

Title of Rule: Revision to the Medical Assistance Act Rule concerning Care and Case Management System, Sections 8.390, 8.393, 8.400, 8.500 & 8.615 .  
Rule Number: MSB 23-01-13-A  
Division / Contact / Phone: Office of Community Living / Michelle Topkoff / 303-866-3659

## STATEMENT OF BASIS AND PURPOSE

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

This proposed rule amends Sections 8.390, 8.393, 8.400, 8.500 and 8.614 in anticipation of adoption of a new assessment instrument, the Colorado Single Assessment Level of Care Eligibility Determination Screen. The current rule identifies by name the ULTC 100.2 as the instrument used to determine eligibility for Long Term Services and Supports (LTSS) and incorporates the instrument in its entirety into the regulations. The amendments to rule update terminology and language to allow for use of a second instrument, which will be used concurrently with the ULTC 100.2 during the phase in of the use of the new Colorado Single Assessment Level of Care Eligibility Determination Screen. During the phase in period, only one of the two instruments will be used on any one member for any single certification period. This is in preparation for the eventual complete phase out of the ULTC 100.2 and replacement with the Colorado Single Assessment Level of Care Eligibility Determination Screen.

An emergency rule-making is imperatively necessary

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

Explain:

2. Federal authority for the Rule, if any:

3. State Authority for the Rule:

Sections 25.5-1-301 through 25.5-1-303, 25.5-6-104, C.R.S. (2023);

Initial Review  
Proposed Effective Date

**05/12/23**  
**07/30/23**

Final Adoption  
Emergency Adoption

**06/09/23**

**DOCUMENT #08**

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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.

This proposed rule will affect Case Management Agencies and Medicaid LTSS members. Case management agencies and members will benefit from the proposed rule changes because it will allow the Department to phase in the implementation of the new Colorado Single Assessment, which is a new comprehensive level of care and needs assessment housed in the new Care and Case Management system. The new assessment process is required by SB 16-192 (codified at Section 25.5-6-104, C.R.S.)

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

The new assessment has automated features that will streamline the assessment process for members and reduce duplication in administrative work for case managers. It is also more objective and standardized.

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.

Initial cost associated with the change have been addressed through the fiscal note for SB 16-192. Enforcement costs are not anticipated to change. No other agency will incur any costs and there will be no effect on state revenues as a result of this rule change.

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

Funding for the initial costs for the development and implementation of the new assessment instrument was allocated in a fiscal note for SB 16-192. The benefits of the proposed rule are that clients and case managers will benefit from the streamlined assessment process and the more objective and standardized Colorado Single Assessment Level of Care Eligibility Determination Screen. The cost of inaction is that the Department will fail comply with statute and clients and case managers will be deprived of the efficiency, objectivity and standardization of the Colorado Single

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Assessment Level of Care Eligibility Determination Screen. No benefits of inaction have been identified.

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

Because the current rules identify and incorporate the ULTC 100.2 as the single instrument to be used for assessments, the rule must be changed to allow use of the Colorado Single Assessment Level of Care Eligibility Determination Screen.

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 alternative methods for achieving the purpose of the proposed rule change were considered.

1

2 **8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM**

3 The long-term care Single Entry Point system consists of Single Entry Point Agencies, representing  
 4 geographic districts throughout the state, for the purpose of enabling persons in need of long-term  
 5 services and supports to access appropriate services and supports.

6 **8.390.1 DEFINITIONS**

7 ~~A. Agency Applicant means a legal entity seeking designation as the provider of Single Entry Point~~  
 8 ~~Agency functions within a Single Entry Point district.~~

9 ~~AB. Applicant means an individual who is seeking a long-term services and supports eligibility~~  
 10 ~~determination and who has not affirmatively declined to apply for Medicaid or participate in a~~  
 11 ~~Level of Care Eligibility Determination Screen.~~

12 ~~C. Assessment means a comprehensive evaluation ~~with the individual seeking services of an~~~~  
 13 ~~Applicant or Member, including but not limited to and appropriate collaterals, as appropriate (such~~  
 14 ~~as family members, advocates, friends and/or caregivers) and, chosen by the individual, and~~  
 15 ~~conducted by the case manager, with supporting diagnostic information from the individual's~~  
 16 ~~medical provider to determine the individual's level of functioning care, service needs, available~~  
 17 ~~resources, and potential funding resources using Department prescribed instrument(s), as~~  
 18 ~~required by the program for which they are applying or in which they are enrolled.~~

19 ~~BDC. Case Management means the ~~assessment~~ Assessment of an individual seeking or receiving~~  
 20 ~~long-term services and supports' needs, the development and implementation of a Person-~~  
 21 ~~Centered Support Plan for such individual, referral and related activities, the coordination and~~  
 22 ~~monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic~~  
 23 ~~R reassessment of such individual's needs.~~

24 ~~EGD. Corrective Action Plan means a written plan by the CMA, which includes a detailed description of~~  
 25 ~~actions to be taken to correct non-compliance with waiver requirements, regulations, and~~  
 26 ~~direction from the Department, and which sets forth the date by which each action shall be~~  
 27 ~~completed and the persons responsible for implementing the action.~~

28 ~~FDE. Critical Incident means an actual or alleged event that creates the risk of serious harm to the~~  
 29 ~~health or welfare of an individual receiving services; and it may endanger or negatively impact the~~  
 30 ~~mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to,~~  
 31 ~~injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement;~~  
 32 ~~lost or missing person; criminal activity; unsafe housing/displacement; or death.~~

33 ~~GEF. Department means the Colorado Department of Health Care Policy and Financing, the Single~~  
 34 ~~State Medicaid Agency.~~

35 ~~HGF. Failure to Satisfy the Scope of Work means acts or failures to act by the Single Entry Point~~  
 36 ~~Agency that constitute nonperformance or breach of the terms of its contract with the Department.~~

37 ~~IGH. Financial Eligibility means an individual meets the eligibility criteria for a publicly funded program,~~  
 38 ~~based on the individual's financial circumstances, including income and resources.~~

39 ~~I. Functional Eligibility means an individual meets the level of care criteria for a Long Term Services~~  
 40 ~~and Supports (LTSS) Program as determined by the Department.~~

- 1 ~~J. Functional Needs Assessment means a comprehensive evaluation with the individual seeking~~  
2 ~~services and appropriate collaterals (such as family members, friends and/or caregivers) chosen~~  
3 ~~by the individual and a written evaluation by the case manager utilizing the ULTC 100.2, with~~  
4 ~~supporting diagnostic information from the individual's medical provider, to determine the~~  
5 ~~individuals level of care and medical necessity for admission or continued stay in certain Long-~~  
6 ~~Term Services and Supports (LTSS) Programs.~~
- 7 JHK. Home and Community Based Services (HCBS) waivers means services and supports authorized  
8 through a waiver under Section 1915(c) of the Social Security Act and provided in home- and  
9 community-based settings to individuals who require an ~~institutional~~ level of care that would  
10 otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals  
11 with Intellectual Disabilities (ICF-IID).
- 12 KIL. Information Management System (IMS) means an automated data management system  
13 ~~approved-prescribed~~ by the Department to ~~enter document~~ case management ~~activities and~~  
14 information for each individual seeking or receiving long-term ~~and/or State General Fund~~ services  
15 as well as to compile and generate standardized or custom summary reports.
- 16 MLJ. Intake, Screening and Referral means the initial contact with individuals by the Single Entry Point  
17 Agency and shall include, but not be limited to, a preliminary screening in the following areas: an  
18 individual's need for long-term services and supports; an individual's need for referral to other  
19 programs or services; an individual's ~~eligibility-need~~ for financial and program assistance; and the  
20 need for an ~~Assessment comprehensive functional assessment~~ of the individual seeking services.
- 21 MKN. ~~Level of Care Eligibility means an individual requires the level of care that is provided in a~~  
22 ~~hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities,~~  
23 ~~as determined by the Department prescribed Level of Care Eligibility Determination Screen, meets~~  
24 ~~the level of care criteria for Long Term Service and Supports (LTSS) programs, as determined by~~  
25 ~~the Department.~~
- 26 ~~L. Institutional Level of Care means an individual requires the level of care that is provided in a~~  
27 ~~hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities,~~  
28 ~~as determined by the Department prescribed Level of Care Eligibility Determination Screen.~~
- 29 ~~OM. Level of Care Eligibility Determination means the outcome of a comprehensive evaluation of an~~  
30 ~~individual seeking Long Term Services and Supports to determine their need for Institutional~~  
31 ~~Level of Care using a Department prescribed assessment instrument of the LOC Screen,~~
- 32 ~~PN. Long Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen)~~  
33 ~~means a comprehensive evaluation withof the Applicant or individual seeking services Member~~  
34 ~~and collaterals as appropriate (such as family members, advocates, friends and/or caregivers)~~  
35 ~~and chosen by the individual, and conducted by the case manager, with supporting diagnostic~~  
36 ~~information from the individual's medical provider to determine the individual's level of care,~~  
37 ~~service needs, available resources, and potential funding resources using a Department~~  
38 ~~prescribed instrument(s) to determine an applicant or member's eligibility for Long Term Services~~  
39 ~~and Supports based on their need for Institutional Level of Care as determined using a~~  
40 ~~Department prescribed assessment instrument as outlined in section 8.401.~~
- 41 QQ.- Long-Term Services and Supports (LTSS) means the services and supports used by individuals  
42 of all ages with functional limitations and chronic illnesses who need assistance to perform  
43 routine daily activities such as bathing, dressing, preparing meals, and administering medications.
- 44 PRQ. LTSS Program means any of the following: publicly funded programs, Home and Community-  
45 Based Services ~~for the Elderly, Blind and Disabled~~ Waiver (HCBS-EBD), Home and Community-  
46 Based Services ~~for Persons with a Spinal Cord Injury~~ Complementary and Integrative Health

1 Waiver (HCBS-~~SCICIH~~) ~~(where applicable)~~, Home and Community-Based Services ~~for Persons~~  
 2 ~~with a~~ Brain Injury Waiver (HCBS-BI), Home and Community-Based Services Community Mental  
 3 Health Supports Waiver (HCBS-CMHS), Home and Community-Based Services ~~for~~ Children with  
 4 a Life Limiting Illness Waiver (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All-  
 5 Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult  
 6 Long-Term Home Health (LTTH).

7 SQP. Member means an individual who meets long-term services and support eligibility requirements  
 8 and has been approved for and agreed to receive Home and Community-Based Services  
 9 (HCBS).

10 T. Person-Centered Support Planning means the process of collaborating with the individual  
 11 receiving services and other people of their choosing to identify goals, needed services, individual  
 12 choices and preferences, and service providers. This is based on Assessment and knowledge of  
 13 the individual and of community resources and includes informing the individual of their rights and  
 14 responsibilities.

15 U.R Person-Centered Support Plan (PCSP) means the documentation of the Person-Centered  
 16 Planning Process in the Department prescribed IMS using the Department prescribed format,  
 17 including but not limited to the individual's chosen goals, services and providers.

18 VS. Pre-Admission Screening and Resident Review (PASRR) means the pre-screening of individuals  
 19 seeking nursing facility admission to identify individuals with mental illness (MI) and/or intellectual  
 20 disability (ID), to ensure that individuals are placed appropriately, whether in the community or in  
 21 a NF, and to ensure that individuals receive the services they require for their MI or ID.

22 QWT. Professional Medical Information Page (PMIP) ~~means the medical information form signed by a~~  
 23 ~~licensed medical professional used to certify level of care~~ means the medical information form  
 24 signed by a licensed medical professional used to verify the individual's medical necessity for  
 25 Long-Term Care Services.

26 RXU. Reassessment means a comprehensive reevaluation of an Applicant or Member, including but  
 27 not limited to the individual's level of care, service needs, available resources, and potential  
 28 funding resources using Department prescribed instrument(s), as required by the program for  
 29 which they are applying or in which they are enrolled.~~with the individual seeking services and~~  
 30 ~~collaterals, as appropriate (such as family members, advocates, friends and/or caregivers) and~~  
 31 ~~chosen by the individual, and conducted by the case manager, with supporting diagnostic~~  
 32 ~~information from the individual's medical provider to determine the individual's level of care,~~  
 33 ~~service needs, available resources, and potential funding resources using a Department~~  
 34 ~~prescribed instrument.~~ means a periodic comprehensive reevaluation with the individual receiving  
 35 services, appropriate collaterals, chosen by the individual, and case manager, to re-determine the  
 36 individual's level of functioning, service needs, available resources and potential funding  
 37 resources.

38  
 39 SYV. Resource Development means the study, establishment and implementation of additional  
 40 resources or services which will extend the capabilities of community LTSS systems to better  
 41 serve individuals receiving long-term services and individuals likely to need long-term services in  
 42 the future.

43 ZWT. Single Entry Point (SEP) means the availability of a single access or entry point within a local  
 44 area where an individual seeking or currently receiving LTSS can obtain LTSS information,  
 45 screening, assessment of need and referral to appropriate LTSS programs and case  
 46 management services.

1 ~~AAXU~~. Single Entry Point Agency means the organization selected to provide intake, screening, referral,  
2 eligibility determination, and case management functions for persons in need of LTSS within a  
3 Single Entry Point District.

4 ~~BBYV~~. Single Entry Point District means one or more counties that have been designated as a  
5 geographic region in which one agency serves as the Single Entry Point for persons in need of  
6 LTSS.

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

12 ~~CCZX~~. Target Group Criteria means the factors that define a specific population to be served through an  
13 HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic  
14 conditions, age, or diagnosis, and May include other criteria such as demonstrating an  
15 exceptional need.

## 18 8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

### 20 8.393.1.M. Functions of the Case Manager.

- 21 1. The SEP Agency's case manager(s) shall be responsible for: intake, screening and  
22 referral, ~~A~~assessment/~~R~~reassessment, development of Person-Centered Support Plans,  
23 ongoing case management, monitoring of individuals' health and welfare, documentation  
24 of contacts and case management activities in the Department-prescribed IMS, resource  
25 development, and case closure.
  - 26 a. The case manager shall contact the individual at least once within each quarterly  
27 period, or more frequently if warranted by the individual's condition or as  
28 determined by the rules of the LTSS Program in which the individual is enrolled.
  - 29 b. The case manager shall have in-person monitoring at least one (1) time during  
30 the ~~Support Plan~~Person-Centered Support Plan~~PCSP~~ -year. The case manager  
31 shall ensure one required monitoring is conducted in-person with the Member, in  
32 the Member's place of residence. Upon Department approval, contact may be  
33 completed by the case manager at an alternate location, via the telephone or  
34 using virtual technology methods. Such approval may be granted for situations  
35 in which ~~face-to-face~~in-person meetings would pose a documented safety risk to  
36 the case manager or client (e.g., natural disaster, pandemic, etc.).
  - 37 c. The case manager shall complete a new ULTC-100.2LOC Screen during a ~~face-~~  
38 ~~to-face~~in-person ~~R~~reassessment annually, or more frequently if warranted by the  
39 individual's condition or if required by the rules of the LTSS Program in which the  
40 individual is enrolled. Upon Department approval, ~~R~~reassessment may be  
41 completed by the case manager at an alternate location, via the telephone or  
42 using virtual technology methods. Such approval may be granted for situations in

1 which ~~face-to-face~~in-person meetings would pose a documented safety risk to  
2 the case manager or client (e.g., natural disaster, pandemic, etc.).

3 d. The case manager shall monitor the delivery of services and supports identified  
4 within the ~~Support Plan~~PCSP and the Prior Authorization Request (PAR). This  
5 includes monitoring:

6 i. The quality of services and supports provided;

7 ii. The health and safety of the individual; and

8 iii. The utilization of services.

9 e. The following criteria may be used by the case manager to determine the  
10 individual's level of need for case management services:

11 i. Availability of family, volunteer, or other support;

12 ii. Overall level of functioning;

13 iii. Mental status or cognitive functioning;

14 iv. Duration of disabilities;

15 v. Whether the individual is in a crisis or acute situation;

16 vi. The individual's perception of need and dependency on services;

17 vii. The individual's move to a new housing alternative; and

18 viii. Whether the individual was discharged from a hospital or Nursing  
19 Facility.

## 22 **8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY**

### 25 **8.393.2.B. Intake, Screening and Referral**

26 1. The intake, screening and referral function of a SEP Agency shall include, but not be  
27 limited to, the following activities:

28 a. The completion and documentation of the intake, screening and referral functions  
29 using the Department's prescribed intake, screening and referral instruments in  
30 the IMS;

31 SEPs may ask referring agencies to complete and submit an intake and  
32 screening form to initiate the process;



- 1 b. The provision of information and referral to other agencies, as needed, and the  
2 documentation of those referrals in the IMS;
- 3 c. A screening to determine whether a ~~functional-eligibility-assessment~~LOC Screen  
4 is ~~indicated~~needed;
- 5 d. The identification of potential payment source(s), including the availability of  
6 private funding resources; and
- 7 e. The implementation of a SEP Agency procedure for prioritizing urgent inquiries.
- 8 2. When LTSS are to be reimbursed through one or more of the publicly funded LTSS  
9 Programs served by the SEP system:
- 10 a. The SEP Agency shall verify the individual's demographic information collected  
11 during the intake;
- 12 b. The SEP Agency shall coordinate the completion of the financial eligibility  
13 determination by:
- 14 i. Verifying the individual's current financial eligibility status; or
- 15 ii. Referring the individual to the county department of social services of the  
16 individual's county of residence for application; or
- 17 iii. Providing the individual with financial eligibility application form(s) for  
18 submission, with required attachments, to the county department of  
19 social services for the county in which the individual resides; and
- 20 iv. Conducting and documenting follow-up activities to complete the  
21 ~~functional-eligibility-determination~~LOC Screen and ~~coordinate-facilitate~~  
22 the completion of the financial eligibility determination, as needed.
- 23 c. The determination of the individual's financial eligibility shall be completed by the  
24 county department of social services for the county in which the individual  
25 resides, pursuant to Section 8.100.7 A-U.
- 26 d. Individuals shall be notified by the SEP Agency at the time of their application for  
27 publicly funded ~~long-term services and supports-~~LTSS that they have the right to  
28 appeal actions of the SEP Agency, the Department, and contractors acting on  
29 behalf of the Department. The notification shall include the right to request a fair  
30 hearing before an Administrative Law Judge.
- 31 e. The county department shall notify the SEP Agency of the Medicaid application  
32 date for the individual seeking services upon receipt of the Medicaid application.
- 33 f. The county shall not notify the SEP Agency for individuals being discharged from  
34 a hospital or nursing facility or Adult Long-Term Home Health.

