (Community Living Activities), and E (Health and Safety Activities) (ABE) from the SIS assessment;

   b. Total scores from Section 1A: Exceptional Medial Support Needs score from the SIS assessment;

   c Total scores from Section 1B: Exceptional Behavioral Support Needs score from the SIS assessment; and,

   d. Whether the Member presents as a safety risk, defined at Section 8.600.4 definitions, as follows:

      1) In the HCBS-SLS waiver, Public Safety Risk-Convicted.

      2) In the HCBS-DD waiver, Public Safety Risk-Convicted/Not Convicted or Extreme Safety Risk to Self.

2. The subgroups in the algorithm table under each Support Level reflect variations of the intensity of the Member's basic medical and behavioral support needs; no matter which subgroup a Member falls into, they are eligible for that Support Level. The subgroups cluster individuals with similar behavioral and medical support needs within each major group.

3. Following an assessment of the factors defined above, standard scores for each factor are applied to the algorithm.

   The Support Level is determined when the scores for each factor meet all of the criteria of a Support Level subgroup.

4. The results of the algorithm are used to assign Members to Support Levels one through six; with a Support Level one indicating a minimal need for supports and a Support Level six indicating a significantly higher need for supports.

5. For the HCBS-SLS waiver, the Support Level determines the Service Plan Authorization Limit (SPAL), which is defined at Section ~~8.600.4~~8.7200.B. The SPALs are posted annually by the Department on the Department's webpage.

6. For the HCBS-DD waiver, the Support Level determines the rate of reimbursement for the provider(s).

C. The CMA in consultation with the ~~IDT~~ Member Identified Team shall ~~make a determination~~determine whether a Member meets the definition of Public Safety Risk or Extreme Safety Risk to Self through the following process:

1. The decision shall be made by a case management supervisor. They shall:

   a. Document the ~~IDT~~ Member Identified Team discussion of the Rights Modification identifying the line of sight supervision and/or secured, controlled setting justification, in the Member's record in the Department's prescribed system;

   b. Document that the Member meets the definition of Public Safety Risk or Extreme Safety Risk to Self ~~definition(s)~~ in the Department prescribed data system; and,

   c. Verify that the signed Informed Consent for the Rights Modification is in the Member's record in the Department's prescribed system.

2. The CMA shall review the status of the Member's Safety Risk Factors at least annually or when significant changes occur, to assure that the Member continues to meet the definition(s).

D. At the point when a Member no longer meets the definition(s) of Public Safety Risk or Extreme Safety Risk to Self , their status must be changed in the Department prescribed data system which will auto-calculate the Member's current algorithm Support Level and the Member's Person-Centered Support Plan (PCSP) shall be updated to reflect the removal of the Risk Factor and any changes in related, identified support needs within 10 business days of the definition(s) no longer being met or, in cases where Section 8.612.3.D.1-4, applies, within 10 business days of receipt of approval or denial of the SLR request.

1. For cases in which a Member's behavior does not satisfy a Safety Risk Factor definition but the Member's needs continue to be substantially higher than those typical of their assigned Support Level (without adjustments for risk factors) and a Rights Modification continues to be in place, the ~~IDT~~ Member Identified Team may consider a ~~Support Level Review (~~SLR~~)~~ request, as outlined in ~~10 CCR 2505-10~~Section 8.612.4, as a part of the person-centered support planning and Rights Modification process.

2. If the ~~IDT~~ Member Identified Team determines a SLR ~~request~~ is needed, the CMA shall submit a SLR request which includes, but is not limited to, detailed information from the PCSP describing the extensive supports needed and the Rights Modification(s), to include all requirements outlined in Section 8.7001.B~~8.508.102 and Section 8.484.5~~.

3. The Department shall review the SLR request as outlined in 10 ~~CCR~~ C.C.R. 2505-10, Section 8.612.4.

4. Rights shall be restored as soon as circumstances justify.

a, When rights are restored prior to the end date of the SLR approval period, the CMA shall notify the Department of the change in support needs in a manner determined by the Department.

b. When the right(s) are restored the Department shall adjust the Support Level override in the prescribed system to the original assessed algorithm Support Level.

c. The CMA shall make any necessary PCSP and Prior Authorization (PAR) revisions resulting from the Support Level changes within ~~ten (~~10~~)~~ business days of the affected Support Level change.

E. The CMA shall inform each Member, their legal guardian, or their legally authorized representative of their Support Level at the time of the initial or annual person-centered support planning process or when the Support Level changes for any reason.

F. Notification to the Member of a Support Level change shall occur within ~~twenty (~~20~~)~~ business days of the date after the Support Level change.

G. Pursuant to Section 8.057.2.A., ~~T~~the Member shall be notified~~, pursuant to the Department of Health Care Policy and Financing rules in Section 8.057.2.A~~ when a waiver service is terminated, reduced, or denied. ~~At any time, the~~The Member may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3.A.

H. In HCBS-DD, the Department may assign a Support Level seven ~~(7)~~ reimbursement rate for Day Habilitation Services and Residential Habilitation Services provided to a Member with extraordinary overall needs in accordance with the ~~Support Level Review~~SLR Process.

I The formula for the algorithm is:

Support Level/Subgroup
Support Level 1
Subgroup 1A: ∑ 2ABE ≤ 25; 1A ≤ 1 AND 1B ≤ 2
Subgroup 1B: ∑ 2ABE ≤ 25; 1A ≤ 2 AND 1B 3-5
Subgroup 1C: ∑ 2ABE ≤ 25; 1A 3-4 AND 1B 3-5
Support Level 2
Subgroup 2A: ∑ 2ABE 26-30; 1A ≤ 1 AND 1B ≤ 2
Subgroup 2B: ∑ 2ABE 26-30; 1A ≤ 2 AND 1B 3-5
Subgroup 2C: ∑ 2ABE 26-30; 1A 3-4 AND 1B 3-5
Subgroup 1D: ∑ 2ABE ≤ 25; 1A 5-6
Subgroup 1G: ∑ 2ABE ≤ 25; 1B 6-9
Subgroup 2D: ∑ 2ABE 26-30; 1A 5-6

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

Subgroup 4E: ∑ 2ABE ≥ 34; 1A 7-8
Subgroup 4H: ∑ 2ABE ≥ 34; 1B 10-13
Subgroup 4I: ∑ 2ABE ≥ 34; 1B 14-15
Group 5A: Public Safety Risk (either status) AND 1b ≤ 11
Support Level 6
Subgroup 4J: ∑ 2ABE ≥ 34; 1B ≥ 16
Subgroup 3F: ∑ 2ABE 31-33; 1A ≥ 9
Subgroup 4F: ∑ 2ABE ≥ 34; 1A ≥ 9
Group 6A: Extreme Safety Risk to Self AND Public Safety Risk (either status) AND 1b ≥ 12
Group 6B: Public Safety Risk (either status) AND 1b ≥ 12

Extreme Safety Risk to Self– this factor acts to increase the level otherwise determined by the above criteria. Level 1 increases to level 3, levels 2 ~~increases to level 4, level~~and 3 increases to level 4, level 4 increases to level 5. Subgroup 6A outlines the conditions in which level 5 may increase to level 6.

Public Safety Risk– this factor acts to increase the level otherwise determined by the above criteria. Levels 1 through 3 ~~increases to level 5, level 2~~ increases to level 5, ~~level 3 increases to level 5,~~ and level 4 increases to level 6. Subgroup 6B outlines the conditions in which level 5 may increase to level 6.

8.612.4 Support Level Review Process [Eff. 2/1/12]

A. The Member, their legal guardian, or their legally authorized representative, ~~,~~ or CMA may request a review of the Support Level assigned when they have reason to believe it does not meet the Member's needs.

B. When a ~~Support Level Review (~~SLR~~)~~ is requested, the CMA shall complete the SLR request in a manner determined by the Department on the Department's prescribed request form~~.~~. Once the SLR request form is completed, the CMA shall provide an opportunity for the Member, their legal guardian, or their legally authorized representative to review the request and provide additional information prior to submission to the Department for review.

C. The Department shall convene a review panel to examine ~~Support Level Review~~ SLR requests monthly or as needed.

1. The review panel shall be comprised of the following:

a. A minimum of three (3) members designated by the Department.

b. Members shall include staff from the Department, with extensive knowledge and experience with the SIS assessment, the Support Levels, case management, and HCBS waiver services.

2. The review panel:

a. Shall examine all of the information submitted by the CMA and seek to identify any significant factors not included in the Support Level calculation, which cause the Member to have substantially higher support needs than those in the established Support Level.

b. In cases where the panel finds that the Member does have substantially higher support needs than those in the initial Support Level, the panel may assign the Member to a Support Level that is a closer representation of the Member's overall support needs.

3. A Member who has been assigned to a higher Support Level shall have this assignment re-examined by the review panel at least annually or at a greater or lesser frequency determined by the Department.

a. The CMA shall submit a SLR request to have the Member's Support Level re-examined no later than thirty (30) days prior to the end date determined by the department.,

b. The panel may determine that the Member's condition necessitating a higher Support Level is unlikely to improve and, therefore; does not require a re-examination.

D. The Department shall provide the CMA and the Member, their legal guardian, or their legally authorized representative with the written decision regarding the requested review of the Member's Support Level within fifteen (15) business days after the panel meeting. The written decision notification shall include the date of the SLR request, the Support Level determination, the effective and the end date of the increased Support Level and, if denied, the reason for denial of an increased Support Level.

1. The results of the panel review for a Member enrolled in the HCBS-DD waiver are conclusive.

2. If a Member enrolled in the HCBS-SLS waiver, their legal guardian, or their legally authorized representative disagrees with the decision provided by the panel, the Member, their legal guardian, or their legally authorized representative may request a review by the Department's Executive Director or their designee, within fifteen (15) business days after the receipt of the decision.

a. The Department's Executive Director, or their designee, shall review the request and provide a written decision within fifteen (15) business days.

b. The decision of the Department's Executive Director, or their designee, shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.

3. The CMA shall make any necessary PCSP and PAR revisions resulting from the Support Level changes, within 10 business days of receipt of approval or denial of the SLR request.

E. The Member shall be notified, pursuant to the Department of Health Care Policy and Financing rules in Section 8.057.2.A when a waiver service is terminated, reduced, or denied. At any time, the Member may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3.A.

8.612.5 Definitions

A. "Algorithm" means a formula that establishes a set of rules that precisely defines a sequence of operations. An algorithm is used to assign Clients into one of six support levels in the Home and Community Based Services for Persons with Developmental Disabilities (HCBS-DD) and Home and Community Based Services-Supported Living Services (HCBS-SLS) waivers.