35 **8.393.2.C. Initial Assessment Level of Care Eligibility Determination**

- 36 1. ~~For additional guidance on the ULTC-100.2, as well as the actual tool itself, see Section~~  
37 ~~8.401.1. GUIDELINES FOR LONG TERM CARE SERVICES~~

- 1 a. The SEP Agency shall complete the ULTC 100.2 LOC Screen within the following time  
2 frames:
- 3 i.a. For an individual who is not being discharged from a hospital or a nursing facility,  
4 the individual assessment LOC Screen shall be completed within ten (10) working  
5 days after receiving confirmation that the Medicaid application has been received  
6 by the county department of social services, unless a different time frame  
7 specified below applies.
- 8 b.ii. For a resident who is changing pay source (Medicare/private pay to Medicaid) in  
9 the nursing facility, the SEP Agency shall complete the assessment LOC Screen  
10 within five (5) working days after notification by the nursing facility.
- 11 c.iii. For a resident who is being admitted to the nursing facility from the hospital, the  
12 SEP Agency shall complete the assessment LOC Screen, including a PASRR  
13 Level 1 Screen within two (2) working days after notification, as required by  
14 Section 8.401.18.
- 15 ~~1) For PASRR Level 1 Screen regulations, refer to 8.401.18, PRE-ADMISSION~~  
16 ~~SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED~~  
17 ~~SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS~~  
18 ~~WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY~~
- 19 d.b. For an individual who is being transferred from a nursing facility to an HCBS  
20 program or between nursing facilities, the SEP Agency shall complete the  
21 assessment LOC Screen within five (5) working days after notification by the  
22 nursing facility.
- 23 e.e. For an individual who is being transferred from a hospital to an HCBS program,  
24 the SEP Agency shall complete the assessment LOC Screen within two (2)  
25 working days after notification from the hospital.
- 26 2. ~~The start date of the Level of Care Eligibility Determination shall not be back dated by the~~  
27 ~~SEP. Neither the state nor its agent(s) will approve late PAR revisions. Under no~~  
28 ~~circumstances shall the start date for functional eligibility Level of Care Eligibility~~  
29 ~~Determination be backdated by the SEP, based on the~~ See Section 8.486.30, LONG  
30 TERM SERVICES AND SUPPORTS-LEVEL OF CARE ELIGIBILITY DETERMINATION  
31 SCREEN (LOC SCREEN). Under no circumstances shall late PAR revisions be approved  
32 by the state or its agent. See and Section 8.485.90 STATE PRIOR AUTHORIZATION OF  
33 SERVICES. ASSESSMENT.
- 34 3. ~~The A~~ trained SEP Agency Case Manager shall complete the ULTC 100.2 LOC Screen  
35 for LTSS pPrograms, in accordance with Section 8.401.1.
- 36 a. If enrolled as a provider of case management services for Children's Home and  
37 Community Based Services (CHCBS), SEP agencies may complete the ULTC  
38 100.2 LOC Screen for CHCBS.
- 39 4. The SEP Agency shall assess the individual's functional status level of care face-to-  
40 face in-person, in the location where the person currently resides. Upon Department  
41 approval, assessment the LOC Screen may be completed-conducted by the case  
42 manager at an alternate location, via the telephone or using virtual technology methods.  
43 Such approval may be granted for situations in which face-to-face in-person meetings  
44 would pose a documented safety risk to the case manager or client (e.g. natural disaster,  
45 pandemic, etc.). -

- 1 5. The Applicant may choose to have family members, advocates, friends and/or  
 2 caregivers, as appropriate, participate as respondents in the assessment process either  
 3 by attending with the Applicant or separate interviews with the case manager.
- 4 5. The SEP Agency shall conduct the following activities for a comprehensive  
 5 assessment/Level of Care Eligibility Determination of an individual seeking  
 6 services/Applicant:
- 7 a. Obtain supporting diagnostic information, including but not limited to, through the  
 8 Professional/Professional Medical Information Page (PMIP) form from the  
 9 individual's medical provider for individuals in nursing facilities, HCBS Programs  
 10 for Community Mental Health Supports Waiver (HCBS-CMHS), Persons with a  
 11 Brain Injury Waiver (HCBS-BI), Elderly, Blind and Disabled Wavier (HCBS-EBD),  
 12 Persons with a Spinal Cord Injury/Complementary and Integrated Health Waiver  
 13 (HCBS-CHISC) and Children with a Life Limiting Illness Waiver (HCBS-CLLI).
- 14 i. If enrolled as a provider of case management services for Children's  
 15 Home and Community Based Services (CHCBS), SEP agencies may  
 16 obtain diagnosis(es) information from the individual's medical provider.
- 17 b. Determine the individual's functional capacity/level of care during an evaluation,  
 18 with observation of the individual and family, if appropriate, in his or her  
 19 residential setting and determine the functional capacity score in each of the  
 20 areas identified in Section 8.401.1 using a Department prescribed instrument as  
 21 outlined in Section 8.401.1.
- 22 c. Determine the length of stay for individuals seeking/receiving nursing facility care  
 23 using the Nursing Facility Length of Stay Assignment Form in accordance with  
 24 Section 8.402.10.15.
- 25 d. Determine/Assess the need for long-term services and supports/LTSS services  
 26 on the ULTC-100.2 during the evaluation using a Department prescribed  
 27 instrument.
- 28
- 29
- 30 e. For HCBS Programs and admissions to nursing facilities from the community, the  
 31 original ULTC-100.2 copy a copy of the LOC Eligibility Determination shall be sent  
 32 to the prospective provider agencies/agency, and a copy shall be placed-retained  
 33 in the individual's agency's case record for the individual. If there are changes in  
 34 the individual's condition which significantly change the payment or services  
 35 amount, a copy of the ULTC-100.2/LOC Eligibility Determination documenting the  
 36 change must be sent to the provider agency, and a copy is to be maintained in  
 37 the agency's case record for the individual.
- 38 f. When the SEP Agency assesses the individual's functional capacity-on-the  
 39 ULTC-100.2/level of care using the Department's prescribed instrument, the  
 40 Assessment is not an adverse action that is directly appealable. The individual's  
 41 right to appeal arises only when an individual is denied enrollment into an LTSS  
 42 Program by the SEP based on the ULTC-100.2 thresholds for functional/Level of  
 43 Care e/Eligibility Determination as outlined in Section 8.401.1. The appeal  
 44 process is governed by the provisions of Section 8.057.

- 1           6.       The case manager and the nursing facility shall complete the following activities for  
2           discharges from nursing facilities:
- 3           a.       The nursing facility shall contact the SEP Agency in the district where the nursing  
4           facility is located to inform the SEP Agency of the discharge if placement into  
5           home- or community-based services is being considered.
- 6           b.       The nursing facility and the SEP case manager shall coordinate the discharge  
7           date.
- 8           c.       When placement into HCBS Programs is being considered, the SEP Agency  
9           shall determine the remaining length of stay.
- 10           i.       If the end date for the nursing facility is indefinite, the SEP Agency shall  
11           assign an end date not past one (1) year from the date of the most  
12           recent assessmentLevel of Care Eligibility Determination.
- 13           ii.       If the ULTC 100.2Level of Care Eligibility Determination is less than six  
14           (6) months, the SEP Agency shall generate a new certificationLevel of  
15           Care Determinationpage that reflects the end date that was assigned to  
16           the nursing facility.
- 17           iii.       The SEP Agency shall complete a new ULTC 100.2LOC Screen if the  
18           current completion date is six (6) months old or older. The assessment  
19           results shall be used to determine level of care and the new length of  
20           stay.
- 21           iv.       The SEP Agency shall ~~send a provide copy of the~~ ULTC 100.2Level of  
22           Care Determination-certification page to the eligibility enrollment  
23           specialist at the county department of social services.
- 24           v.       The SEP Agency shall submit the HCBS prior authorization request to  
25           the Department or its fiscal agent.
- 26       7.       For individuals receiving services in HCBS Programs who are already determined to be  
27       at the nursing facility level of care and seeking admission into a nursing facility, the SEP  
28       Agency shall:
- 29           a.       Coordinate the admission date with the facility;
- 30           b.       Complete the PASRR Level 1 Screen, and if there is an indication of a mental  
31           illness or developmental disability, submit to the Department or its agent to  
32           determine whether a PASRR Level 2 evaluation is required;
- 33           c.       Maintain the Level 1 Screen in the individual's case file regardless of the  
34           outcome of the Level 1 Screen; and
- 35           d.       If appropriate, assign the remaining HCBS length of stay towards the nursing  
36           facility admission if the completion date of the ULTC 100.2Level of Care Eligibility  
37           Determination is not six (6) months old or older.

38       **8.393.2.D.       Ongoing Level of Care Eligibility DeterminationReassessment**

- 1           1.       The case manager shall determine level of care eligibility on an ongoing basis~~commence~~  
2           ~~a regularly scheduled reassessment~~ by completing the LOC Screen at least one (1) but  
3           no more than three (3) months before the required completion date. The case manager  
4           shall complete a reassessment-LOC Screen of an individual receiving services within  
5           twelve (12) months of the initial or most recent LOC screen ~~individual assessment or the~~  
6           ~~most recent reassessment. A reassessment shall be completed sooner if the individual's~~  
7           ~~condition changes or if required by program criteria.~~
- 8           2.       A Level of Care Eligibility Determination shall be completed sooner if the individual's  
9           ~~condition changes or if required by program criteria.~~ The case manager shall update  
10           ~~document changes~~ the information provided at the previous assessment or  
11           ~~reassessment,~~ utilizing the ULTC 100.2 LOC Screen.
- 12           3.       Reassessment-Ongoing Level of Care Determination assessments shall be made  
13           according to 8.393.2.C.4 and shall include the following activities:~~include, but not be~~  
14           ~~limited to, the following activities:~~
- 15           ~~a.       Assess the individual's functional status face to face, in the location where the person~~  
16           ~~currently resides.. Upon Department approval, assessment may be completed by the~~  
17           ~~case manager at an alternate location, via the telephone or using virtual technology~~  
18           ~~methods. Such approval may be granted for situations in which face to face meetings~~  
19           ~~would pose a documented safety risk to the case manager or client (e.g. natural disaster,~~  
20           ~~pandemic, etc.).~~
- 21           ~~a~~b.       Review Person-Centered Support Plan, service agreements and provider  
22           contracts or agreements;
- 23           ~~b~~c.       Evaluate effectiveness, appropriateness and quality of services and supports;
- 24           ~~c~~d.       Verify continuing Medicaid eligibility, other financial and program eligibility;
- 25           ~~e.       Annually, or more often if indicated, complete a new Support Plan and service~~  
26           ~~agreements;~~
- 27           f.       Inform the individual's medical provider of any changes in the individual's needs;
- 28           g.       Maintain appropriate documentation, including type and frequency of LTSS the  
29           individual is receiving for ~~certification~~ approval of continued program eligibility, if  
30           required by the program;
- 31           h.       Refer the individual to community resources as needed and develop resources  
32           for the individual if the resource is not available within the individual's community;  
33           and
- 34           j.       Submit appropriate documentation for authorization of services, in accordance  
35           with program requirements.
- 36           4.       The SEP Agency shall be responsible for completing Level of Care Eligibility  
37           Determination R~~re~~assessments of individuals receiving care in a nursing facility. A  
38           R~~re~~assessment shall be completed if the nursing facility determines there has been a  
39           significant change in the resident's physical/medical status, if the individual requests a  
40           R~~re~~assessment or if the case manager assigns a definite determination end date. The  
41           nursing facility shall be responsible to send the SEP Agency a referral for a ~~new~~  
42           ~~assessment~~Reassessment, as needed.

- 1           5.       In order to assure quality of services and supports and the health and welfare of the  
2           individual, the case manager shall ask for permission from the individual to observe the  
3           individual's residence as part of the reassessment process, but this shall not be  
4           compulsory of the individual. Upon Department approval, observation may be completed  
5           using virtual technology methods or delayed. Such approval may be granted for  
6           situations in which in-person observation would pose a documented safety risk to the  
7           case manager or client (e.g. natural disaster, pandemic, etc.). -

8       **8.393.2.E.       Person-Centered Support Plan**

- 9           1.       The nursing facility shall be responsible for developing a Support Plan for individuals  
10          residing in nursing facilities.
- 11          2.       The SEP Agency shall develop the Person-Centered Support Plan (PCSP) for individuals  
12          not residing in nursing facilities within fifteen (15) working days after determination of  
13          program eligibility.
- 14          3.       The SEP Agency shall:
- 15           a.       Address the functional needs identified through the individual assessment;
- 16           b.       Offer informed choices to the individual regarding the services and supports they  
17           receive and from whom, as well as the documentation of services needed,  
18           including type of service, specific functions to be performed, duration and  
19           frequency of service, type of provider and services needed but that may not be  
20           available;
- 21           c.       Include strategies for solving conflict or disagreement within the process,  
22           including clear conflict-of-interest guidelines for all planning participants;
- 23           d.       Reflect cultural considerations of the individual and be conducted by providing  
24           information in plain language and in a manner that is accessible to individuals  
25           with disabilities and individuals who have limited English proficiency;
- 26           e.       Formalize the Person-Centered Support Plan agreement, including appropriate  
27           physical or digital signatures, in accordance with program requirements;
- 28           f.       Contain prior authorization for services, in accordance with program directives,  
29           including cost containment requirements;
- 30           g.       Contain prior authorization of Adult Long-Term Home Health Services, pursuant  
31           to Sections 8.520-8.527;
- 32           h.       Include a method for the individual to request updates to the plan as needed;
- 33           i.       Include an explanation to the individual of complaint procedures;
- 34           j.       Include an explanation to the individual of critical incident procedures; and
- 35           k.       Explain the appeals process to the individual.
- 36          4.       The case manager shall provide necessary information and support to ensure that the  
37          individual directs the process to the maximum extent possible and is enabled to make



1 informed choices and decisions and shall ensure that the development of the Person-  
2 Centered Support Plan:

- 3 a. Occurs at a time and location convenient to the individual receiving services;
- 4 b. Is led by the individual, the individual's parent's (if the individual is a minor),  
5 and/or the individual's authorized representative;
- 6 c. Includes people chosen by the individual;
- 7 d. Addresses the goals, needs and preferences identified by the individual  
8 throughout the planning process;
- 9 e. Includes the arrangement for services by contacting service providers,  
10 coordinating service delivery, negotiating with the provider and the individual  
11 regarding service provision and formalizing provider agreements in accordance  
12 with program rules; and
- 13 f. Includes referral to community resources as needed and development of  
14 resources for the individual if a resource is not available within the individual's  
15 community.

16 5. Prudent purchase of services:

- 17 a. The case manager shall arrange services and supports using the most cost-  
18 effective methods available in light of the individual's needs and preferences.
- 19 b. When family, friends, volunteers or others are available, willing and able to  
20 support the individual at no cost, these supports shall be utilized before the  
21 purchase of services, providing these services adequately meet the individual's  
22 needs.
- 23 c. When public dollars must be used to purchase services, the case manager shall  
24 encourage the individual to select the lowest-cost provider of service when  
25 quality of service is comparable.
- 26 d. The case manager shall assure there is no duplication in services provided by  
27 LTSS programs and any other publicly or privately funded services.

- 28 6. In order to assure quality of services and supports and health and welfare of the  
29 individual, the case manager shall observe the individual's residence prior to completing  
30 and submitting the individual's Person-Centered Support Plan. Upon Department  
31 approval, observation may be completed using virtual technology methods may be  
32 delayed. Such approval may be granted for situations in which in-person observation  
33 would pose a documented safety risk to the case manager or client (e.g. natural disaster,  
34 pandemic, etc.).

35 **8.393.2.F. Cost Containment**

- 36 1. If the case manager expects that the cost of services required to support the individual  
37 will exceed the Department-determined Cost Containment Review Amount, the  
38 Department or its agent will review the Person-Centered Support Plan to determine  
39 whether the individual's request for services is appropriate and justifiable based on the

1 individual's condition and quality of life and, if it is, will sign the Prior Authorization  
2 Request.

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

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

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

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

### 10 **8.393.2.G. Ongoing Case Management**

11 1. The functions of the ongoing case manager shall be:

12 a. Assessment/Reassessment: The case manager shall continually identify  
13 individuals' strengths, needs, and preferences for services and supports as they  
14 change or as indicated by the occurrence of critical incidents;

15 b. Person Centered Support Plan (PCSP) Development: The case manager shall  
16 work with individuals to design and update Support Plansa PCSP that address  
17 individuals' goals and assessed needs and preferences;

18 c. Referral: The case manager shall provide information to help individuals choose  
19 qualified providers and make arrangements to assure providers follow the  
20 Support Plan,PCSP including any subsequent revisions based on the changing  
21 needs of individuals;

22 d. Monitoring: The case manager shall ensure that individuals obtain authorized  
23 services in accordance with their PCSPSupport Plan and monitor the quality of  
24 the services and supports provided to individuals enrolled in LTSS Programs.  
25 Monitoring shall:

26 1. Be performed when necessary to address health and safety and services  
27 in the ~~care plan~~; Person-Centered Support PlanPCSP.

28 2. Include activities to ensure:

29 A. Services are being furnished in accordance with the individual's  
30 Support Plan;PCSP

31 B. Services in the Support Plan-PCSP are adequate; and

32 C. Necessary adjustments in the Support Plan-PCSP and service  
33 arrangements with providers are made if the needs of the  
34 individual have changed;

35 3. Include an in-person contact and observation with the individual in their  
36 place of residence, at least once per certification period. Additional in  
37 person monitoring shall be performed when required by the individual's  
38 condition or circumstance. Upon Department approval, observation may



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

5 e. Remediation: The case manager shall identify, resolve, and to the extent  
6 possible, establish strategies to prevent Critical Incidents and problems with the  
7 delivery of services and supports.