B. "Authorized Representative" means as defined in 8.7001.A.7

C.

"Extreme Safety Risk to Self" means a factor in addition to specific Supports Intensity Scale (SIS) scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client:

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

2. Has a rights suspension in accordance with Section 8.604.3 or has a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits the ability of the Client to harm himself or herself.

E. "Home and Community Based Services (HCBS)" means as defined in 8.7201.B.4

F.B. "Member" has the same meaning as the terms "Member" and/or "Client" as defined in Sections 8.500 and 8.500.90C. ."Public Safety Risk-Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

1. Been found guilty through the criminal justice system for a criminal action involving harm to another person or arson and who continues to pose a current risk of repeating a similar serious action; and,

2. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.

I.D. "Public Safety Risk-Not Convicted" means a factor in addition to specific SIS scores that is considered in the calculation of a Client's support level. This factor shall be identified when a Client has:

1. Not been found guilty through the criminal justice system, but who does pose a current and serious risk of committing actions involving harm to another person or arson; and,

2. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or a court order that imposes line of sight supervision unless the Client is in a controlled environment that limits his or her ability to engage in the behaviors that pose a risk or to leave the controlled environment unsupervised.I. "Respondent" means a person participating in the SIS assessment who has known the Client for at least three months and has knowledge of the

~~Client's skills and abilities. The respondent must have recently observed the Client directly in one or more places such as home, work, or in the community.~~

~~J. "SIS Interviewer" means an individual formally trained in the administration and implementation of the Supports Intensity Scale by a Department approved trainer using the Department approved curriculum. SIS Interviewers must maintain a standard for conducting SIS assessments as measured through periodic interviewer reliability reviews.~~

~~K. "Supports Intensity Scale" (SIS) means the standardized assessment tool that gathers information from a semi-structured interview of respondents who know the Client well. It is designed to identify and measure the practical support requirements of adults with developmental disabilities.~~

~~L. "Support Level" means a numeric value determined using an algorithm that places Clients into groups with other Clients who have similar overall support needs.~~

8.7100 Waiver/Program Eligibility Requirements

8.7100.A Definitions:

Unless otherwise specified, the following definitions apply throughout Section 8.7000-8.7500.

9. Member ~~,~~ is as defined in 8.7001.A.8-B~~for purposes of this Section 8.7100, et seq. means an individual who has met Long-Term Services and Supports (LTSS) eligibility requirements and has been offered and agreed to receive HCBS Waiver Services~~.

17. Cost Containment means the same as Provisions for Compliance with Federal Cost Effectiveness at 8.7100.A.52-A. ~~limiting the cost of providing care in the community to less than or equal to the cost of providing care in an institutional setting based on the average aggregate cost. The cost of providing care in the community shall include the cost of HCBS services and Medicaid State Plan benefits including long-term home health services and Targeted Case Management.~~

63-A. Target Group Criteria means the factors that define a specific population to be served through an HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic conditions, age, or diagnosis, and may include other criteria such as demonstrating an exceptional need.

52-A. Provisions for Compliance with Federal Cost Effectiveness means the person centered and needs based assessed approach in which HCBS waiver services are approved. They ensure HCBS waiver services are not duplicative, are based on assessed need of the member seeking services, and that services are the most economical and reliable means to meet an identified need of a member.

~~71. Individual Daily PAR total means the individual standard daily cost the Department uses to determine when person-centered and needs based assessed services shall be submitted by a Service Accommodation Request for prior approval.~~

~~72. Service Accommodation Request means the Department prescribed request reviewed by a 3rd party vendor or Department for prior approval of services over the Daily PAR total.~~

8.7100.G ~~Cost-Effectiveness~~Provisions for Compliance with Federal Cost Effectiveness

1. The Department of Health Care Policy and Financing shall conduct periodic aggregate cost ~~containment~~ effectiveness analyses per federal requirements and in partnership with the Centers for Medicare and Medicaid.

8.7101 HCBS Waiver Program-Specific Member Eligibility

8.7101.J Developmental Disabilities Waiver (HCBS-DD)

6. Other

a. The Member shall maintain eligibility by meeting the General Eligibility and waiver program-specific requirements set forth herein and maintaining residence i~~I~~n a GRSS or IRSS setting.

b. Enrollment in the HCBS-DD waiver may be limited when utilization of the HCBS-DD waiver program is projected to exceed legislative pending authority.

c. When the HCBS-DD waiver reaches capacity for enrollment, an individual determined eligible for a waiver shall be placed on a waiting list.

d. As openings become available in the HCBS-DD waiver program, individuals shall be considered for services in order of placement on the statewide waiting list. Exceptions to this requirement shall be limited to situations in which:

i. An emergency greatly endangers the health, safety, and welfare of the individual or others and the emergency cannot be resolved in another way. For the purposes of this subsection, emergencies are defined as follows:

1) Homelessness: the individual does not have a place to live or is in imminent danger of losing their place of abode.

2) Abusive or Neglectful Situation: the individual is experiencing ongoing physical, sexual, or emotional abuse or neglect in their present living situation and their health, safety or well-being are in serious jeopardy.

3) Danger to Others: the individual's behavior or psychiatric is such that others in the home are at risk of being hurt by them. Sufficient supervision cannot be provided by the current caretaker to ensure the safety of persons in the community.

4) Danger to Self: an individual's medical, psychiatric, or behavioral challenges are such that they are seriously injuring/harming themselves or are in imminent danger of doing so.

5) 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.

e. The Legislature has appropriated funds specific to individuals or to a specific class of persons.

f. If an eligible individual is placed on a waiting list for DD Waiver Services, a written notice, including information regarding the Member appeals process, shall be sent to the individual and/or his/her legal Guardian in accordance with the provisions of Section 8.057, et seq.

8.7200 Case Management Agency Requirements

8.7200.B. Definitions

Unless otherwise specified, the following definitions apply throughout Sections 8.7000-7500.

1-A. Business Day means any day in which the state is open and conducting business, but shall not include Saturday, Sunday, or any day in which the state observes one of the holidays listed in Section 24-11-101(1), C.R.S.

22. Member means as defined in 8.7001.A.8-B.~~any person enrolled in the state medical assistance program, the children's basic health plan, HCBS waiver program or State General Funded program.~~

24-A. Performance and Quality Review means a review conducted by the Department or its contractor at any time but no less than the frequency as specified in the approved waiver application. The review shall include a review of required case management services performed by the agency to ensure quality and compliance with all requirements.

26-A. Prior Authorization Requests (PAR) means approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the Case Management Agency.

26-B. Post Eligibility Treatment of Income (PETI) means the calculation used to determine the Member's obligation (payment) for the payment of residential services.

27-A. Regional Center means as defined at § 24-10.5-102, C.R.S.

27-B. Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds available to purchase services to meet the Member's ongoing needs. Purchase of services not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department

based on the annual appropriation for the HCBS-SLS waiver, the number of Members in each level, and projected utilization.

28-A. Supports Intensity Scale (SIS) means as defined at 8.7100.A.62.

28-B. Support Level means as defined at 8.7100.A.63.

29. Target Group Criteria means as defined at 8.7100.A.63-A. ~~the factors that define a specific population to be served through an HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic conditions, age, or diagnosis, and May include other criteria such as demonstrating an exceptional need~~.

29-A. Targeted Case Management (TCM) means case management services provided to Members enrolled in the HCBS waivers in accordance with Section 8.760 et seq,

8.7201 Case Management Agency Overall Requirements

8.7201.A Administration of a Case Management Agency

1. The Case Management Agency shall be required ~~by federal or state statute,~~in their mission statement, by-laws, articles of incorporation, and contracts, ~~or rules and~~ to comply with all regulations which govern the Case Management Agency, and to comply with the following standards:

   a. The Case Management Agency shall serve individuals in need of Long-Term Services and Supports as defined in Section 8.7100.A.48

   b. The Case Management Agency shall have the capacity to accept funding from multiple sources;

   c. The Case Management Agency may subcontract with individuals, for-profit entities and not-for-profit entities to provide Case Management Agency Targeted Case Management and administrative Case Management Activities up to the limitations established in the Case Management Agency contract. Subcontractors must abide by the terms of the Case Management Agency contract with the Department ~~and these regulations~~ and are obligated to follow all applicable federal and state ~~rules~~ statutes and regulations. The Case Management Agency is responsible for subcontractor performance.

   d. The Case Management Agency may receive funds from public or private foundations and corporations; and

   e. The Case Management Agency shall be required to publicly disclose all sources and amounts of revenue as described in Section 25.5-6-1708 CRS.

2. The Case Management Agency shall fulfill all functions of a Case Management Agency and Case Manager as described in these rules.

3. The Case Management Agency shall:

   a. Not provide guardianship services for any individual applying for Long-Term Services and Supports or Member enrolled in a Long-Term Services and Supports program.

b. 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 individual, Member and/or persons inquiring upon their behalf.

c. Be separate from the delivery of direct services and supports paid for by any payer for the same individual they provide Case Management, unless otherwise approved by the Department through a Conflict Free Case Management Waiver and except pursuant to Section 8.7202.W when the Case Management Agency is acting as the Organized Health Care Delivery System, or approved by the Department through a Conflict Free Case Management Waiver and in accordance with Section 25.5-6-1703(6) C.R.S.

d. Establish and maintain working relationships through Memorandum of Understanding processes and procedures with community-based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the individuals' and Members' needs including but not limited to local Regional Accountable Entities, Behavioral Health Administration, Aging and Disability Resource Centers, counties, schools, and Medical Assistance sites as necessary for individual and Member support.

e. Maintain a website that at a minimum contains contact information for the Case Management Agency, the ability for electronic communication, hours of operation, available resources, program options, services provided, and the transparency documentation required in Section 25.5-6-1708 C.R.S.

f. Provide Case Management services without Discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression or disability.

4. The Department may grant a Case Management Agency ~~may be granted~~ a Conflict Free Case Management waiver (CFCMW) ~~by the Department~~ to provide direct services and Case Management in the event that no other willing and qualified providers are available for the capacity of Member services necessary.

a. Applications for this waiver shall be received and evaluated in the manner in which has been communicated by the Department.

b. The Department may grant a Case Management Agency ~~may be granted~~ a Conflict-Free Case Management Waiver (formerly known as a rural exception) ~~by the Department~~ to provide specific direct services within their Defined Service Area to ensure access to these services in rural and frontier areas across Colorado.

c. The Case Management Agency shall:

i. Submit a formal application (found on the Department website) for a Conflict-Free Case Management Waiver.

ii. The Department shall provide formal notification to the Case Management Agency within 10 business days of the receipt of the application. The Department shall notify Applicants of their approval or denial within 90 days of receipt of the application.

iii. If the Applicant submits a response to the Case Management Agency Request for Proposal (RFP), the Department shall notify the Agency of approval or denial

prior to the delivery of intent to award letters to RFP Respondents or within 90 day of receipt of the application whichever ~~comes~~ occurs first.

iv. If the Conflict-Free Case Management Waiver application is denied, the Department will coordinate with the Case Management Agency for a transition period, if necessary.

v. If a Case Management Agency requires a waiver between Case Management Agency contract cycles, the Case Management Agency must submit the application for the Conflict Free Case Management Waiver and maintain the documentation for the next RFP submission.