8 2. The case manager shall assure quality of services and supports, the health and welfare  
9 of the individual, and individual safety, satisfaction and quality of life, by monitoring  
10 service providers to ensure the appropriateness, timeliness and amount of services  
11 provided. The case manager shall take corrective actions as needed.

12 3. The case manager may require the Contractor to revise the Support Plan PCSP and Prior  
13 Authorization if the results of the monitoring indicate that the plan is inappropriate, the  
14 services as described in the plan are untimely, or the amount of services need to be  
15 changed to meet the Client's needs.

16 4. Ongoing case management shall include, but not be limited to, the following tasks:

17 a. Review of the individual's Support Plan PCSP and service agreements;

18 b. Contact with the individual concerning their safety, quality of life and satisfaction  
19 with services provided;

20 c. Contact with service providers to coordinate, arrange or adjust services, to  
21 address quality issues or concerns and to resolve any complaints raised by  
22 individuals or others;

23 d. Conflict resolution and/or crisis intervention, as needed;

24 e. Informal assessment of changes in individual functioning, service effectiveness,  
25 service appropriateness and service cost-effectiveness;

26 f. Notification of appropriate enforcement agencies, as needed; and

27 g. Referral to community resources as needed.

28 5. The case manager shall immediately report, to the appropriate agency, any information  
29 which indicates an overpayment, incorrect payment or mis-utilization of any public  
30 assistance benefit and shall cooperate with the appropriate agency in any subsequent  
31 recovery process, in accordance with Department of Human Services Income  
32 Maintenance Rules at 9 C.C.R. 2503-8, Section 3.810 and Section 8.076.

33 6. The case manager shall contact the individual at least quarterly, or more frequently as  
34 determined by the individual's needs or as required by the program.

35 7. The case manager shall review the Department prescribed assessment and the Support  
36 Plan PCSP with the individual every six (6) months. The review shall be conducted by  
37 telephone or at the individual's place of residence, place of service or other appropriate  
38 setting as determined by the individual's needs or preferences.

- 1 8. The case manager shall complete a new ULTC 100.2 when there is a significant change  
2 in the individual's condition and when the individual changes LTSS programs.
- 3 9. The case manager shall contact the service providers, as well as the individual, to  
4 monitor service delivery as determined by the individual's needs and as required by the  
5 authorities applicable to the service.
- 6 10. Case Managers shall report critical incidents within 24 hours of notification within the  
7 State Approved IMS.
- 8 a. Critical Incident reporting is required when the following occurs
- 9 i. Injury/Illness;
- 10 ii. Missing Person;
- 11 iii. Criminal Activity;
- 12 iv. Unsafe Housing/Displacement;
- 13 v. Death;
- 14 vi. Medication Management Issues;
- 15 vii. Other High-Risk Issues;
- 16 viii. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;
- 17 ix. Damage to the Consumer's Property/Theft.
- 18 b. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which  
19 require emergency medical treatment or result in hospitalization or death shall be  
20 reported immediately to the Agency administrator or designee.
- 21 c. Case Managers shall comply with mandatory reporting requirements set forth at  
22 Section 18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102,  
23 C.R.S.
- 24 d. Each Critical Incident Report must include:
- 25 i. incident type
- 26 a. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined  
27 at Section 19-1-103, 26-3.1-101, 16-22-102 (9), and 25.5-10-202  
28 C.R.S.
- 29 b. Non-Mane: A Critical Incident, including but not limited to, a  
30 category of criminal activity, damage to a consumer's property,  
31 theft, death, injury, illness, medication management issues,  
32 missing persons, unsafe housing or displacement, other high-risk  
33 issues.
- 34 ii. Date and time of incident;

- 1                   iii.     Location of incident, including name of facility, if applicable;
- 2                   iv.     Individuals involved;
- 3                   v.     Description of incident, and
- 4                   vi.     Resolution of incident, if applicable.
- 5                   e.     The Case Manager shall complete required follow up activities and reporting in
- 6                         the State approved IMS within assigned timelines.

7   **8.393.2.H.     Case Recording/Documentation**

- 8           1.     The SEP Agency shall complete and maintain all required records included in the State
- 9                 approved IMS and shall maintain individual case records at the Agency level for any
- 10                additional documents associated with the individual applying for or enrolled in a LTSS
- 11                Program.
- 12           2.     The case record and/or IMS shall include:
  - 13               a.     Identifying information, including the individual's state identification (Medicaid)
  - 14                         number and Social Security number (SSN);
  - 15               b.     All State-required forms; and
  - 16               c.     Documentation of all case management activity required by these regulations.
- 17           3.     Case management documentation shall meet all the following standards:
  - 18               a.     Documentation must be objective and understandable for review by case
  - 19                         managers, supervisors, program monitors and auditors;
  - 20               b.     Entries must be written at the time of the activity or no later than five (5) business
  - 21                         days from the time of the activity;
  - 22               c.     Entries must be dated according to the date of the activity, including the year;
  - 23               d.     Entries must be entered into Department's IMS;
  - 24               e.     The person making each entry must be identified;
  - 25               f.     Entries must be concise, but must include all pertinent information;
  - 26               g.     All information regarding an individual must be kept together, in a logical
  - 27                         organized sequence, for easy access and review by case managers,
  - 28                         supervisors, program monitors and auditors;
  - 29               h.     The source of all information shall be recorded, and the record shall clarify
  - 30                         whether information is observable and objective fact or is a judgment or
  - 31                         conclusion on the part of anyone;
  - 32               i.     All persons and agencies referenced in the documentation must be identified by
  - 33                         name and by relationship to the individual;

1 j. All forms prescribed by the Department shall be completely and accurately filled  
2 out by the case manager; and

3 k. Whenever the case manager is unable to comply with any of the regulations  
4 specifying the time frames within which case management activities are to be  
5 completed, due to circumstances outside the SEP Agency's control, the  
6 circumstances shall be documented in the case record. These circumstances  
7 shall be taken into consideration upon monitoring of SEP Agency performance.

8 4. Summary recording to update a case record shall be entered into the IMS at least every  
9 six (6) months, whenever a case is transferred from one SEP Agency to another, and  
10 when a case is closed.

#### 11 **8.393.4. COMMUNICATION**

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

14 1. The case manager shall inform the eligibility enrollment specialist of any and all changes  
15 affecting the participation of an individual receiving services in SEP Agency-served  
16 programs, including changes in income, within one (1) working day after the case  
17 manager learns of the change. The case manager shall provide the eligibility enrollment  
18 specialist with copies of the certification page of the approved ULTC-100.2 form.

19 2. If the individual has an open adult protective services (APS) case at the county  
20 department of social services, the case manager shall keep the individual's APS worker  
21 informed of the individual's status and shall participate in mutual staffing of the  
22 individual's case.

23 3. The case manager shall inform the individual's physician of any significant changes in the  
24 individual's condition or needs.

25 4. The case manager shall report to the Colorado Department of Public Health and  
26 Environment (CDPHE) any congregate facility which is not licensed.

#### 27 **8.393.5 FUNCTIONAL ELIGIBILITY LEVEL OF CARE ELIGIBILITY DETERMINATION**

28 A. The SEP Agency shall be responsible for the following:

29 1. Ensuring that the ~~ULTC 100.2 is~~ Level of Care Screen is completed in the IMS in  
30 accordance with Section 8.401.1 and justifies that the individual seeking or receiving  
31 services ~~should be approved is eligible~~ or ~~disapproved ineligible~~ for admission to or  
32 continued stay in an applicable LTSS program.

33 2. Once the assessment is complete in the IMS, the case manager shall generate a Level of  
34 Care Eligibility Determination certification page in Determination in the IMS within three (3)  
35 business days for hospital discharge to a Nursing Facility, within six (6) business days for  
36 Nursing Facility discharge and within eleven (11) business days of receipt of referral.

37 3. If the assessment indicates approval, the SEP Agency shall notify the appropriate parties.

38 4. If the assessment indicates denial, the SEP Agency shall notify the appropriate parties in  
39 accordance with 8.393.3.A.2.

- 1           5.       If the individual or individual's legally authorized representative appeals, the SEP Agency  
2 shall process the appeal request, according to Section 8.057.

3       **8.393.6.       INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES**

4       **8.393.6.A.       Intercounty Transfers**

- 5           1.       SEP agencies shall complete the following procedures to transfer individuals receiving  
6 case management services to another county within the same SEP district:
- 7           a.       Notify the current county department of social services eligibility enrollment  
8 specialist of the individual's plans to relocate to another county and the date of  
9 transfer, with financial transfer details at Section 8.100.3.C.
- 10          b.       If the individual's current service providers do not provide services in the area  
11 where the individual is relocating, make arrangements, in consultation with the  
12 individual, for new service providers.
- 13          c.       In order to assure quality of services and supports and health and welfare of the  
14 individual, the case manager must observe and evaluate the condition of the  
15 individual's residence. Upon Department approval, observation may be  
16 completed using virtual technology methods. Such approval may be granted for  
17 situations in which in-person observation would pose a documented safety risk to  
18 the case manager or client (e.g., natural disaster, pandemic, etc.).
- 19          d.       If the individual is moving from one county to another to enter an Alternative Care  
20 Facility (ACF), forward copies of the following individual records to the ACF prior  
21 to the individual's admission to the facility:
- 22           i.       ~~ULTC 100.2, Level of Care Eligibility Determination, certified by the SEP;~~
- 23           ii.       The individual's updated draft Prior Authorization Request (PAR) and/or  
24 Post Eligibility Treatment of Income (PETI) form; and
- 25           iii.       Verification of Medicaid eligibility status.

26       **8.393.6.B.       Inter-district Transfers**

- 27           1.       SEP Agencies shall complete the following procedures in the event an individual  
28 receiving services transfers from one SEP district to another SEP district:
- 29           a.       The transferring SEP Agency shall contact the receiving SEP Agency by  
30 telephone and give notification that the individual is planning to transfer,  
31 negotiate a transfer date and provide all necessary information.
- 32           b.       The transferring SEP Agency shall notify the original county department of social  
33 services eligibility enrollment specialist of the individual's plan to transfer and the  
34 transfer date, and eligibility enrollment specialist shall follow rules described in  
35 Section 8.100.3.C. The receiving SEP Agency shall coordinate the transfer with  
36 the eligibility enrollment specialist of the new county.
- 37           c.       The transferring SEP Agency shall make available in the IMS the individual's  
38 case records to the receiving SEP Agency prior to the relocation.

- 1 d. If the individual is moving from one SEP District to another SEP District to enter  
2 an ACF, the transferring SEP Agency shall forward copies of the individual's  
3 records to the ACF prior to the individual's admission to the facility, in  
4 accordance with section 8.393.6.A.
- 5 e. To ensure continuity of services and supports, the transferring SEP Agency and  
6 the receiving SEP Agency shall coordinate the arrangement of services prior to  
7 the individual's relocation to the receiving SEP Agency's district and within ten  
8 (10) working days after notification of the individual's relocation.
- 9 f. The receiving SEP Agency shall complete a ~~face-to-face~~ in person meeting  
10 with the individual in the individual's residence and a case summary update  
11 within ten (10) working days after the individual's relocation, in accordance with  
12 assessment procedures for individuals served by SEP Agencies. Upon  
13 Department approval, meeting may be completed using virtual technology  
14 methods or may be delayed. Such approval may be granted for situations in  
15 which in-person observation would pose a documented safety risk to the case  
16 manager or client (e.g., natural disaster, pandemic, etc.)
- 17 g. The receiving SEP Agency shall review the PCSP Support Plan and the ULTC  
18 400-2LOC Screen and change or coordinate services and providers as  
19 necessary.
- 20 h. If indicated by changes in the PCSP Support Plan, the receiving SEP Agency  
21 shall revise the PCSP Support Plan and prior authorization forms as required by  
22 the publicly funded program.
- 23 i. Within thirty (30) calendar days of the individual's relocation, the receiving SEP  
24 Agency shall forward to the Department, or its fiscal agent, revised forms as  
25 required by the publicly funded program.

#### 29 **8.400 LONG-TERM CARE**

- 30 .12 Home and Community Based Services under the Medicaid Waivers include distinct service  
31 programs designed as alternatives to standard Medicaid nursing facility or hospital services for  
32 discrete categories of clients. These waivers are Home and Community Based Services Waiver  
33 for Persons Who Are Elderly, Blind and Disabled (HCBS-EBD), Home and Community Based  
34 Services Waiver for Complementary and Integrative Health ~~Persons with Spinal Cord Injury~~  
35 (HCBS-~~SCI~~CHI), Community Mental Health Supports Waiver (HCBS-CMHS), Home and  
36 Community Based Services Waiver for Persons With Brain Injury (HCBS-BI); Home and  
37 Community Based Services Waiver for Persons with Developmental Disabilities (HCBS-DD),  
38 Supportive Living Services Waiver (HCBS-SLS); Home and Community Based Services Waiver  
39 for Children with Autism (HCBS-CWA), Children with Life-limiting Illness Waiver (HCBS-CLLI),  
40 Children's Habilitation Residential Program Waiver (HCBS-CHRP), Children Extensive Supports  
41 Waiver (HCBS-CES), Children's Home and Community Based Services Waiver (HCBS-CHCBS)  
42 and Home and Community Based Services for those inappropriately residing in nursing facilities  
43 (OBRA '87).

- 1 .13 Unless specified by reference to the specific programs described above, the term Home and  
2 Community Based Services where it appears in these rules and regulations shall refer to the  
3 programs described herein above, and the rules and regulations within this section shall be  
4 applicable to all Home and Community Based Services programs.
- 5 .14 Nursing facilities are prohibited from admitting any new client who has mental illness or  
6 intellectual or developmental disability, as defined in Section 8.401.18 Determination Criteria for  
7 Mentally Ill or Individuals with an Intellectual or Developmental Disability unless that client has  
8 been determined to require the level of services provided by a nursing facility as defined in  
9 Section 8.401.19.
- 10 .15 Clients eligible for Home and Community Based Services are eligible for all Medicaid services  
11 including home health services.
- 12 .16 Target Population Definitions. For purposes of determining appropriate type of long-term  
13 services, including home and community-based services, as well as providing for a means of  
14 properly referring clients to the appropriate community agency, the following target group  
15 designations are established:
- 16 A. Developmentally Disabled - includes all clients whose need for long-term care services is  
17 based on a diagnosis of Developmental Disability and Related Conditions, as defined in  
18 Section 8.401.18.
- 19 B. Mentally Ill - includes all clients whose need for long-term care is based on a diagnosis of  
20 mental disease as defined in Section 8.401.18.
- 21 C. Functionally Impaired Elderly - includes all clients who meet the level of care ~~screening~~  
22 ~~guidelines~~ for SNF or ICF care, as determined by the LOC Screen and who are age 65 or  
23 over. ~~Clients who are mentally ill, as defined in Section 8.401.18, shall not be included in~~  
24 ~~the target group of Functionally Impaired Elderly, unless the person's need for long term~~  
25 ~~care services is primarily due to physical impairments that are not caused by any~~  
26 ~~diagnosis included in the definition of mental illness at Section 8.401.18, and determined~~  
27 ~~by (URC) from the medical evidence.~~
- 28 D. Physically Disabled or Blind Adult - includes all clients who meet the level of care  
29 ~~screening guidelines~~ for SNF or ICF care, as determined by the LOC Screen and who are  
30 age 18 through 64. ~~Clients who are developmentally disabled or mentally ill, as defined in~~  
31 ~~Section 8.401.18, shall not be included in the Physically Disabled or Blind target group,~~  
32 ~~unless the person's need for long term care services is primarily due to physical~~  
33 ~~impairments not caused by any diagnosis included in the definition of intellectual or~~  
34 ~~developmental disability or mental illness at Section 8.401.18, as determined by URC~~  
35 ~~from the medical evidence.~~
- 36 E. Persons Living with AIDS - includes all clients of any age who meet either the nursing  
37 home level of care or acute level of care ~~screening guidelines~~ for nursing facilities or  
38 hospitals and have the -diagnosis of Human Immunodeficiency Virus (HIV) or Acquired  
39 Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may  
40 alternatively request to be designated as any other target group for which they meet the  
41 definitions above.
- 42 .17 Services in Home and Community Based Services programs established in accordance with  
43 federal waivers shall be provided to clients in accordance with the URC determined target  
44 populations as defined herein above.



1 **8.401 LEVEL OF CARE SCREENING GUIDELINES**

2 .01 The client must have been found by the URC Case Management Agency to meet the applicable  
3 level of care guidelines for the type of services to be provided.

4 .02 The URC Case Management Agency shall not make a Llevel of Care Eligibility Ddetermination  
5 unless the recipient has been determined to be Medicaid eligible or an application for Medicaid  
6 services has been filed with the County Department of Social/Human services.

7 .03 Payment for skilled (SNF) and intermediate nursing home care (ICF) Payment for skilled (SNF)  
8 and intermediate nursing home care (ICF) will only be made for clients whose functional Level of  
9 Care Eligibility Determination assessment and frequency of need for skilled and maintenance  
10 services meet the level of care guidelines for long-term care.

11 .04 Payment for care in an intermediate care facility for individuals with intellectual disabilities  
12 (ICF/IID) will only be made for developmentally disabled clients whose programmatic and/or  
13 health care needs meet the level of care guidelines for the appropriate class of ICF/IIDs.

14 .05 Services provided by nursing facilities are available to those clients/individuals who that meet the  
15 guidelines-level of care below and are not identified as mentally ill or individuals with an  
16 intellectual or developmental disability by the Determination Criteria for Mentally Ill or Individuals  
17 with an Intellectual or Developmental Disability in Section 8.401.18.