1) If the Conflict-Free Case Management Waiver application is approved, the Department will coordinate with the Case Management Agency for next steps in implementation and execution, if necessary.

2) If the Conflict-Free Case Management Waiver application is denied, the Department will coordinate with the Case Management Agency for a transition period within their contract period, if necessary.

vi. A Case Management Agency that is granted a Conflict-Free Case Management Waiver shall provide an annual report to the Department subject to Department approval that includes but will not be limited to:

1) a summary of individuals participating in direct services and Case Management;

2) how the Case Management Agency has ensured i~~I~~nformed c~~C~~onsent and/or choice, if other providers exist in the Defined Service Area; and

3) how the Case Management Agency continues to support the recruitment of willing and qualified providers in their Defined Service Area.

4) how ~~T~~the direct service provider functions and Case Management Agency functions ~~must be~~are administratively separated (including staff) with safeguards in place to ensure a distinction between direct services and Case Management exists as a protection against conflict of interest.

vii. If a new service provider(s) becomes available in the area, the Case Management Agency may continue to provide direct services until the Department has determined that the alternate provider(s) is capable of meeting all needs in that service area.

viii. If other service providers are available in the area, the Case Manager must document the offering of choice of provider and/or that no provider had capacity to serve new Members in the Information Management System.

ix. To ensure conflict of interest is being mitigated by the Case Management Agency, the Department will conduct annual quality reviews that will include but not be limited to, reviews of documentation of ~~provider~~ Members' choice of provider and i~~I~~nformed c~~C~~onsent for services.

8.7201.I Confidentiality of Information

1. The Case Management Agency shall protect the confidentiality of all records of individuals seeking and receiving services required by Section 26-1-114(3)(a)(I), C.R.S. and 45 C.F.R., Parts 160 and 165, Subparts A and C (HIPAA). Release of information forms obtained from the individual must be signed, dated, and kept in the Member's record. Release of information forms shall be renewed at least annually, or with the new Provider Agency whenever there is a change of provider. Fiscal data, budgets, financial statements and reports which do not identify individuals by name or Medicaid ID number, and which do not otherwise include Protected Health Information, are subject to disclosure pursuant to the Colorado Open Records Act, Title 24, Article 72, Part 2, C.R.S.

8.7201.L. Incident Reporting

1. Case Management Agencies shall have a written policy and procedure for the timely reporting, recording and reviewing of Incidents occurring on the Case Management Agency property or care which shall include, but not be limited to:

   a. Allegations of abuse, mistreatment, neglect, or exploitation;

   b. Serious Illnesses and injuries to a person receiving services that require intervention that is above and beyond basic first aid;

   c. Lost or missing persons receiving services;

   d. Medical emergencies involving Members that require intervention that is above and beyond basic first aid or that are not screened out by medical professionals;

   e. Hospitalization of Members;

   f. Death of Members;

   g. Errors in medication administration;

   ~~h. Use of safety control procedures;~~

   ~~i. Use of emergency control procedures;~~ and,

   h~~j~~. Stolen personal property belonging to a Member.

8.7202 Functions of A Case Management Agency

8.7202.B Intake, Screening, and Referral

8. When a person needs assistance with challenging behavior, including ~~a person whose~~ behavior that presents a danger to self ~~is dangerous to himself~~, or others, or ~~engages in~~ behavior which results in significant property destruction, the Provider Agency in conjunction with the individual, their Guardian or other Legally Authorized Representative, and other m~~M~~embers of Member Identified Team, as appropriate including the Member's appointed Case Manager shall complete a Comprehensive Review of the Person's Life Situation including:

   a. 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;

b. 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;

c. 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;

d. 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;

e. A review of the person's medical situation which may be contributing to the challenging behavior; and

f. A review of the person's Individualized Plan and any Individual Service and Person-Centered Support Plans to see if the services being provided are meeting the individual's needs and are addressing the challenging behavior using positive approaches.

8.7202.C Nursing Facility Admission and Discharge

~~4. The Case Manager shall view and document the current Personal Care Boarding Home license, if the individual lives, or plans to live, in a Congregate Facility as defined at Section 8.7100.A.112 and 8.485.50.E.~~

~~4~~5. A Case Manager may determine that an individual is eligible to receive Waiver Services while the individual resides in a nursing facility when the individual meets the eligibility criteria as established at Section~~s 8.400, and~~ 8.7100 and the individual requests to transition out of the nursing facility .

8.7202.G Waitlist Management

7. Enrollments are reserved to meet statewide priorities that may include:

a. An individual 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,

b. Individuals 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,

c. Members enrolled in a Home and Community-Based Services CES or CHRP waivers who are under 18 years of age and are eligible for the HCBS-DD waiver.

d. Individuals who are in an emergency situation.