18 **8.401.1 GUIDELINES FOR LONG TERM CARE SERVICES/LONG-TERM SERVICES AND**  
19 **SUPPORTS LEVEL OF CARE -ELIGIBILITY DETERMINATION (CLASS I SNF AND ICF**  
20 **FACILITIES, HCBS-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-SCI, HCBS-CLLI,**  
21 **HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP, PACE and Long-term Home Health)**

22 .11 ~~The guidelines-Eligibility~~ for long-term care ~~are is~~ based on a ~~level of care functional needs/OC~~  
23 ~~Screen, as defined in Section 8.390.1, -assessment~~ in which ~~an~~ individual's ~~needs~~ are evaluated  
24 in at least the following areas of activities of daily living:

- 25 - Mobility
- 26 - Bathing
- 27 - Dressing
- 28 - Eating
- 29 - Toileting
- 30 - Transferring
- 31 - Need for supervision

32 ~~A. The functional needs of an individual ages 18 and under shall be assessed in accordance~~  
33 ~~with Appendix A, the Age Appropriate Guidelines for the Use of ULTC 100.2 on Children.~~

34 .12 Skilled services shall be defined as those services which can only be provided by a skilled person  
35 such as a nurse or licensed therapist or by a person who has been extensively trained to perform  
36 that service.



1 .13 Maintenance services shall be defined as those services which may be performed by a person  
 2 who has been trained to perform that specific task, e.g., a family member, a nurses' aide, a  
 3 therapy aide, visiting homemaker, etc.

4 .14 Skilled and maintenance services are performed in the following areas:

- 5 - Skin care
- 6 - Medication
- 7 - Nutrition
- 8 - Activities of daily living
- 9 - Therapies
- 10 - Elimination
- 11 - Observation and monitoring

12 .15

13 A. The ~~URC case management agency~~ shall certify as to the ~~functional~~ need for the nursing  
 14 facility level of care. ~~A URC reviews the information submitted on the, as demonstrated~~  
 15 ~~by ULTC 100.2 the Level of Care Eligibility Determination Screen outcome and assigns a~~  
 16 ~~score to each of the functional areas described using criteria outlined in 10 CCR 2505-10~~  
 17 ~~Section 8.401.11. The scores in each of the functional areas are based on a set of criteria~~  
 18 ~~and weights approved by the State which measures the degree of impairment in each of~~  
 19 ~~the functional areas. When the score in a minimum of two ADLs or the score for one~~  
 20 ~~category of supervision is at least a (2), the URC may certify that the person being~~  
 21 ~~reviewed is eligible for nursing facility level of care.~~

22 ~~B.~~ The URC's review shall include the information provided by the functional assessment  
 23 ~~screen~~ LOC Screen.

24 B.G. A person's need for ~~basic~~ Medicaid state plan benefits is not a proper consideration in  
 25 determining whether a person needs long-term care services (including Home and  
 26 Community Based Services).

27 ~~D.~~ ~~The ULTC 100.2 shall be the comprehensive and uniform client assessment process for~~  
 28 ~~all individuals in need of long-term care, the purpose of which is to determine the~~  
 29 ~~appropriate services and levels of care necessary to meet clients' needs, to analyze~~  
 30 ~~alternative forms of care and the payment sources for such care, and to assist in the~~  
 31 ~~selection of long-term care programs and services that meet clients' needs most cost-~~  
 32 ~~efficiently.~~

### 33 .16 LONG-TERM CARE ELIGIBILITY ASSESSMENTS

34 The Department is implementing a new Level of Care Eligibility Determination Screen instrument- the  
 35 Colorado Single Assessment Level of Care Screen, or CSA LOC Screen. The new LOC Screen will  
 36 replace the current instrument, the Uniform Long-Term Care (ULTC) 100.2. The intent of the new  
 37 instrument is to better understand individual needs, obtain objective and consistent assessment data,  
 38 including standardized Functional Assessment Standardized Items (FASI), and is not intended to reduce  
 39 eligibility or services. The Department will implement the new LOC Screen gradually, meaning the ULTC

1 100.2 and the new CSA LOC Screen instruments will both be in use concurrently for Level of Care  
 2 Eligibility Determination Screens until the new CSA LOC Screen has been fully implemented across  
 3 Colorado. During the transition, Case Management Agencies will use ~~only one of~~ one of the two  
 4 instruments, as determined by the Department, for initial and ongoing Level of Care Eligibility  
 5 Determinations.

6 **A. UNIFORM LONG-TERM CARE 100.2**

7 ~~General Instructions:~~ To qualify for Medicaid long-term care services using the ULTC 100.2, the  
 8 recipient/member/Applicant must have deficits in 2 of 6 Activities of Daily Living ~~-(ADL)s~~, (2+  
 9 score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under  
 10 Supervision as outlined below. The needs of an individual ages 18 and under shall be assessed  
 11 in accordance with Appendix A, the ~~Age-Appropriate~~ Age-Appropriate Guidelines for the Use of  
 12 ULTC 100.2 on Children. Specific ULTC scoring criteria is as follows:

13

14 **ACTIVITIES OF DAILY LIVING**

15 **I. ~~————~~ BATHING**

16 Definition: The ability to shower, bathe or take sponge baths for the purpose of maintaining adequate  
 17 hygiene.

18 ADL SCORING CRITERIA

19 0=The client is independent in completing the activity safely.

20 1=The client requires oversight help or reminding; can bathe safely without assistance or supervision,  
 21 but may not be able to get into and out of the tub alone.

22 2=The client requires hands on help or line of sight standby assistance throughout bathing activities in  
 23 order to maintain safety, adequate hygiene and skin integrity.

24 3=The client is dependent on others to provide a complete bath.

25 **Due To: (Score must be justified through one or more of the following conditions)**

<p><u>Physical Impairments:</u></p> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Falls <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Muscle Tone <input type="checkbox"/> Amputation	<input type="checkbox"/> Open Wound <input type="checkbox"/> Stoma Site <p><u>Supervision:</u></p> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <p><u>Mental Health:</u></p> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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Comments:

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2 **II. ~~\_\_\_\_\_~~ DRESSING**

3 Definition: The ability to dress and undress as necessary. This includes the ability to put on prostheses,  
 4 braces, anti-embolism hose or other assistive devices and includes fine motor coordination for buttons  
 5 and zippers. Includes choice of appropriate clothing for the weather. Difficulties with a zipper or buttons at  
 6 the back of a dress or blouse do not constitute a functional deficit.

7 ADL SCORING CRITERIA

8 0=The client is independent in completing activity safely.

9 1= The client can dress and undress, with or without assistive devices, but may need to be reminded or  
 10 supervised to do so on some days.

11 2= The client needs significant verbal or physical assistance to complete dressing or undressing, within  
 12 a reasonable amount of time.

13 3= The client is totally dependent on others for dressing and undressing.

14 **Due To: (Score must be justified through one or more of the following conditions)**

<p><u>Physical Impairments:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Sensory Impairment</li> <li><input type="checkbox"/> Limited Range of Motion</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Balance Problems</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Decreased Endurance</li> <li><input type="checkbox"/> Fine Motor Impairment</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Bladder Incontinence</li> <li><input type="checkbox"/> Bowel Incontinence</li> <li><input type="checkbox"/> Amputation</li> <li><input type="checkbox"/> Oxygen Use</li> <li><input type="checkbox"/> Muscle Tone</li> </ul>	<ul style="list-style-type: none"> <li><input type="checkbox"/> Open Wound</li> </ul> <p><u>Supervision:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Behavior Issues</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Seizures</li> </ul> <p><u>Mental Health:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> </ul>
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Comments:

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1 **III. TOILETING**

2 Definition: The ability to use the toilet, commode, bedpan or urinal. This includes transferring on/off the  
 3 toilet, cleansing of self, changing of apparel, managing an ostomy or catheter and adjusting clothing.

4 **ADL SCORING CRITERIA**

5 0=The client is independent in completing activity safely.

6 1=The client may need minimal assistance, assistive device, or cueing with parts of the task for safety,  
 7 such as clothing adjustment, changing protective garment, washing hands, wiping and cleansing.

8 2=The client needs physical assistance or standby with toileting, including bowel/bladder training, a  
 9 bowel/bladder program, catheter, ostomy care for safety or is unable to keep self and environment clean.

10 3=The client is unable to use the toilet. The client is dependent on continual observation, total  
 11 cleansing, and changing of garments and linens. This may include total care of catheter or ostomy. The  
 12 client may or may not be aware of own needs.

13 **Due To: (Score must be justified through one or more of the following conditions)**

<p><u>Physical Impairments:</u></p> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Bladder Incontinence <input type="checkbox"/> Bowel Incontinence <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Physiological defect <input type="checkbox"/> Balance <input type="checkbox"/> Muscle Tone <input type="checkbox"/> Impaction	<input type="checkbox"/> Ostomy <input type="checkbox"/> Catheter <p><u>Supervision Need:</u></p> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <p><u>Mental Health:</u></p> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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**Comments:**

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 16 **IV. MOBILITY**

17 Definition: The ability to move between locations in the individual's living environment inside and outside  
 18 the home. Note: Score client's mobility without regard to use of equipment other than the use of  
 19 prosthesis.

1 ADL SCORING CRITERIA

- 2 0=The client is independent in completing activity safely.
- 3 1=The client is mobile in their own home but may need assistance outside the home.
- 4 2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by
- 5 assistance, or hands on assistance for safety both in the home and outside the home.
- 6 3=The client is dependent on others for all mobility.

7 **Due To: (Score must be justified through one or more of the following conditions)**

<p><u>Physical Impairments:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Pain</li> <li><input type="checkbox"/> Sensory Impairment</li> <li><input type="checkbox"/> Limited Range of Motion</li> <li><input type="checkbox"/> Weakness</li> <li><input type="checkbox"/> Shortness of Breath</li> <li><input type="checkbox"/> Decreased Endurance</li> <li><input type="checkbox"/> Fine or Gross Motor Impairment</li> <li><input type="checkbox"/> Paralysis</li> <li><input type="checkbox"/> Neurological Impairment</li> <li><input type="checkbox"/> Amputation</li> <li><input type="checkbox"/> Oxygen Use</li> <li><input type="checkbox"/> Balance</li> <li><input type="checkbox"/> Muscle Tone</li> </ul>	<p><u>Supervision Need:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Cognitive Impairment</li> <li><input type="checkbox"/> Memory Impairment</li> <li><input type="checkbox"/> Behavior Issues</li> <li><input type="checkbox"/> Lack of Awareness</li> <li><input type="checkbox"/> Difficulty Learning</li> <li><input type="checkbox"/> Seizures</li> <li><input type="checkbox"/> History of Falls</li> </ul> <p><u>Mental Health:</u></p> <ul style="list-style-type: none"> <li><input type="checkbox"/> Lack of Motivation/Apathy</li> <li><input type="checkbox"/> Delusional</li> <li><input type="checkbox"/> Hallucinations</li> <li><input type="checkbox"/> Paranoia</li> </ul>
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**Comments:**

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10 **~~V.~~ TRANSFERRING**

11 Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or

12 standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted

13 devices, including properly functioning prosthetics, for transfers. Note: Score Client's ability to transfer

14 without regard to use of equipment.

15 ADL SCORING CRITERIA

- 16 0=The client is independent in completing activity safely.
- 17 1=The client transfers safely without assistance most of the time, but may need standby assistance for
- 18 cueing or balance; occasional hands on assistance needed.
- 19 2=The client transfer requires standby or hands on assistance for safety; client may bear some weight.
- 20 3=The client requires total assistance for transfers and/or positioning with or without equipment.

1 **Due To: (Score must be justified through one or more of the following conditions)**

<u>Physical Impairments:</u> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Balance Problems <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Falls <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use	<u>Supervision Need:</u> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <u>Mental Health:</u> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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**Comments:**

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4 **VI. — EATING**

5 Definition: The ability to eat and drink using routine or adaptive utensils. This also includes the ability to  
 6 cut, chew and swallow food. Note: If a person is fed via tube feedings or intravenously, check box 0 if  
 7 they can do independently, or box 1, 2, or 3 if they require another person to assist.

8 **ADL SCORING CRITERIA**

9 0=The client is independent in completing activity safely.

10 1=The client can feed self, chew and swallow foods but may need reminding to maintain adequate  
 11 intake; may need food cut up; can feed self if food brought to them, with or without adaptive feeding  
 12 equipment.

13 2=The client can feed self but needs line of sight standby assistance for frequent gagging, choking,  
 14 swallowing difficulty; or aspiration resulting in the need for medical intervention. The client needs  
 15 reminder/assistance with adaptive feeding equipment; or must be fed some or all food by mouth by  
 16 another person.

17 3=The client must be totally fed by another person; must be fed by another person by stomach tube or  
 18 venous access.

19 **Due To: (Score must be justified through one or more of the following conditions)**

<p><u>Physical Impairments:</u></p> <input type="checkbox"/> Pain <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Limited Range of Motion <input type="checkbox"/> Weakness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Decreased Endurance <input type="checkbox"/> Paralysis <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Amputation <input type="checkbox"/> Oxygen Use <input type="checkbox"/> Fine Motor Impairment <input type="checkbox"/> Poor Dentition <input type="checkbox"/> Tremors <input type="checkbox"/> Swallowing Problems <input type="checkbox"/> Choking <input type="checkbox"/> Aspiration	<input type="checkbox"/> Tube Feeding <input type="checkbox"/> IV Feeding <p><u>Supervision Need:</u></p> <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Behavior Issues <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Seizures <p><u>Mental Health:</u></p> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia
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**Comments:**

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**VII. SUPERVISION**

**A. Behaviors**

5 Definition: The ability to engage in safe actions and interactions and refrain from unsafe actions and  
 6 interactions (Note, consider the client's inability versus unwillingness to refrain from unsafe actions and  
 7 interactions).

8 SCORING CRITERIA

9  0=The client demonstrates appropriate behavior; there is no concern.

10  1=The client exhibits some inappropriate behaviors but not resulting in injury to self, others and/or  
 11 property. The client may require redirection. Minimal intervention is needed.

12  2=The client exhibits inappropriate behaviors that put self, others or property at risk. The client  
 13 frequently requires more than verbal redirection to interrupt inappropriate behaviors.

14  3=The client exhibits behaviors resulting in physical harm to self or others. The client requires  
 15 extensive supervision to prevent physical harm to self or others.

16 **Due To: (Score must be justified through one or more of the following conditions)**

<p><u>Physical Impairments:</u></p> <input type="checkbox"/> Chronic Medical Condition <input type="checkbox"/> Acute Illness <input type="checkbox"/> Pain <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Choking <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Communication Impairment (not inability to speak English) <p><u>Mental Health:</u></p> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability	<p><u>Supervision needs:</u></p> <input type="checkbox"/> Short Term Memory Loss <input type="checkbox"/> Long Term Memory Loss <input type="checkbox"/> Agitation <input type="checkbox"/> Aggressive Behavior <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Memory Impairment <input type="checkbox"/> Verbal Abusiveness <input type="checkbox"/> Constant Vocalization <input type="checkbox"/> Sleep Deprivation <input type="checkbox"/> Self-Injurious Behavior <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Disruptive to Others <input type="checkbox"/> Disassociation <input type="checkbox"/> Wandering <input type="checkbox"/> Seizures <input type="checkbox"/> Self Neglect <input type="checkbox"/> Medication Management
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**Comments:**

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3 **SUPERVISION- B. — Memory/Cognition Deficit**

4 Definition: The age appropriate ability to acquire and use information, reason, problem solve, complete  
 5 tasks or communicate needs in order to care for oneself safely.

6 **SCORING CRITERIA**

7  0= Independent no concern

8  1= The client can make safe decisions in familiar/routine situations, -but needs some help with decision  
 9 making support when faced with new tasks, consistent with individual's values and goals.

10  2= The client requires consistent and ongoing reminding and assistance with planning, -or requires  
 11 regular assistance with adjusting to both new and familiar routines, including regular monitoring and/or  
 12 supervision, or is unable to make safe decisions, or cannot make his/her basic needs known.

13  3= The client needs help most or all of time.

14 **Due To: (Score must be justified through one or more of the following conditions)**



<p><u>Physical Impairments:</u></p> <input type="checkbox"/> Metabolic Disorder <input type="checkbox"/> Medication Reaction <input type="checkbox"/> Acute Illness <input type="checkbox"/> Pain <input type="checkbox"/> Neurological Impairment <input type="checkbox"/> Alzheimer's/Dementia <input type="checkbox"/> Sensory Impairment <input type="checkbox"/> Chronic Medical Condition <input type="checkbox"/> Communication Impairment (does not include ability to speak English) <input type="checkbox"/> Abnormal Oxygen Saturation <input type="checkbox"/> Fine Motor Impairment <p><u>Supervision Needs:</u></p> <input type="checkbox"/> Disorientation <input type="checkbox"/> Cognitive Impairment <input type="checkbox"/> Difficulty Learning <input type="checkbox"/> Memory Impairment	<input type="checkbox"/> Self-Injurious Behavior <input type="checkbox"/> Impaired Judgment <input type="checkbox"/> Unable to Follow Directions <input type="checkbox"/> Constant Vocalizations <input type="checkbox"/> Perseveration <input type="checkbox"/> Receptive Expressive Aphasia <input type="checkbox"/> Agitation <input type="checkbox"/> Disassociation <input type="checkbox"/> Wandering <input type="checkbox"/> Lack of Awareness <input type="checkbox"/> Seizures <input type="checkbox"/> Medication Management <p><u>Mental Health:</u></p> <input type="checkbox"/> Lack of Motivation/Apathy <input type="checkbox"/> Delusional <input type="checkbox"/> Hallucinations <input type="checkbox"/> Paranoia <input type="checkbox"/> Mood Instability
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**Comments:**

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**B. CSA LEVEL OF CARE SCREEN**

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~~To qualify for Medicaid long-term care services using the Level of Care Screen must meet the level of care for the program for which they are enrolling. The Level of Care Eligibility Determination outcome is based on an individual's performance level as documented in the LOC Screen, in areas including, but not limited to, completing to, completing Activities of Daily Living, memory and cognition, sensory and communication, and behavior, as well as other criteria specific to the program for which they are enrolling or the age of the individual applicable program. The eligibility criteria and thresholds are as follows:~~

10

~~1. Nursing Facility Level of Care Eligibility for ages four (4) and older~~

11

1.