8. Enrollments shall be authorized for individuals based on the criteria set forth by the General Assembly in appropriations when applicable.

a. An individual shall accept or decline the offer of enrollment within ~~thirty (~~30~~)~~ calendar days from the date the enrollment was offered. Reasonable effort, such as a second notice or phone call, shall be made to contact the individual, family, legal Guardian, or other interested party.

b. Upon a written request of the individual, family, legal Guardian, or other interested party the Case Management Agency may grant an additional ~~thirty (~~30~~)~~ calendar days to accept or decline an enrollment offer. The delineation reason shall be recorded in the Department's Information Management System within 10 business days.

c. If an individual does not respond to the offer of enrollment within the time set forth in subsection 2 and/or 3 above, the offer is considered declined and the individual shall maintain their position on the waiting list as determined by their placement date but will be moved to safety net status until the Member is willing or able to accept an enrollment. The Member may notify their Case Management Agency of their desire to move back to a status of As Soon As Available (ASAA) when they would be ready to accept an enrollment into the DD waiver.

d. The Case Management Agency shall record all waiting list communications, enrollments, and declinations in the Department's Information Management System within 10 business days.

e. The Case Management Agency shall record an annual waiting list review within the Department's Information Management System within 10 business days or as directed by the Department.

8.7202.J Person-Centered Support Coordination

1. Service and support coordination shall be the responsibility of the Case Management Agencies. Service and support coordination shall be provided in partnership with the Member receiving services, the Parents of a minor, and legal Guardians.

a. The M~~m~~ember shall designate a Member Identified Team which may include but not be limited to: a LTSS Representative, family members, or individuals from public and private agencies to the extent such partnership is requested by the M~~m~~ember.

12. Case Managers shall follow all documented policy and operational guidance from the Department for Case Management services including but not limited to:

a. Home modification

b. Vehicle modification

c. Organized Health Care Delivery System

d. Consumer~~-~~-Directed Attendant Supports ~~and~~ Services

e. In~~-~~-Home Support ~~s and~~ Services

f. Nursing Facilities

g. Transition Services

h. Long Term Home Health

i. Private Duty Nursing

8.7202.Q Human Rights Committees

10. RESEARCH

a. Any experimental research performed by or under the supervision of the Case Management Agency, the Community Centered Board, service agency or Regional Center shall be governed by policies/procedures which shall:

i. Require adherence to ethical and design standards in the conduct of research;

ii. Require review by the Human Rights Committee;

iii. Address the adequacy of the research design;

iv. Address the qualifications of the individuals responsible for coordinating the project;

v. Address the benefits of the research in general;

vi. Address the benefits and risks to the participants;

vii. Address the benefits to the agency;

viii. Address the possible disruptive effects of the project on agency operations;

ix. Require obtaining informed consent from participants, their guardians or the parents of a minor. Such consent may be given only after consultation with:

a. The member selected team; and,

b. A developmental disabilities professional not affiliated with the service agency from which the person receives services; and

x. Require procedures for dealing with any potentially harmful effects that may occur in the course of the research activities.

b. No person shall be subjected to experimental research or hazardous treatment procedures if the person implicitly or expressly objects to such procedures or such procedures are prohibited.

8.7202.R Denials/Discontinuations/Adverse Actions

4. The Case Management Agency shall provide the Long-Term Care Waiver Program Notice of Action form to Applicants and individuals within ~~eleven (~~11~~)~~ business days regarding their appeal rights in accordance with Section 8.057 et seq. when

a. The individual or Applicant is determined to not have a Developmental Disability,

b. The individual or Applicant is found ~~eligible or~~ ineligible for Long-Term Services and Supports.

c. The individual or Applicant is determined eligible or ineligible for placement on a waiting list for Long-Term Services and Supports,

d. An adverse action occurs that affects the individual's or Applicant's waiver enrollment status,

e. The individual or Applicant voluntarily withdraws.

8.7202.Y Communication

1. 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 preferred means of communication of the individual.

2. In addition to any communication requirements specified elsewhere in these rules, the Case Manager shall be responsible for the following communications:

a. The Case Manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of a Member 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.

b. 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.

~~c. The Case Manager shall inform the individual's physician of any significant changes in the individual's condition or needs.~~

cd. The Case Manager shall report to the Colorado Department of Public Health and Environment (CDPHE) any Congregate Facility which is not licensed.

~~e~~d. The Case Manager shall inform all Alternative Care Facility individuals 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.

~~f~~e. Within five ~~(5)~~ working days of receipt of the approved Prior Authorization Request (PAR) form, from the fiscal agent, the Case Manager shall provide copies to all the HCBS providers in the Person-Centered Support Plan.

~~g~~f. 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.

~~h~~g. The Case Manager shall notify the Utilization Review Contractor (URC), on a form prescribed by the Department, within ~~thirty (~~30~~)~~ calendar days, of the outcome when a Member is not Diverted~~, as defined at Section 8.485.50~~.

~~i~~h. Case Managers shall maintain communication with Members, Family Members, providers and other necessary parties within minimum standards for returned communication as described in contract.