12

a. Participants four (4) years of age or older must meet the Nursing Facility Level of Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.-B.-1 -to be determined eligible for Long-Term Services and Supports.

14

i. Eligibility Criteria

16

1. Meets one or more ADL and Health Condition criteria thresholds in at least two areas to include Mobility, Transferring, Bathing, Dressing, Toileting, Eating (ADLs) or Health Condition; or

18

2. Meets one or more Behavior threshold(s); or

19

3. Meets one or more Memory and Cognition threshold(s); or

20

4. Meets the Sensory & Communication threshold.

21

ii. Criteria Thresholds

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1. ADL and Health Condition criteria thresholds are as follows:

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- a. Mobility threshold is met with either of the following:
    - i. Participant does not walk but walking is indicated in the future or Participant does not walk and walking is not indicated in the future; or
    - ii. Participant requires a cane or walker during all mobility activities; or
    - iii. Participant uses a wheelchair or scooter as their primary mechanism for mobility; or
    - iv. Participant requires, at minimum, partial/moderate assistance to walk (once standing) 10 feet indoors; or
    - v. Participant requires, at minimum, supervision or touching assistance to walk (once standing) 150 feet indoors; or
    - vi. Participant requires, at minimum, supervision or touching assistance to walk 10 feet outside of the home; or
    - vii. Participant requires, at minimum, supervision or touching assistance to walk 150 feet outside of the home.
  - b. Transferring threshold is met with either of the following:
    - i. Participant requires use of a cane or walker during all transfer activities; or
    - ii. Participant requires, at minimum, partial/moderate assistance for the ability to roll left and right: from lying on back to left and right side, and return to lying on back on the bed; or
    - iii. Participant requires, at minimum, partial/moderate assistance for the ability to complete a sit to stand transfer: safely come to a standing position from sitting in a chair or on the side of the bed.
  - c. Bathing threshold is met with the following:
    - i. Participant requires, at minimum, partial/moderate assistance for the ability to shower/bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower
  - d. Dressing threshold is met with either of the following:
    - i. Participant requires, at minimum, partial/moderate assistance with upper body dressing; or
    - ii. Participant requires, at minimum, partial/moderate assistance with lower body dressing; or
    - iii. Participant requires, at minimum, partial/moderate assistance with putting on/taking off footwear.
  - e. Toileting threshold is met with either of the following:
    - i. Participant requires, at minimum, partial/moderate assistance with toilet hygiene/transfers; or
    - ii. Participant requires, at minimum, partial/moderate assistance with toilet transfers; or
    - iii. Participant requires, at minimum, partial/moderate assistance with menses care; or
    - iv. Participant requires assistance with managing equipment related to bladder incontinence; or
    - v. Participant is currently using a bladder program to manage participant's bladder continence; or

1 vi. Participant requires assistance with managing  
 2 equipment related to bowel incontinence; or

3 vii. Participant is currently using a bowel program to  
 4 manage the participant's bowel continence.

5 f. Eating threshold is met with either of the following:

6 i. Participant requires, at minimum, partial/moderate  
 7 assistance for eating; or

8 ii. Participant requires, at minimum, partial/moderate  
 9 assistance for tube feeding.

10 g. Health Condition threshold is met with the following:

11 i. Participant has a diagnosis of paralysis; or

12 ii. A missing limb.

13 2. ~~NF-LOC 4+ eligibility~~**B behavior** criteria thresholds are as follows:

14 a. Behavior threshold area one is as follows:

15 i. Participant's behavior status previously or currently  
 16 requires interventions or presents symptoms for  
 17 Injury to Self, Physical Aggression or Property  
 18 Destruction; and

19 ii. One or more of the following are met:

20 1. Cueing frequency, at minimum, is required  
 21 more than once per month and up to weekly;  
 22 or

23 2. Physical intervention frequency, at  
 24 minimum, is required more than once per  
 25 month up to weekly; or

26 3. Planned intervention frequency, at minimum,  
 27 is required less than monthly up to once per  
 28 month.

29 b. Behavior criteria threshold area two is as follows:

30 i. Participant's behavior status for Verbal Aggression  
 31 currently requires interventions or presents  
 32 symptoms for this behavior; and

33 ii. Participant presents threat(s) to own or other's  
 34 safety; and

35 iii. One or more of the following are met:

36 1. Cueing frequency, at minimum, is required  
 37 more than once per month and up to weekly;  
 38 or

39 2. Physical intervention frequency, at  
 40 minimum, is required more than once per  
 41 month up to weekly; or

42 3. Planned intervention frequency, at minimum,  
 43 is required less than monthly up to once per  
 44 month.

45 c. Behavior criteria threshold area three is as follows:

46 i. Injurious to Self, property destruction, physical  
 47 aggression, or verbal aggression behavior status  
 48 currently requires intervention and/or displays  
 49 symptoms and

50 ii. Likelihood behavior would occur and/or escalate if  
 51 HCBS services were withdrawn is likely or highly  
 52 likely.

53 3. ~~NF-LOC 4+ eligibility~~Memory and Cognition criteria thresholds are  
 54 as follows:

- 1 a. Participant has a Level of Impairment of moderately or  
 2 higher in at least one area (Memory, Attention, Problem  
 3 Solving, Planning, or Judgment); or  
 4 b. Participant has a level of impairment of mildly or higher in at  
 5 least two areas (Problem Solving, Planning, Judgment).  
 6 4. NF-LOC 4+ eligibility-Sensory and Communication criteria threshold  
 7 is as follows:  
 8 a. Participant frequently exhibits difficulty expressing needs  
 9 and/or ideas with individuals they are familiar with; or  
 10 a. Participant rarely or never expresses themselves or is very difficult  
 11 to understand.  
 12 b.   
 13 2. Nursing Facility Level of Care Eligibility Criteria for individuals zero to three (0-3) years of age  
 14 a. Participants zero to three (0-3) years of age must meet the Nursing Facility Level of  
 15 Care criteria and thresholds outlined in 10 CCR 2505-10 Section 8.401.16.B.2,  
 16 according to age, ~~Section XXXX~~ to be determined eligible for Long-Term Services  
 17 and Supports.  
 18 i. Eligibility Criteria  
 19 1. The participant must meet the criteria threshold for two or more  
 20 Activities of Daily Living, based on participant age.  
 21 2. If the participant meets one or more of the two required ADL  
 22 thresholds by selecting only "Other Concerns," a second level review  
 23 is required to determine eligibility.  
 24 3. Participants may also meet LOC using the behavior criteria for adults  
 25 in Section 8.401-XXX.16.B.1.ii.2.  
 26 ii. Activities of Daily Living thresholds by age 0-5 months  
 27 1. Bathing:  
 28 a. Needs adaptive equipment, or  
 29 b. Utilizes medical devices that make bathing very difficult,  
 30 such as feeding tubes, breathing tubes, etc., or  
 31 c. Other concerns that may affect the amount of support the  
 32 child needs and  
 33 d. at least one of the bathing impairments above is expected to  
 34 last for at least one year from the date of assessment.  
 35 2. Dressing:  
 36 a. Has physical characteristics that make dressing very difficult,  
 37 such as contractures, extreme hypotonia, or extreme  
 38 hypertonia., or  
 39 b. Utilizes medical devices that make dressing very difficult,  
 40 such as feeding tubes, breathing tubes, etc., or  
 41 c. Other concerns that may affect the amount of support the  
 42 child needs and  
 43 d. at least one of the impairments above is expected to last for  
 44 at least one year from the date of assessment.  
 45 3. Eating:  
 46 a. Requires more than one hour per feeding, or  
 47 b. Receives tube feedings or TPN, or  
 48 c. Requires more than three hours per day for feeding or  
 49 eating, or  
 50 d. Other concerns that may affect the amount of support the  
 51 child needs and  
 52 e. at least one of the impairments above is expected to last for  
 53 at least one year from the date of assessment.  
 54 iii. Activities of Daily Living thresholds by age 6-11 months  
 55 1. Bathing:

- a. Needs adaptive equipment, or
- b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

- a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
- b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

- a. Requires more than one hour per feeding, OR
- b. Receives tube feedings or TPN, OR
- c. Requires more than three hours per day for feeding or eating, OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

- a. Unable to maintain a sitting position when placed, OR
- b. Unable to move self by rolling, crawling, or creeping, OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

iv. Activities of Daily Living thresholds by age 12-17 months

1. Bathing:

- a. Needs adaptive equipment, OR
- b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. becomes agitated requiring alternative bathing methods OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

- a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
- b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

- a. Requires more than one hour per feeding, OR

- b. Receives tube feedings or TPN, OR
- c. Requires more than three hours per day for feeding or eating, OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

- a. Unable to sit alone, OR
- b. Requires a stander or someone to support the child's weight in a standing position, OR
- c. Unable to crawl or creep, OR
- d. Other concerns that may affect the amount of support the child needs AND
- e. at least one of the impairments above is expected to last for at least one year from the date of assessment.

v. Activities of Daily Living thresholds by age 18-23 months

1. Bathing:

- a. Needs adaptive equipment, OR
- b. Utilizes medical devices that make bathing very difficult, such as feeding tubes, breathing tubes, etc., OR
- c. becomes agitated requiring alternative bathing methods OR Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

2. Dressing:

- a. Has physical characteristics that make dressing very difficult, such as contractures, extreme hypotonia, or extreme hypertonia., OR
- b. Utilizes medical devices that make dressing very difficult, such as feeding tubes, breathing tubes, etc., Does not assist with dressing by helping to place arms in sleeves or legs into pants, OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Eating:

- a. Receives tube feedings or TPN, OR
- b. Requires more than three hours per day for feeding or eating, OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

4. Mobility:

- a. Requires a stander or someone to support the child's weight in a standing position, OR
- b. Uses a wheelchair or other mobility device not including a single cane, OR
- c. Unable to take steps holding on to furniture, OR
- d. other concerns that may affect the amount of support the child needs AND

- 1 e. at least one of the impairments above is expected to last for  
2 at least one year from the date of assessment.
- 3 vi. Activities of Daily Living thresholds by age 24-35 months
- 4 1. Bathing:
- 5 a. Needs adaptive equipment, OR  
6 b. Utilizes medical devices that make bathing very difficult,  
7 such as feeding tubes, breathing tubes, etc., OR  
8 c. becomes agitated requiring alternative bathing methods OR  
9 Other concerns that may affect the amount of support the  
10 child needs AND  
11 d. at least one of the impairments above is expected to last for  
12 at least one year from the date of assessment.
- 13 2. Dressing:
- 14 a. Has physical characteristics that make dressing very difficult,  
15 such as contractures, extreme hypotonia, or extreme  
16 hypertonia., OR  
17 b. Utilizes medical devices that make dressing very difficult,  
18 such as feeding tubes, breathing tubes, etc., Does not assist  
19 with dressing by helping to place arms in sleeves or legs into  
20 pants, OR  
21 c. Unable to pull hats, socks, and mittens, OR  
22 d. Other concerns that may affect the amount of support the  
23 child needs AND  
24 e. at least one of the impairments above is expected to last for  
25 at least one year from the date of assessment.
- 26 3. Eating:
- 27 a. Receives tube feedings or TPN, OR  
28 b. Requires more than three hours per day for feeding or  
29 eating, OR  
30 c. Cannot pick up appropriate foods with hands and bring them  
31 to his/her mouth, OR  
32 d. Other concerns that may affect the amount of support the  
33 child needs AND  
34 e. at least one of the impairments above is expected to last for  
35 at least one year from the date of assessment.
- 36 4. Mobility:
- 37 a. Requires a stander or someone to support the child's weight  
38 in a standing position, OR  
39 b. Does not walk or needs physical help to walk, OR  
40 c. Uses a wheelchair or other mobility device not including a  
41 single cane, OR  
42 d. Other concerns that may affect the amount of support the  
43 child needs AND  
44 e. at least one of the impairments above is expected to last for  
45 at least one year from the date of assessment.
- 46 5. Transfers:
- 47 a. Requires transfer assistance due to physical or cognitive  
48 deficits, OR  
49 b. Other concerns that may affect the amount of support the  
50 child needs AND  
51 c. at least one of the impairments above is expected to last for  
52 at least one year from the date of assessment.
- 53 vii. Activities of Daily Living thresholds by age 36-47 months
- 54 1. Bathing:
- 55 a. Needs adaptive equipment, OR



- 1 b. Utilizes medical devices that make bathing very difficult,  
2 such as feeding tubes, breathing tubes, etc., OR  
3 c. Is combative during bathing (e.g., flails, takes two caregivers  
4 to accomplish task), OR  
5 d. Other concerns that may affect the amount of support the  
6 child needs AND  
7 e. at least one of the impairments above is expected to last for  
8 at least one year from the date of assessment.

9 2. Grooming:

- 10 a. Is combative during grooming (e.g., flails, clamps mouth  
11 shut, takes two caregivers to accomplish task), OR  
12 b. Has physical limitations that prevent completing the task  
13 (e.g. limited range of motion, unable to grasp brush), OR  
14 c. Other concerns that may affect the amount of support the  
15 child needs AND  
16 d. at least one of the impairments above is expected to last for  
17 at least one year from the date of assessment.

18 3. Dressing:

- 19 a. Has physical characteristics that make dressing very difficult,  
20 such as contractures, extreme hypotonia, or extreme  
21 hypertonia., OR  
22 b. Utilizes medical devices that make dressing very difficult,  
23 such as feeding tubes, breathing tubes, etc., OR  
24 c. Is combative during dressing (e.g., flails, resists efforts to put  
25 clothes on, takes two caregivers to accomplish task), OR  
26 d. Does not or cannot assist with dressing by helping to place  
27 arms in sleeves or legs into pants, OR  
28 e. Unable to undress self independently, OR  
29 f. Other concerns that may affect the amount of support the  
30 child needs AND  
31 g. at least one of the impairments above is expected to last for  
32 at least one year from the date of assessment.

33 4. Eating:

- 34 a. Is combative while eating (e.g., flails, throws food so will not  
35 have to eat, takes two caregivers to accomplish task), OR  
36 b. Receives tube feedings or TPN, OR  
37 c. Requires more than three hours per day for feeding or  
38 eating, OR  
39 d. Needs to be fed by another individual, OR  
40 e. Needs one-on-one monitoring to prevent choking, aspiration,  
41 or other serious complications, OR  
42 f. Other concerns that may affect the amount of support the  
43 child needs AND  
44 g. at least one of the impairments above is expected to last for  
45 at least one year from the date of assessment.

46 5. Toileting:

- 47 a. Is combative during toileting (e.g., flails, takes two caregivers  
48 to accomplish task), OR  
49 b. Has no awareness of being wet or soiled, OR  
50 c. Requires caregiver assistance to be placed onto the  
51 toilet/potty chair, OR  
52 d. Does not use toilet/potty chair when placed there by a  
53 caregiver, OR  
54 e. Other concerns that may affect the amount of support the  
55 child needs AND



f. at least one of the impairments above is expected to last for at least one year from the date of assessment.

6. Mobility:

- a. Does not walk or needs physical help to walk, OR
- b. Uses a wheelchair or other mobility device not including a single cane, OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

7. Transfers:

- a. Needs physical help with transfers, OR
- b. Uses a mechanical lift, OR
- c. Other concerns that may affect the amount of support the child needs AND
- d. at least one of the impairments above is expected to last for at least one year from the date of assessment.

3. Nursing Facility Level of Care Eligibility Alternative Criteria

- a. Alternative ADL criteria shall be applicable for participants four (4) and older whose level of support for Activities of Daily Living (Mobility, Transferring, Bathing, Dressing Toileting, Eating) has varied over the last 30 days; and
  - i. Meet the following alternate ADL thresholds in two or more ADL areas (Mobility, Transferring, Bathing, Dressing Toileting, Eating):
    - 1. Participant's performance level is, at minimum, scored at partial/moderate assistance or higher AND
    - 2. Frequency of enhanced support is scored, at minimum, 1-2 times per month in the past 30 days, or
  - ii. Meets at least one Nursing Facility Level of Care ADL (Mobility, Transferring, Bathing, Dressing Toileting, Eating) thresholds as required at 10 CCR 2505-10 Section 8.401.16.B.1.a.ii.1., ~~insert citation NF-LOC 4+~~; and
  - iii. Meets the alternate ADL thresholds in at least one ADL area.
- b. If the alternative LOC criteria is used, a second level review is required to determine eligibility.

4. Hospital Level of Care Eligibility Criteria

- a. Complementary and Integrative Health (CIH), Brain Injury (BI), Children's Home and Community Based Services (CHCBS), and Children with Life Limiting Illness (CLLI) have a Hospital Level of Care (H-LOC).
  - i. CIH and BI may be met through NF-LOC and H-LOC Criteria.
  - ii. CHCBS and CLLI have distinct criteria.
- b. H-LOC for SCI and BI participants must meet in at least one of the following areas:
  - i. Transfers:
    - 1. Participant has met Nursing Facility Level of Care (NF-LOC) AND
    - 2. Participant's performance level is, at minimum, substantial/maximum assistance for Chair/Bed -to-Chair Transfers-the ability to safely transfer to and from a bed to a chair.
  - ii. Bathing:
    - 1. Participant has met NF-LOC AND
    - 2. Participant's performance level is, at minimum, substantial/maximum assistance for Shower/bathe self-the ability to bathe self in shower or tub, including washing, rinsing, and drying self. Does not include transferring in/out of tub/shower.
  - iii. Dressing:
    - 1. Participant has met NF-LOC AND



- 1                   a. Participant has met NF-LOC or Alt-LOC AND  
2                   b. Participant's performance level is, at minimum,  
3                   substantial/maximum assistance for Shower/bathe self- The  
4                   ability to bathe self in shower or tub, including washing,  
5                   rinsing, and drying self. Does not include transferring in/out  
6                   of tub/shower.