8.7202.BB Post Eligibility of Treatment of Income (PETI)

1. Post Eligibility Treatment of Income Application

a. When a Member has been determined eligible for Home and Community Based Services (HCBS) according to the 300% income standard (300% eligible Members), according to Section 8.100, the Department may reduce the Medicaid payment for Alternative Care Facility -and Facility and Supported Living Programs services according to the procedures set forth in this section.

b. Post Eligibility Treatment of Income Application is required for Medicaid Members enrolled in the HCBS Elderly, Blind, and Disabled (EBD), HCBS-Community Mental Health Supports (CMHS), and HCBS Brain Injury (BI) waivers who reside in Alternative Care Facilities (ACF) and Supported Living Programs (SLP).

2. Case Management Responsibilities

a. For 300% eligible Members who reside in an Alternative Care Facility or Supported Living Program, the Case Manager shall complete the State-prescribed form, which calculates the Member payment according to the following procedures:

i. The Member's Total Gross Monthly Income is determined by adding the Gross Monthly Income to the Gross Monthly Long-Term Care (LTC) Insurance amount if the Long-Term Care Insurance amount is applicable.

ii. The Member's Room and Board amount shall be deducted from the gross income and paid to the Provider Agency.

iii. The Member's Personal Needs Allowance amount is based upon a Member's gross income, up to the maximum amount set by the Department.

iv. For a Member with financial responsibility for only a spouse, the amount protected under Spousal Protection as defined in Section 8.100.7 .K and shall be deducted from the Member's gross income.

v. If the Member is financially responsible for a spouse plus other dependents, or with financial responsibility for other dependents only, an amount equal to the appropriate Temporary Assistance to Needy Families (TANF) grant level, less any income of the spouse and/or dependents, excluding part-time employment earnings of dependent children (with dependent child as defined at Section 8.100.1) shall be deducted from the Members gross income.

vi. Amounts for incurred expenses for medical or remedial care for the Member that are not covered by Medicare, Medicaid, or other third party, shall be deducted from the member's gross income as follows:

1) Health insurance premiums, deductibles, or co-insurance charges if health insurance coverage is documented; and

2) Necessary dental care not to exceed amounts equal to actual expenses incurred; and

3) Vision and auditory care expenses not to exceed amounts equal to actual expenses incurred; and

4) Medications except for the following:

a) Medications which may be purchased through regular Medicaid prior authorization procedures shall not be deducted from the Member's gross income.

b) The full cost of brand-name medications shall not be deducted from the member's gross income if a generic form is available at a lower price, unless the prescriber has specifically prescribed a name brand medication over the generic formula.

vii. Other necessary medical or remedial care or items shall be deducted from the Member's gross income, with the following limitations:

1) The need for such care must be documented in writing by the attending physician. The documentation shall list the service, supply, or equipment; state why it is medically necessary; be signed by the physician; and shall be renewed whenever there is a change in the member's care needs, or if the member's needs do not change, annually.

2) Any service, supply, or equipment that is available under the Medicaid State Plan, with or without prior authorization, shall not be allowed as a deduction.

viii. Deductions for medical and remedial care may be allowed up to the end of the next full month while the physician's prescription is being obtained. If the physician's prescription cannot be obtained by the end of the next full month, the deduction shall be discontinued.

1) The Member must provide documentation, such as a receipt, for all Non-covered medical items to the Case Manager to be attached to the State-prescribed form.

ix. If the Case Manager cannot immediately determine whether a particular medical or remedial service, supply, equipment, or medication is a benefit of Medicaid, the deduction may be allowed up to the end of the next full month while the Case Manager determines whether such deduction is a benefit of the Medicaid program. If it is determined that the service, supply, equipment, or medication is a benefit of Medicaid, the deduction shall be discontinued.

x. Verifiable Federal and State tax liabilities shall be an allowable deduction up to $300 per month from the Member's gross income.

xi. Any remaining income shall be applied to the per-diem cost of the Alternative Care Facility, as defined at Section 8.7506 or Support Living Program as defined at Section 8.7550 shall be paid by the Member directly to the Provider Agency.

xii. If income remains after the entire cost of Alternative Care Facility or Supported Living Program services is paid from the Member's income, the remaining income shall be retained by the Member and may be used at the Member's discretion.

b. Case Managers shall inform HCBS Alternative Care Facility and Supported Living Program Members of their payment obligations in a manner prescribed by the Department at the beginning of each support plan year and whenever this is a significant change to their payment obligation.

i. Significant change is defined as fifty dollars ($50) or more.

c. The Case Management Agency shall maintain signed copies of Member payment forms in their files. The Case Management Agency shall provide a copy of the form to the Department upon request.

8.7202.CC PRIOR AUTHORIZATION REQUESTS (PAR)

1. All Home and Community-based Services must be prior authorized by the Department or its agent.

a. The Case Manager shall complete and submit the Department's approved PAR form within one calendar month of determination of eligibility for a waiver.

2. All units of service requested shall be listed on the Person Centered Support Plan.

3. The first date for which services may be authorized is the latest date of the following:

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

b. The assigned start date on the certification page of the Department approved assessment tool.

c. The date, on which the Member's parent(s) and/or legal guardian signs the Person Centered Support Plan or Intake form, as prescribed by the Department, agreeing to receive services.

4. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of the Department approved assessment tool.

5. The Case Manager shall submit a revised PAR if a change in the Person Centered Support Plan results in a change in services.

6. The revised Person Centered Support Plan shall list the service being changed and state the reason for the change. The services being revised, as indicated in the revised Person Centered Support Plan, plus all services not revised, as shown on the Plan prior to revision, shall be entered on the revised PAR.