7                   3. Dressing:

- 8                   a. Participant has met NF-LOC or Alt-LOC AND  
9                   b. Participant's performance level is, at minimum,  
10                   substantial/maximum assistance for Upper Body Dressing -  
11                   The ability to put on and remove shirt or pajama top.  
12                   Includes buttoning, if applicable OR  
13                   c. Participant's performance level is, at minimum,  
14                   substantial/maximum assistance for Lower Body Dressing -  
15                   The ability to dress and undress below the waist, including  
16                   fasteners. Does not include footwear.

17                   4. Toileting:

- 18                   a. Participant has met NF-LOC or Alt-LOC AND  
19                   b. Participant's performance level is, at minimum,  
20                   substantial/maximum assistance for toilet hygiene-The ability  
21                   to maintain perineal/feminine hygiene, adjust clothes before  
22                   and after using toilet, commode, bedpan, urinal. If managing  
23                   ostomy, include wiping opening but not managing  
24                   equipment. OR  
25                   c. Participant's performance level is, at minimum,  
26                   substantial/maximum assistance for Toilet Transfer: The  
27                   ability to safely get on and off a toilet or commode.

28                   5. Eating:

- 29                   a. Participant has met NF-LOC or Alt-LOC AND  
30                   b. Participant's performance level is, at minimum,  
31                   substantial/maximum assistance for Eating - The ability to  
32                   use suitable utensils to bring food to the mouth and swallow  
33                   food once the meal is presented on a table/tray. This  
34                   includes modified food consistency OR  
35                   c. Participant's performance level is, at minimum,  
36                   substantial/maximum assistance for Tube feeding - The  
37                   ability to manage all equipment/supplies related to obtaining  
38                   nutrition.

39                   ii. Threshold Area 2:

- 40                   1. Participant has not met NF-LOC or Alt-LOC AND  
41                   2. One of the following conditions apply to the participant:  
42                   a. Technologically dependent for life or health-sustaining  
43                   functions, OR  
44                   b. Complex medication regimen or medical interventions to  
45                   maintain or improve health status, OR  
46                   c. Need of ongoing assessment or intervention to prevent  
47                   serious deterioration of health status or medical  
48                   complications that place life, health or development at risk.  
49                   3. A second-level review is required to verify whether the conditions  
50                   documented justify a H-LOC.

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2 **8.402.10 ADMISSION PROCEDURES FOR CLASS I NURSING FACILITIES**

3 .11 The URC/Single Entry Pointy (SEP) shall certify a client for nursing facility admission after a client  
 4 is determined to meet the ~~functional~~ level of care and passes the PASRR Level 1 screen  
 5 requirements for long-term care. However, the URC/SEP shall not certify a client for nursing  
 6 facility admission unless the client has been advised of long-term care options including Home  
 7 and Community Based Services as an alternative to nursing facility care.

8 .12 The medically licensed provider must complete the necessary documentation prior to the client's  
 9 admission.

10 .13 The ULTC 100.2 Level of Care Eligibility Determination Screen and other transfer documents  
 11 concerning medical information as applicable, must accompany the client to the facility.

12 .14 The nursing facility or hospital shall notify the URC/SEP agency of the pending admission by  
 13 faxing or emailing the appropriate form. The date the form is received by the URC/SEP agency  
 14 shall be the effective start date if the client meets all eligibility requirements for Medicaid long-  
 15 term care services.

16 .15 The URC/SEP case manager shall determine the client's length of stay using the appropriate  
 17 form developed by the Department. The length of stay shall be less than a year, one year or  
 18 indefinite. All indefinite lengths of stay shall be approved by the case manager's supervisor.

19 .16 The URC/SEP agency shall notify in writing all appropriate parties of the initial length of stay  
 20 assigned. Appropriate parties shall include, but are not limited to, the client or the client's  
 21 designated representative, the attending physician, the nursing facility, the Fiscal Agent, the  
 22 appropriate County Department of Social/Human Services, the appropriate community agency,  
 23 and for clients within the developmentally disabled or mentally ill target groups, the Department of  
 24 Human Services or its designee.

25 .17 The nursing facility shall be responsible for tracking the length of stay end date so that a timely  
 26 R reassessment is completed by the URC/SEP.

27 .18 The URC will determine the start date for nursing facility services. The start date of eligibility for  
 28 nursing facility services shall not precede the date that all the requirements (functional level of  
 29 care, financial eligibility, disability determination) have been met.

30 **8.402.30 ADMISSION PROCEDURES FOR HOME AND COMMUNITY BASED SERVICES**

31 .31 When the client meets the level of care requirements for long-term care, is currently living in the  
 32 community, and could possibly be maintained in the community, the URC/SEP agency shall  
 33 immediately communicate with the appropriate community agency, according to the URC/SEP  
 34 agency-determined target group, for an evaluation for alternative services. The URC/SEP agency  
 35 shall forward a copy of the worksheet plus a State prescribed disposition form to the agency  
 36 either immediately after the telephone referral, or in place of the telephone referral.

37 .32 Based upon information obtained in the pre-admission review, the URC/SEP case manager shall  
 38 make the referral to the appropriate community agency based on the client's target group  
 39 designation, as defined below:

- 1 A. Individuals determined by the URC/SEP agency to be in the Mentally Ill target group,  
2 regardless of source, shall be referred to the appropriate community mental health center  
3 or clinic.
- 4 B. Individuals determined by the URC to be in the Functionally Impaired Elderly target  
5 group, or the Physically Disabled or Blind target group shall be referred to the appropriate  
6 Single Entry Point Agency for evaluation for Home and Community Based Services for  
7 the Elderly, Blind and Disabled (HCBS-EBD).
- 8 C. Individuals identified by the URC to be in the Developmentally Disabled target group shall  
9 be referred to the appropriate Community Centered Board.
- 10 D. Individuals determined by the URC to be in the Persons Living with AIDS target group  
11 shall be referred to the appropriate Single Entry Point Agency for evaluation for HCBS-  
12 EBD.
- 13 E. The URC shall notify any clients referred to case management agencies of the referral,  
14 the provisions of the program, and shall inform them of the complaint procedures.
- 15 .33 The case management agency or community mental health center or clinic shall complete an  
16 evaluation for alternative services within five (5) working days of the referral by the URC.
- 17 .34 Single Entry Point Agencies shall conduct the evaluation in accordance with the procedures at 10  
18 CCR 2505-10 Sections 8.486 and 8.390.
- 19 .35 Community Centered Boards shall conduct the evaluation in accordance with procedures at 10  
20 CCR 2505-10 Section 8.500.
- 21 .36 Community mental health centers and clinics shall conduct the evaluation in accordance with  
22 Standards/Rules and Regulations for Mental Health 2 CCR 502-1 Section 21.940 and Rules and  
23 Regulations Concerning Care and Treatment of the Mentally Ill, 2 CCR 502-1 Section 21.280.
- 24 .37 If the community agency develops an approved plan for long-term care services, the URC will  
25 approve one (1) certification for long-term care services and the client shall be placed in  
26 alternative services. Following receipt of the fully completed ULTC-LOC Screen the URC will  
27 review the information submitted and make a certification decision. If certification is approved, the  
28 URC shall assign an initial length of stay for alternative services. If certification is denied, the  
29 decision of the URC may be appealed in accordance with 10 CCR 2505-10 Section 8.057  
30 through 8.057.8.
- 31 .38 If the appropriate community agency cannot develop an approved plan for long-term care  
32 services, the URC will approve certification for long-term care services and utilize the procedure  
33 for nursing home admissions described previously in this section.

34 **8.402.40 ADMISSION TO NURSING FACILITY WITH REFERRAL FOR COMMUNITY**  
35 **SERVICES**

- 36 .41 When a client who meets the level of care requirements for long-term care is currently  
37 hospitalized but could possibly be maintained in the community, certification shall be issued. The  
38 client may be placed in the nursing facility, given a short length of stay and immediately referred  
39 to the appropriate community agency for evaluation for alternative services in accordance with  
40 the procedure described in the preceding section.

41 **8.402.50 DENIALS (ALL TARGET GROUPS)**

1 .51 When, based on the pre-admission review, the client does not meet the level of care  
2 requirements for skilled and maintenance services, certification shall not be issued. The client  
3 shall be notified in writing of the denial.

4 .52 If the URC denied long-term care certification based upon the information on the ULTC  
5 400.2.LOC Screen written notification of the denial shall be sent to the client, the attending  
6 physician, and the referral source (hospital, nursing facility, etc.).

7 If the information provided on the ULTC-400.2LOC Screen indicates the client does meet the  
8 level of care requirements, the URC shall proceed with the admission and/or referral procedures  
9 described above.

10 .53 Denials of certification for long-term care may be appealed in accordance with the procedures  
11 described at 10 CCR 2505-10 Section 8.057 through 8.057.8.

12 .54 Denial of designation into a specifically requested target group may also be appealed in  
13 accordance with 10 CCR 2505-10 Section 8.057 through 8.057.8.

#### 14 **8.405.2 ADMISSION PROCEDURES FOR ICF/IID FACILITIES**

15 .21 When the client, based on CCB review, cannot reasonably be expected to make use of ICF/IID or  
16 HCBS-DD-, the CCB shall notify the physician and the URC. The physician and the  
17 URC/Community Center Board (URC/CCB) agency then proceed with the SNF or ICF placement  
18 under the provisions set forth at 10 CCR 2505-10 Section 8.402.10. ~~Section.~~

19 22 When the CCB determines that a client is not appropriately served through HCBS-DD services or,  
20 in accordance with provisions permitting the client or the client's designated representative to  
21 choose institutional services as an alternative to HCBS-DD services, the CCB shall recommend  
22 placement to an ICF/IID facility. The CCB shall seek the approval of the client's physician. The  
23 physician shall notify the URC/CCB agency of the proposed placement. Based on information  
24 provided by the CCB and the client's physician, the URC/SEP agency may certify the client for  
25 long-term care prior to ICF/IID admission.

26 .23 The URC/CCB agency shall advise the County Department of Social/Human Services of the  
27 certification to enable the County Department staff to assist with the placement arrangements.

28 24. The ULTC-400.2LOC Screen and other transfer documents concerning medical information as  
29 applicable must accompany the client to the facility.

30 .25 Following receipt of the fully completed ULTC-400.2LOC Screen, the URC/CCB shall review the  
31 information and make a final certification decision. If certification is approved, the URC/CCB shall  
32 assign an initial length of stay according to 10 CCR 2505-10 Section 8.404.1. If certification is  
33 denied, the decision of the URC/CCB may be appealed in accordance with the appeals process  
34 at 10 CCR 2505-10 Section 8.057.

#### 35 **8.405.30 ADMISSION PROCEDURES FOR HCBS-DD**

36 .31 CCBs may evaluate clients for HCBS-DD services if, in the judgment of the CCB, such services  
37 represent a viable alternative to SNF, ICF, or ICF/IID services. The evaluation shall be carried out  
38 in accordance with the procedures set forth in 2 CCR Section 503-1.

39 .32 If the CCB recommends HCBS-DD placement, then the URC/CCB will approve certification for  
40 services for the developmentally disabled at the level of care recommended by the CCB. The  
41 client will be placed in alternative service.

1 Following receipt of the completed ULTC-100.2-LOC Screen and any other supporting  
2 information, the URC/CCB will review the information and make a final certification determination.

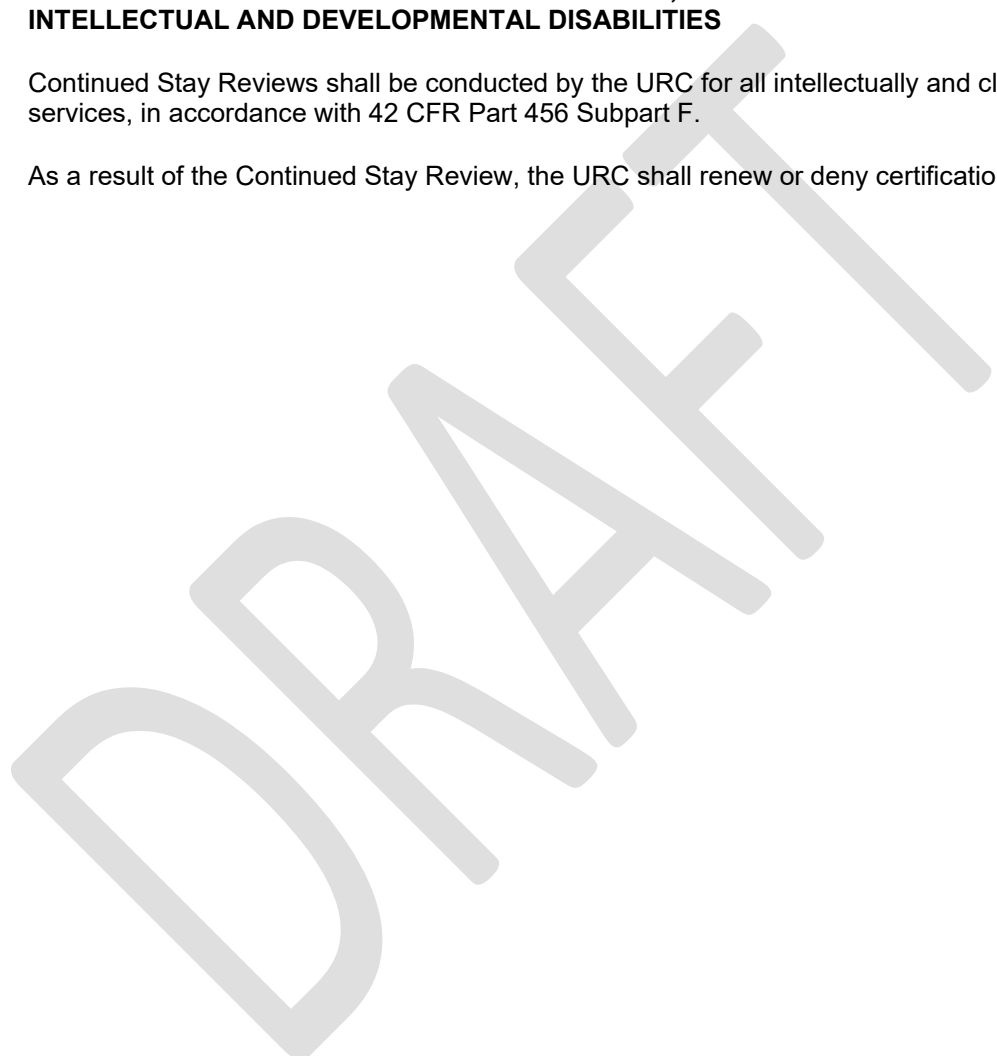
3 If certification is approved, the URC/CCB shall assign an initial length of stay for HCBS-DD  
4 services.

5 If certification is denied, the decision of the URC/CCB may be appealed in accordance with  
6 Section 8.057.

7 **8.405.4 CONTINUED STAY REVIEW PROCEDURES; SERVICES FOR INDIVIDUALS WITH**  
8 **INTELLECTUAL AND DEVELOPMENTAL DISABILITIES**

9 .41 Continued Stay Reviews shall be conducted by the URC for all intellectually and clients in ICF/IID  
10 services, in accordance with 42 CFR Part 456 Subpart F.

11 .42 As a result of the Continued Stay Review, the URC shall renew or deny certification.





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## **8.470 HOSPITAL BACK UP LEVEL OF CARE**

### **8.470.1 DEFINITION**

The Hospital Back Up (HBU) Program is a long-term care program that provides hospital level care in a skilled nursing facility (SNF) setting. Clients who no longer need acute care in a hospital but require 24-hour monitoring and life sustaining technology for complex medical conditions may apply to receive long-term care in an HBU certified facility.