7. Revisions to the Person Centered Support Plan requested by providers after the end date on a PAR shall be disapproved.

8. If the revisions to the Person Centered Support Plan result in a decrease in services without the Member's parent's(s) and/or legal guardian's agreement, the Case Manager shall notify the Member's parent(s) and/or legal guardian of the adverse action and appeal rights using the appropriate forms, timelines and process as described in 8.7202.R.

9. REIMBURSEMENT

a. Providers shall be reimbursed at the lower of:

i. Submitted charges; or

ii. The fee schedule amount as determined by the Department.

b. Claims for services are not reimbursable if:

i. Services are not consistent with the Member's documented medical condition and functional capacity;

ii. Services are not medically necessary or are not reasonable in amount, scope, frequency, and duration;

iii. Services are duplicative of other services included in the Member's Support Plan;

iv. The Member is receiving non-Medicaid funds to purchase services; or

v. Services total more than 24 hours per day of care.

10. Revisions to the PAR that are requested six months or more after the end date shall be disapproved.

11. Payment for HCBS waiver services is also conditional upon:

a. The Member's eligibility for HCBS waiver services;

b. The provider's certification status, if appropriate; and

c. The submission of claims in accordance with proper billing procedures.

12. Prior authorization of services is not a guarantee of payment. All services must be provided in accordance with regulations and medically necessary.

13. Services requested on the PAR shall be supported by information on the Person Centered Support Plan and written documentation of the Member's current monthly income from the income maintenance technician.

14. The PAR start date shall not precede the start date of HCBS waiver eligibility.

15. The PAR end date shall not exceed the end date of the HCBS eligibility certification period.

8.7202.DD SERVICE PLAN AUTHORIZATION LIMITS (SPAL)

1. The Service Plan Authorization Limit (SPAL) sets an upper payment limit of total funds available to purchase services to meet a Member's ongoing service needs within one service plan year.

2. The following services are not subject to the service plan authorization limit: non-medical transportation, dental services, vision services, assistive technology, home accessibility adaptations, vehicle modifications, health maintenance activities available under the Consumer Directed Attendant Support Services (CDASS), home delivered meals, life skills training, peer mentorship, transition setup, individual job coaching, individual job development, job placement, workplace assistance, and benefits planning.

3. The total of all HCBS-SLS services in one service plan shall not exceed the overall authorization limitation as set forth in the federally approved HCBS-SLS waiver.

4. Each SPAL is assigned a specific dollar amount determined through an analysis of historical utilization of authorized waiver services, total reimbursement for services, and the spending authority for the HCBS-SLS waiver. Adjustments to the SPAL amount may be determined by the Department and Operating Agency as necessary to manage waiver costs.

5. Each SPAL is associated with one of the six support levels determined by an algorithm which analyzes the level of support needed by a Member as determined by the SIS assessment, and additional factors, including whether a Member meets the definition of Public Safety Risk-Convicted, Public Safety Risk-Non Convicted, and Extreme Safety Risk to Self.

6. The SPAL determination shall be implemented in a uniform manner statewide and the SPAL amount is not subject to appeal.

   a. If an Adverse Action occurs regarding a Member's HCBS waiver eligibility and/or services, the Case Manager shall send the Member their appeal rights as required at Sections 8.7202.R and 8.057.2.A.

7. The Department and/or Utilization Review Contractor (URC) shall implement an Exception Review to allow a Member's SPAL and/ or HCBS unit limitations to be exceeded in certain situations.

   a. To be eligible for the Exception Review Process, the following shall be demonstrated:

      i. The Member must be at risk for seeking an emergency Developmental Disability (DD) waiver enrollment because one or more of the following criteria such as listed below are not currently being met through other Long-Term Services and Supports (LTSS) and or State Plan services:

         1) Medically fragile with skilled care needs;

         2) Behavioral and/or Mental Health needs;

         3) Criminal convictions and/or law enforcement involvement;

         4) Homelessness;

         5) Mistreatment, Abuse, Neglect, Exploitation (MANE) reports with potential need to remove from home;

6) Extreme danger to self/others;

7) Caregiver capacity or;

8) 1:1 supervision needed.

ii. The Member must demonstrate that less than 10% of current SPAL remains; or

iii. The Member must demonstrate that the current rate of utilization of Home and Community-Based Services (HCBS) will exhaust the number of approved units prior to the Member's regularly scheduled monitoring.

b. When a client is eligible for the Exception Review Process, the Case Manager (CM) shall send the following documentation to the URC for review:

i. "Request for Exception Review Process" form;

ii. Service Plan;

iii. PAR; and,

iv. Any documentation from current providers that demonstrate need to exceed service limitation caps for additional planned services.

c. The URC shall review and approve or deny the Exception Review Process requests made.

i. Upon completion of the review, the URC shall notify the CM of the outcome.

1) The outcome letter shall include the reason for approval or denial, and/ or any information on partial approvals or negotiated outcomes.

ii. The URC shall complete the review in accordance with the timelines as identified in their contract.

d. The Exception Review Process shall not be used in place of a Support Level Review or request for a Support Intensity Scale (SIS) reassessment. Provider rates shall not be changed based on the outcome of the Exception Review Process.

e. The Exception Review Process shall be implemented in a uniform manner applied to Members statewide, but outcomes shall be based on individual needs and circumstances. The Exception Review Process outcome is not an adverse action subject to appeal.

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