### **8.470.2 PROGRAM ELIGIBILITY**

In order to be eligible for the hospital back up program, a client shall:

1. Meet [ULTC 100.2-LOC Screen](#) level of care eligibility for long term care as determined by the appropriate single-entry point agency (SEP); and
2. Meet the client clinical eligibility requirements as identified in [10 CCR 2505-10 Section 8.470.3](#) as determined by the State Utilization Review Contractor (SURC);
3. Be medically stable in a chronically acute state;
4. Be in a hospital or **long-term** acute care facility prior to approval; or
5. Be in An HBU skilled facility under a qualified Medicare stay

### **8.470.3 CLIENT CLINICAL ELIGIBILITY**

All prospective clients must meet the requirements of at least one of the following three categories in the clinical eligibility criteria in to participate in the Hospital Back Up Program:

1. Complex Wound as outlined in 8.470.3.A;



- 1           2.     Ventilator Dependent as outlined in 8.470.3.B; or
- 2           3.     Medically Complex as outlined in 8.470.3.C
- 3   8.470.3.A.   Complex Wound Care means the client must meet all the following criteria:
- 4           1.     At least one stage 3-4 pressure ulcer or injury, second- or third-degree burns, or a  
5           Medicare “pressure relieving support surface” rating of 2-3 to heal or prevent skin  
6           breakdown;
- 7           2.     Documentation of extensive skin loss, active infection, compromised blood flow,  
8           sloughing, tunneling, fistulae, or undermining of surrounding tissue or necrosis with  
9           potential extension to underlying fascia;
- 10          3.     Documentation of nutritional deficiencies including:
- 11           a.     Identification of diagnostic markers and specific nutritional deficiencies;
- 12           b.     A plan of treatment to address underlying conditions such as malabsorption or  
13           excess loss of nutrients; and
- 14           c.     The modality of supplementation: oral, intramuscular or intravenous, and
- 15          4.     Documentation of at least one of the following:
- 16           a.     Full thickness wound graft surgery;
- 17           b.     Negative pressure wound therapy, electromagnetic therapy, compression  
18           therapy or hyperbaric oxygen therapy;
- 19           c.     Debridement (surgical, mechanical, chemical, autolytic or larval biotherapy); or
- 20           d.     Advanced dressings with growth factors, silver/alginates, hyaluronic acid or  
21           collagens.
- 22   8.470.3.B.   Ventilator dependent clients must meet all requirements in at least one of the following  
23           three subsections:
- 24          1.     If the client is actively weaning off the ventilator, the client must:
- 25           a.     Require direct assessment and monitoring of weaning at least 2 hours each day  
26           by a respiratory therapist;
- 27           b.     Require supportive care at least 12 hours a day by a respiratory therapist or  
28           pulmonary trained nurse (under the supervision of a respiratory therapist) for  
29           ventilator management;
- 30           c.     Require physical therapy, occupational therapy, speech therapy, or a  
31           combination of such therapies at least 5 days per week;
- 32           d.     Have documented rehabilitation potential and a plan of treatment by a respiratory  
33           therapist in place at the time of the HBU referral; and

- 1 e. Have clinical documentation including (but not limited to) arterial bloods gas labs,  
 2 standard breathing and capping trial results, pulmonary function tests,  
 3 capnography, respiratory and speech language pathology progress notes and  
 4 any other documentation to support active weaning efforts.
- 5 2. If active weaning fails, the client must:
- 6 a. Have documentation of failed weaning efforts by a respiratory therapist and a  
 7 plan of treatment with prognosis for liberation from a respiratory therapist or  
 8 pulmonologist;
- 9 b. Require continuous ventilator support at least 8 hours per day and skilled  
 10 respiratory care at least 3.5 hours per day to remain medically stable;
- 11 c. Have difficulty communicating needs to others and/or requires assistance from  
 12 skilled staff to set up adaptive equipment, or is unable to speak due to physical or  
 13 cognitive impairment; and
- 14 d. ~~Have one of the following scores on the ULTC 100.2 assessment form:~~
- 15 i. ~~A score of at least 2 in a minimum of two activities of daily living (ADL);~~  
 16 ~~or~~
- 17 ii. ~~A score of at least 2 in one category of supervision; Meet Nursing Facility Level of~~  
 18 ~~Care as determined by the LOC Screen.~~
- 19 3. If the client has been successfully weaned off the ventilator and is actively working to  
 20 reduce oxygen levels and/or removal of the tracheostomy tube, the client must:
- 21 a. ~~Have one of the following scores on the ULTC 100.2 assessment form:~~
- 22 i. ~~A score of at least 2 in a minimum of two activities of daily living (ADL);~~  
 23 ~~or~~
- 24 ii. ~~A score of at least 2 in one category of supervision; Meet Nursing Facility~~  
 25 ~~Level of Care as determined by the LOC Screen-eligibility.~~
- 26 b. Have documentation from a respiratory therapist and pulmonologist verifying the  
 27 client has been weaned off active ventilation and/or is working to have a further  
 28 reduction to standard home oxygen levels (1-6 LPM);
- 29 c. Require the support of a respiratory therapist under the supervision of a  
 30 pulmonologist at least 3.5 hours a day to remain medically stable and/or show  
 31 progress toward decannulation; and
- 32 d. Be capable of:
- 33 i. Communicating needs and following simple commands; and/or
- 34 ii. Managing basic tracheostomy care or respiratory hygiene.

35 8.470.3.C. Medically complex clients include ventilator dependent individuals and individuals  
 36 successfully weaned off the ventilator with co-morbidities. To be deemed medically complex  
 37 under the HBU program, clients must meet all of the following requirements:

1. ~~Have a score of at least 2 in a minimum of 2 activities of daily living or a score of at least 2 in one category of supervision on the ULTC 100.2 assessment form; Meet Nursing Facility Level of care as determined by the LOC Screen-eligibility.~~
2. Have difficulty communicating needs to others and requires assistance from skilled staff to set up adaptive equipment or be unable to seek assistance due to cognitive or physical impairment;
3. Require on-site assessment by a rounding physician or subspecialist at least once a week to remain stable;
4. Require artificial nourishment to be administered by registered nurse, including but not limited to a gastro-intestinal tube (G tube or NG tube) and/or jejunostomy tube (J tube), total parenteral nutrition (TPN) with or without lipids, or central line in active use for fluids or medication (excluding TPN);
5. Require documentation of rehabilitative therapies including physical, occupational and speech language therapy, and/or skilled nursing notes documenting assessment, monitoring and intervention at a greater frequency than is provided in a class 1 nursing facility;
6. Require suctioning and/or airway maintenance at least every four hours by a respiratory therapist or pulmonary trained nurse under the supervision of a respiratory therapist for ventilator dependent clients or clients with a tracheostomy;
7. Physician documentation of life limiting disease which will require ongoing care in the HBU skilled nursing facility; and
8. Documentation of quarterly updates to plan of treatment, prognosis, status evaluation, care conference and/or palliative consult.

#### 8.470.4 INITIAL ELIGIBILITY DETERMINATION AND ADMISSION

##### 8.470.4.A. SURC Review for Initial Hospital Eligibility Determination

Upon receipt of the completed Hospital Back Up Application, patient choice form and the ~~ULTC 100.2 LOC Screen-assessment~~, the SURC nurse reviewer shall:

1. Conduct a program eligibility review to determine whether the client meets the hospital back up level of care criteria and may successfully be treated in the requested skilled nursing facility;
2. Review the ~~ULTC 100.2 LOC Screen assessment~~ by the SEP;
3. Provide initial assessment for secondary review by SURC physician reviewer;
4. Request additional medical documentation deemed necessary to make such determination;
5. Notify the Department of final eligibility determination;
6. Document all final physician determinations and maintain these records for the Department;

- 1 7. Issue a denial letter to the Department and referring provider within 10 business days of  
2 determination if the prospective client does not meet HBU level of care;
- 3 8. Notify the Department in writing within 10 days of determination if the SURC determines  
4 the Client meets HBU level of care; and
- 5 9. Issue a 90-day initial length of stay letter to the client and skilled nursing facility within 24  
6 hours of approval from the Department, in accordance with the criteria specified below in  
7 subsection 8.470.4.C.
- 8 **8.470.5.D. Annual Continued Stay Review**
- 9 1. The SURC nurse shall conduct an on-site continued stay review for each hospital back  
10 up client 15 days prior to the end of the client's currently approved annual stay.
- 11 2. The SURC may conduct an unscheduled on-site review at any time during the length of  
12 stay for client clinical change of condition or at the request of the Department.
- 13 3. The SURC shall observe the same review criteria and determination requirements as  
14 outlined in 8.470.4.C of the 90-day initial eligibility criteria for determining ongoing annual  
15 eligibility.
- 16 4. A new LOC Screen ULTC 100.2 assessment must be completed annually by the SEP  
17 agency. The nursing facility shall provide a current ULTC 100.2 LOC Screen to the SURC  
18 as part of the annual eligibility assessment.
- 19 5. If the SURC determines that the client no longer meets the hospital back up level of care  
20 criteria or the nursing facility fails to provide documentation to support level of care and  
21 services provided, the SURC shall notify the Department within 24 hours of completion of  
22 the eligibility review.
- 23 6. The SURC shall observe the same determination and notification requirements as  
24 outlined in 8.470.4.C.6-7 of the 90-day initial eligibility criteria for determining ongoing  
25 annual eligibility.

26 **8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED**  
27 **(HCBS-EBD) GENERAL PROVISIONS**

28 **8.485.50 GENERAL DEFINITIONS**

- 29 A. Agency shall be defined as any public or private entity operating in a for-profit or nonprofit  
30 capacity, with a defined administrative and organizational structure. Any sub-unit of the agency  
31 that is not geographically close enough to share administration and supervision on a frequent and  
32 adequate basis shall be considered a separate agency for purposes of certification and contracts.
- 33 B. Assessment shall be as defined at Section 8.390.1 DEFINITIONS.B.
- 34 C. Case Management shall be as defined at Section 8.390.1 C, including the calculation of client  
35 payment and the determination of individual cost-effectiveness.
- 36 D. Categorically eligible shall be defined in the HCBS-EBD program as any client eligible for medical  
37 assistance (Medicaid), or for a combination of financial and medical assistance; and who retains  
38 eligibility for medical assistance even when the client is not a resident of a nursing facility or  
39 hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who

- 1 are eligible for financial assistance, but not for medical assistance, or persons who are eligible for  
2 HCBS-EBD as three hundred percent eligible persons, as defined at Section 8.485.50.T.
- 3 E. Congregate facility shall be defined as a residential facility that provides room and board to three  
4 or more adults who are not related to the owner and who, because of impaired capacity for  
5 independent living, elect protective oversight, personal services and social care but do not require  
6 regular twenty-four hour medical or nursing care.
- 7 F. Uncertified Congregate Facility shall be a facility as defined at Section 8.485.50.E. that is not  
8 certified as an Alternative Care Facility. See Section 8.495.1.
- 9 G. Continued Stay Review shall be a Reassessment as defined at [10 CCR 2505-10](#) Sections  
10 8.402.60 and 8.390.1. ~~DEFINITIONS.R.~~
- 11 H. Corrective Action Plan shall be as defined at Section 8.390.1. ~~DEFINITIONS.D.~~
- 12 I. Cost containment shall be defined as the determination that, on an individual client basis, the cost  
13 of providing care in the community is less than the cost of providing care in an institutional setting.  
14 The cost of providing care in the community shall include the cost of providing HCBS-EBD  
15 services and long-term home health services.
- 16 J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type  
17 services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-EBD.  
18 These include hospitalized clients who were in a nursing facility immediately prior to inpatient  
19 hospitalization and who would have returned to the nursing facility if they had not elected HCBS-  
20 EBD.
- 21 K. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized.
- 22 L. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) shall be  
23 defined as services provided in a home or community setting to clients who are eligible for  
24 Medicaid reimbursement for long-term care, who would require nursing facility or hospital care  
25 without the provision of HCBS-EBD, and for whom HCBS-EBD services can be provided at no  
26 more than the cost of nursing facility or hospital care.
- 27 M. Intake/Screening/Referral shall be as defined [10 CCR 2505-10](#) Section 8.390.1. ~~K.M.~~
- 28 N. Level of ~~C~~care ~~S~~screen shall be as defined as an assessment conducted in accordance with [10](#)  
29 [CCR 2505-10](#) Section 8.401.
- 30 O. Provider agency shall be defined as an agency certified by the Department and which has a  
31 contract with the Department to provide one or more of the services listed at Section 8.485.40. A  
32 Single Entry Point Agency is not a provider agency, as case management is an administrative  
33 activity, not a service. Single Entry Point Agencies may become service providers if the criteria in  
34 Sections 8.390-8.393 are met.
- 35 P. Reassessment shall be as defined at [10 CCR 2505-10](#) Section 8.390.1. ~~R.DEFINITIONS.~~
- 36 Q. ~~Service Plan~~ ~~Person-Centered Support Plan~~ means as defined in [10 CCR 2505-10](#) Section  
37 [8.390.1.DEFINITIONS.](#) ~~means the written document that identifies approved services, including~~  
38 ~~Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a client to~~  
39 ~~remain safely in the community and developed in accordance with the Department rules,~~  
40 ~~including the funding source, frequency, amount and provider of each service, and written on a~~  
41 ~~State-prescribed Long-term Care Plan form.~~

1 R. Single Entry Point Agency shall be defined as an organization described at Section 8.390.1.U.

2 S. The Department shall be defined described in 8.390.1.F.

3 T. Three hundred percent (300%) eligible shall be defined as persons:

4 1) Whose income does not exceed 300% of the SSI benefit level; and

5 2) Who, except for the level of their income, would be eligible for an SSI payment; and

6 3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an  
7 HCBS program or are in a nursing facility or hospitalized for thirty consecutive days.

## 8 **8.485.60 ELIGIBLE PERSONS**

9 .61 HCBS-EBD services shall be offered to persons who meet ~~all of~~ the eligibility requirements below  
10 provided the individual can be served within the capacity limits in the federal waiver:

### 11 A. Financial Eligibility

12 Clients shall meet the eligibility criteria as stated at [10 CCR 2505-10](#) Section 8.100. Clients must  
13 also meet criteria specified in the Colorado Department of Human Services Income Maintenance  
14 Staff Manual, 9 CCR 2503-1, (2018).

### 15 B. Level of Care and Target Group

16 Clients who have been determined to meet the level of care and target group criteria shall be  
17 certified by a Single Entry Point Agency as eligible for HCBS-EBD. The Single Entry Point  
18 Agency shall only certify HCBS-EBD eligibility for those clients:

19 1. Determined by the Single Entry Point Agency to meet the target group definition for  
20 functionally impaired elderly, or the target group definition for physically disabled or blind  
21 adult; and

22 2. Determined by a ~~formal level of care assessment~~ [LOC Screen](#) to require the [Nursing](#)  
23 [Facility Level of Care](#) ~~level of care available in a nursing facility~~, according to [10 CCR](#)  
24 [2505-10](#) Section 8.401.11 through 8.401.15; or

25 3. Determined by a ~~formal level of care assessment~~ [LOC Screen](#) to require ~~the hospital~~ level  
26 of care ~~available in a hospital~~;

27 4. A length of stay shall be assigned by the Single Entry Point Agency for approved  
28 admissions, according to guidelines at Section 8.402.60.

### 29 C. Receiving HCBS-EBD Services

30 1. Only clients who receive HCBS-EBD services, or who have agreed to accept HCBS-EBD  
31 services as soon as all other eligibility criteria have been met, are eligible for the HCBS-  
32 EBD program.

33 2. Case management is not a service and shall not be used to satisfy this requirement

34 3. Desire or need for home health services or other Medicaid services that are not HCBS-  
35 EBD services, as listed at Section 8.485.30, shall not satisfy this eligibility requirement

1 4. HCBS-EBD clients who have received no HCBS-EBD services for one month must be  
2 discontinued from the program.

3 D. Institutional Status

4 1. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD  
5 services while residing in such institutions unless the Single Entry Point Agency  
6 determines the client is eligible for EBD as described in Section 8.486.33.

7 2. A client who is already an HCBS-EBD recipient and who enters a hospital for treatment  
8 may not receive HCBS-EBD services while in the hospital. If the hospitalization continues  
9 for 30 days or longer, the case manager must terminate the client from the HCBS-EBD  
10 program.

11 3. A client who is already an HCBS-EBD recipient and who enters a nursing facility may not  
12 receive HCBS-EBD services while in the nursing facility.

13 (a) The case manager must terminate the client from the HCBS-EBD program if  
14 Medicaid pays for all or part of the nursing facility care, or if there is a URC-  
15 certified ~~ULTC-100.2~~ LOC Screen for the nursing facility placement, as verified by  
16 telephoning the URC.

17 (b) A client receiving HCBS-EBD services who enters a nursing facility for respite  
18 care as a service under the HCBS-EBD program shall not be required to obtain a  
19 nursing facility ~~ULTC-100.2~~ LOC Screen and shall be continued as an HCBS-  
20 EBD client in order to receive the HCBS-EBD service of respite care in a nursing  
21 facility.

22 E. Cost-effectiveness

23 Only clients who can be safely served within cost containment, as defined at Section 8.485.50,  
24 are eligible for the HCBS-EBD program.

25 F. Waiting List

26 Persons who are determined eligible for services under the HCBS-EBD waiver, who cannot be  
27 served within the capacity limits of the federal waiver, shall be eligible for placement on a waiting  
28 list.

29 1. The waiting list shall be maintained by the Department.

30 2. The date used to establish the person's placement on the waiting list shall be the date on  
31 which eligibility for services under the HCBS-EBD waiver was initially determined.

32 3. As openings become available within the capacity limits of the federal waiver, persons  
33 shall be considered for services based on the following priorities:

34 a. Clients being deinstitutionalized from nursing facilities.

35 b. Clients being discharged from a hospital who, absent waiver services, would be  
36 discharged to a nursing facility at a greater cost to Medicaid.

37 c. Clients who receive long-term home health benefits who could be served at a  
38 lesser cost to Medicaid.



- d. Clients ~~with high ULTC 100.2 scores~~ requiring nursing facility level of care and are who are at risk of imminent nursing facility placement.

### 8.485.70 START DATE

.71 The start date of eligibility for HCBS-EBD services shall not precede the date that all of the requirements at Section 8.485.60 have been met. The first date for which HCBS-EBD services can be reimbursed shall be the later of any of the following:

- A. Financial: The financial eligibility start date shall be the effective date of eligibility, as determined by the income maintenance technician, according to Section 8.100. This may be verified by consulting the income maintenance technician, or by looking it up on the eligibility system.
- B. Level of Care: This date is determined by the official ~~URC's stamp and the URC~~-assigned start date on the ~~ULTC 100.2 form~~ LOC Screen.
- C. Receiving Services: This date shall be determined by the date on which the client signs either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the state, agreeing to accept services.
- D. Institutional Status: HCBS-EBD eligibility cannot precede the date of discharge from the hospital or nursing facility.

.72 The start date for CTS may precede HCBS-EBD enrollment when a client meets the conditions set forth at Section 8.486.33. The start date for CTS shall be no more than 180 calendar days before a client's discharge from a nursing facility.

### 8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

.91 The Department or its agent shall develop the Prior Authorization Request (PAR) form in compliance with all applicable regulations, and determine whether services requested are (a) consistent with the client's documented medical condition, ~~and functional capacity and Level of Care~~, (b) reasonable in amount, frequency and duration, (c) not duplicative, (d) not services for which the client is receiving funds to purchase, and (e) do not total more than twenty four (24) hours per day of care.

- A. The case manager shall submit prior authorization approvals for all HCBS-EBD services to the fiscal agent within one (1) calendar month after the URC's assigned start date and approval of financial eligibility.
- B. The Department or its fiscal agent will approve, deny or return for additional information home modification PARs over \$1,000 within ten (10) working days of receipt.

.92 When home modifications are denied, in whole or in part, the Single Entry Point Agency shall notify the client or the client's designated representative of the adverse action and their appeal rights on a state-prescribed form, according to Section 8.057, et. seq.

.93 Revisions requested by providers six months or more after the end date shall always be disapproved.

.94 Approval of the PAR by the Department or its agent shall authorize providers of services under the ~~Service Plan-PCSP~~ to submit claims to the fiscal agent and to receive payment for authorized services provided during the period of time covered by the PAR. Payment is also conditional upon



1 the client's financial eligibility for long-term care medical assistance (Medicaid) on the dates of  
2 service; and upon provider's use of correct billing procedures.

3 .95 Every PAR shall be supported by information on the ~~Service Plan~~PCSP, the ~~ULTC-100.2-LOC~~  
4 ~~Screen~~ and written documentation from the income maintenance technician of the client's current  
5 monthly income. All units of service requested on the PAR shall be listed on the ~~Service Plan~~  
6 ~~PCSP~~.

7 .96 If a PAR is for an Alternative Care Facility client who is 300% eligible, all medical and remedial  
8 care requested as deductions shall be listed on the Client Payment form.

9 .97 The start date on the Prior Authorization Request form shall not precede the start date of eligibility  
10 for HCBS-EBD services, according to Section 8.485.70, except for CTS. A TCA may provide CTS  
11 up to 180 days prior to nursing facility discharge when authorized by the Single Entry Point  
12 Agency. The TCA is eligible for reimbursement beginning on the first day of the client's HCBS-  
13 EBD enrollment.

14 .98 The PAR shall not cover a period longer than the length of stay assigned by the URC.

15 Note: Sections 8.485.100 - 8.485.101 were deleted effective 7/1/02.

## 16 8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

### 17 8.486.10 HCBS-EBD PROGRAM REQUIREMENTS FOR SINGLE ENTRY POINT AGENCIES

18 Single entry point agencies shall comply with single entry point rules at 10 CCR 2505-10 section 8.390,  
19 et. seq., governing case management functions, and shall comply with all HCBS-specific requirements in  
20 the rest of this section on HCBS-EBD case management functions.

### 21 8.486.20 INTAKE

22 .21 Refer to Section 8.393.2.B for single entry point intake procedures. The intake form shall be  
23 completed before a ~~LOC Screen~~n-assessment is initiated. The intake form may also be used as a  
24 preliminary case plan form when signed by the ~~A~~applicant, for purposes of establishing a start  
25 date.

26 .22 Based upon information gathered on the intake form, the case manager shall determine the  
27 appropriateness of a referral for a ~~comprehensive uniform long term care client assessment~~  
28 ~~(ULTC-100)~~,LOC Screen and shall explain the reasons for the decision on the Intake form. The  
29 client shall be informed of the right to request an ~~assessment~~-LOC Screen if the client disagrees  
30 with the case manager's decision.

### 31 8.486.30 ASSESSMENT LEVEL OF CARE ELIGIBILITY DETERMINATION

32 .31 If the client is being discharged from a hospital or other institutional setting, the discharge planner  
33 shall contact the URC/SEP agency for assessment by emailing or faxing the initial intake and  
34 screening form.

35 .32 The URC/SEP case manager shall view and document the current Personal Care Boarding  
36 Home license, if the client lives, or plans to live, in a congregate facility as defined at Section  
37 8.485.50, in order to ensure compliance with Section 8.485.20.

38 .33 A SEP may determine that a client is eligible for HCBS-EBD while the client resides in a nursing  
39 facility when the client meets the eligibility criteria as established at Section 8.400, et seq., the

1 client requests CTS and the SEP includes CTS in the client's long-term care plan. If the client has  
 2 been evaluated with the ULTC-100.2-LOC Screen and has been assigned a length of stay that  
 3 has not lapsed, the SEP shall not conduct another review when CTS is requested.

#### 4 **8.486.40 HCBS-EBD DENIALS**

5 .41 If a client is determined, at any point in the Level of Care Eligibility Determination assessment  
 6 process, to be ineligible for HCBS-EBD according to any of the requirements at Section 8.485.60,  
 7 the client or the client's designated representative shall be notified of the denial and the client's  
 8 appeal rights in accordance with Long-term Care Single Entry Point System regulations at  
 9 Section 8.393.3.A.

#### 10 **8.486.200 REASSESSMENT**

11 .201 The case manager shall complete a Reassessment of each SEP-managed waiver client before  
 12 the end of the length of stay assigned by the Utilization Review Contractor at the last level of care  
 13 determination. The case manager shall initiate a Reassessment more frequently if required by  
 14 single entry point regulations at 10 CCR 2505-10 section 8.393.25, or when warranted by  
 15 significant changes that may affect HCBS-EBD eligibility.

16 .202 The case manager shall submit a continued stay review PAR, in accordance with requirements at  
 17 10 CCR 2505-10 section 8.485.90. For clients who have been denied by the Utilization Review  
 18 Contractor at continued stay review, and are eligible for services during the appeal, written  
 19 documentation that an appeal is in progress may be used as a substitute for the approved ULTC  
 20 400.2-LOC Screen. Acceptable documentation of an appeal includes: (a) a copy of the request for  
 21 reconsideration or the request for appeal, signed by the client and sent to the Utilization Review  
 22 Contractor or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled  
 23 hearing, sent by the Utilization Review Contractor or the Office of Administrative Courts to the  
 24 client; or (c) a copy of the notice of a scheduled court date. Copies of denial letters, and written  
 25 statements from case managers, are not acceptable documentation that an appeal was actually  
 26 filed, and shall not be accepted as a substitute for the approved ULTC-100.2-LOC Screen. The  
 27 length of the PAR on appeal cases may be up to one year, with the PAR being revised to the  
 28 correct dates of eligibility at the time the appeal is resolved.

#### 29 **8.486.300 TERMINATION**

30 .301 In accordance with Long-term Care Single Entry Point System regulations at Section 8.393.28,  
 31 clients shall be terminated from any SEP-managed waiver whenever they no longer meet one or  
 32 more of the eligibility requirements at Section 8.485.60. Clients shall also be terminated from the  
 33 waiver if they die, move out of state or voluntarily withdraw from the waiver.

#### 34 **8.486.400 COMMUNICATION**

35 .401 In addition to any communication requirement specified elsewhere in these rules, the case  
 36 manager shall be responsible for the following communications:

- 37 A. The case manager shall inform all Alternative Care Facility clients of their obligation to  
 38 pay the full and current State-prescribed room and board amount, from their own income,  
 39 to the Alternative Care Facility provider.
- 40 B. Within five (5) working days of receipt of the approved PAR form, from the fiscal agent,  
 41 the case manager shall provide copies to all the HCBS-EBD providers in the care plan.

1 C. Within five (5) working days of ~~receipt from the URC of the certified ULTC-100.2~~  
2 ~~form, Level of Care Eligibility Determination-LOC Screen certification~~ the case manager  
3 shall send a copy of the ~~ULTC-100.2 form, Level of Care Eligibility Determination the LOC~~  
4 ~~Screen certification~~ to all personal care, and adult day services provider agencies on the  
5 care plan and to alternative care facilities listed on the care plan.

6 D. The case manager shall notify the URC, on a form prescribed by the Department, within  
7 thirty (30) calendar days, of the outcome of all non-diversions, as defined at Section  
8 8.485.50.

9 **8.486.500 CASE RECORDING/DOCUMENTATION**

10 .501 Case management documentation shall meet all of the standards found at Sections 8,393.2.H.  
11

DRAFT

1 **10 CCR 2505-10, Section 8.400-499, Appendix A: Age Appropriate Guidelines for the Use of ULTC**  
 2 **100.2 Assessment on Children**

3 These guidelines provide instructions for using the Uniform Long Term Care (ULTC) – 100.2 assessment  
 4 to assess the needs of children for the following Home and Community-Based Services (HCBS) Waivers:  
 5 Children’s Extensive Support (CES), Children’s HCBS (CHCBS), Children’s Habilitation Residential  
 6 Program (CHRP), Children with Life Limiting Illness (CLLI) and Children with Autism (CWA). Each  
 7 individual and their circumstances must be considered when completing the assessment. Case Managers  
 8 must score each child according to his/her age and individual needs.

9 Please consult evidence based resources and references to further your understanding of child  
 10 development.

11 **A. What is child development?**

- 12 1. Child development refers to the various stages of physical, biological, social, intellectual and  
 13 psychological changes that occur from birth through the end of adolescence.
- 14 2. Growing process refers to the process of becoming physically larger in size and more mature  
 15 through natural development.
- 16 3. The following are child development categories:
  - 17 a. Gross Motor Skill: The ability to coordinate and control large muscles of the body. Some  
 18 examples of gross motor control are sitting upright, balancing, walking, lifting, kicking and  
 19 throwing a ball.
  - 20 b. Fine Motor Skill: The ability to coordinate small muscles for precise small movements  
 21 involving the hands, wrists, feet, toes, lips and tongue. Some examples of fine motor  
 22 control are handwriting, drawing, grasping objects, dressing, cutting and controlling a  
 23 computer mouse.
  - 24 c. Speech and Language: The ability to both understand and use language to communicate  
 25 thoughts and feelings through speaking, body language and gestures.
  - 26 d. Cognitive: The ability to learn, understand, remember, reason, and solve problems.
  - 27 e. Social and Emotional: The ability to interact with others, have relationships with family,  
 28 friends, and teachers, exercise self-control, cooperate and respond to the feelings of  
 29 others.

30 **B. What are developmental milestones?**

- 31 1. Developmental milestones refer to abilities achieved by most children by a certain age.  
 32 Milestones are used to gauge how a child is developing. Each milestone is associated with a  
 33 specific age, however, the age when a developing child actually reaches each milestone may  
 34 vary.

35 **C. What is the Uniform Long Term Care (ULTC) 100.2 Assessment?**

36 The ULTC 100.2 is an assessment to determine the ~~functional nLevel of Care eeds~~ of a client by  
 37 evaluating the client’s ability to independently complete Activities of Daily Living (ADLs). ADLs are  
 38 activities performed in the course of a typical day in a person’s life such as: bathing, dressing, toileting,

1 mobility, transferring, and eating. ADLs also include behavior and memory supervision activities needed  
 2 for daily life. The ULTC 100.2 is a foundational component of the [Person-Centered Support](#)  
 3 [Planning](#) service-planning process that helps:

- 4 1. Determine the appropriate services
- 5 2. Determine the care that is necessary to meet clients' needs, and
- 6 3. Assist in the selection of long-term care supports and services that meet clients' needs.

7 The assessment measures what the child is able to do, not what he/she prefers to do. In other words,  
 8 assess the child's ability to do particular activities, even if he/she doesn't usually do the activity.

9 Consider age-appropriate behavior when assessing the child's ability to complete any ADL. If the child is  
 10 not able to complete the ADL due to his or her age, then the child will not score in the ADL. However, if a  
 11 child needs assistance in completing an ADL that is above and beyond the assistance a typically  
 12 developing peer would require, then a score above 0 may be warranted.

#### 13 **D. Scoring**

14 The ULTC 100.2 asks you to give the child a score between 0 and 3 based on the child's abilities  
 15 in eight ADL areas. Scoring is completed as follows:

16 0 = Independent:

17 The child requires no greater assistance to successfully complete this task than would a  
 18 child of similar age and stage that does not have a disability or impairment. The child has  
 19 age-appropriate independence and reliability in the use of adaptive equipment necessary  
 20 to complete this task, if needed.

21 1 = Minimal Assistance:

22 The child is able to perform all essential components of the activity with some  
 23 impairment, with or without assistive device within a reasonable amount of time.

24 A score of 1 indicates the child is able to perform most of the essential components of the  
 25 activity within a reasonable amount of time and may require:

- 26 a. Minimal assistance to successfully complete the task compared to a child of  
 27 similar age and stage.
- 28 b. Minimal assistance with adaptation and assistive device(s)/medical equipment(s).
- 29 c. Minimal interventions such as occasional standby assistance, oversight and/or  
 30 cueing.

31 2 = Moderate Assistance:

32 The child is unable to perform most of the essential components of the activity even with  
 33 assistive device, requires a great deal of supervision or exceeds a reasonable amount of  
 34 time to perform the activity with or without assistive device.

35 A score of 2 indicates that the child is unable to perform essential components of the  
 36 activity due to requiring:

- 1 a. Hands-on assistance.
- 2 b. Hands-on assistance to use assistive device(s)/medical equipment(s).
- 3 c. Interventions such as regular line of sight.
- 4 d. Significant prompting or step by step cueing to begin a task and to complete it
- 5 successfully.

6 3 = Total Assistance:

7 The child is totally unable to perform the essential components of the activity and needs  
8 extensive assistance.

9 A score of 3 indicates that the child is unable to perform the essential components of the  
10 activity due to requiring (but not limited to):

- 11 a. Assistance with complex assistive device(s)/medical equipment(s).
- 12 b. Extensive for hands-on assistance.
- 13 c. A trained attendant to perform ADLs or prevent complications.

#### 14 **E. Justification of Scoring (Due To's)**

15 All scores must be justified through one or more of the following conditions. Select all applicable  
16 "due to's" to support the ADL score.

- 17 1. Physical Impairment
  - 18 a. Example: client requires assistance due to paralysis
- 19 2. Supervision
  - 20 a. Example: client requires assistance due to lack of awareness
- 21 3. Mental Health
  - 22 a. Example: client requires assistance due to hallucinations

#### 23 **FD. Comment Box (Narratives)**

24 Narratives are required in the "Comment box" to support each score and to help others who read  
25 the assessment understand a client's over all need. Descriptions should be person-centered,  
26 meaningful and should justify level of assistance required based on "due to's." Comment  
27 descriptions should include:

- 28 a. How/Source: How the information obtained: Individual/caregiver, Case Manager  
29 Observation, or other?
- 30 b. What: What type of assistance is required to complete the task and how does the  
31 child manage to complete the task?
- 32 c. Who: Who is providing assistance?

1 d. When: How often is the child able or not able to complete the task each day?

2 e. Why: Why is the child able or not able to complete the activity (task)?

3 In May 2015, the Department published information on the best practices for what to include in  
4 narrative statements in the assessment in the Departments training website as well as in a Dear  
5 Administrator Letter. For additional information or examples of narrative statements, please find  
6 these resources on our website:

7 a. Writing Narrative Statements in the Assessment

8 b. Dear Administrator Letter – May 11, 2015

9 **GE. Activities of Daily Living (ADL)**

10 1. *BATHING*

11 Definition: The ability to shower, bathe or take sponge baths for the purpose of  
12 maintaining adequate hygiene.

13 For older children, this includes the ability to get in and out of the tub and/or shower, the  
14 ability to turn the faucets on and off, regulate water temperature and to wash and dry.

15 A child should be able to physically and/or cognitively perform all essential components  
16 of the task safely and without assistance at 10 years of age or older.

17 Consider what the parent or other caregiver is doing that is above and beyond the  
18 requirements of another child the same age without a disability or impairment.

19 Considerations for a child from birth to 59 months:

20 a. A child younger than 12 months is dependent on a caregiver for bathing.

21 b. A child 12-24 months can typically sit-up in the bath and begin to participate,  
22 however, the child still requires assistance and supervision.

23 c. A child 24-59 months typically participates in bathing, however, still requires  
24 assistance and supervision.

25 Considerations for a child from 5 to 18 years:

26 a. A child 5-18 years old typically has the ability to bathe and does not require  
27 assistance, supervision, and/or help transferring in and out of the tub.

28 A child may score if the child has a unique medical reason or cognitive impairment that  
29 impacts bathing, needs adaptive equipment or skilled/medical care during bathing.  
30 Please remember that all children under 4 years of age need some assistance in bathing.

31 2. *DRESSING*

32 Definition: The ability to dress and undress as appropriate.

33 This includes the ability to put on and remove basic garments such as underwear, shirts,  
34 sweaters, pants, socks, hats, and jackets. It also includes fine motor coordination for

1 buttons, snaps, zippers, and the ability to choose appropriate clothing for the weather.  
2 For older children, this activity includes the ability to put on prostheses, braces, anti-  
3 embolism hose or other assistive devices.

4 A child should be able to physically and/or cognitively perform all essential components  
5 of the task safely and without assistance at 5 years of age or older.

6 Consider what the parent or other caregiver is doing that is above and beyond the  
7 requirements of another child the same age without a disability or impairment.

8 Considerations for a Child from Birth to 59 Months:

- 9 a. A child younger than 12 months is dependent on a caregiver for dressing.  
10 b. A child 12-24 months can typically pull off hat, socks, and mittens.  
11 c. A child 24-35 months can typically begin to help dress self.  
12 d. A child 36-47 months can typically put on shoes (but cannot tie laces) and dress  
13 self with some help (buttons, snaps, zippers).

14 A child 48-59 months can typically dress self without much help.

15 Considerations for a Child from 5 to 18 Years:

- 16 a. A child age 5-18 years old typically participates in dressing and may require  
17 supervision or reminders with selecting appropriate clothing.

18 A child may score if the child has physical characteristics that makes dressing difficult  
19 such as contractures, hypotonia/hypertonia causing a lack of endurance or range of  
20 motion, or paralysis. Consider safety and the need to assist with dressing due to seizure  
21 activity, lack of balance or cognitive impairment when scoring a child. Difficulties with a  
22 zipper or buttons at the back of a garment is not unusual and does not mean there is a  
23 functional deficit.

### 24 3. *TOILETING*

25 Definition: The ability to use the toilet, commode, bedpan, or urinal.

26 This includes independent transferring on and off the toilet, cleansing appropriately, and  
27 adjusting clothes. In older children, this activity could include managing their ostomy or  
28 catheter.

29 A child should be able to physically and cognitively perform all essential components of  
30 the task safely and without assistance at 5 years of age or older.

31 Consider what the parent or other caregiver is doing that is above and beyond the  
32 requirements of another child the same age without a disability or impairment.

33 Considerations for a Child from Birth to 59 Months:

- 34 a. A child younger than 12 months is dependent on a caregiver for toileting.



- 1           b.     A child 12-42 months typically requires the use of diapers, though begins to gain  
2           some control of bowels/bladder.
- 3           c.     A child 43-59 months is typically toilet trained; however occasional night time  
4           bedwetting or accidents may occur.

5           Considerations for a Child from 5 to 18 Years:

- 6           a.     A child age 5-6 years old may need to have intermittent supervision, cueing, or  
7           minor physical assistance and/or; have occasional night time bedwetting or  
8           accidents during waking hours.
- 9           b.     A child age 7-18 years old should have the ability to toilet without assistance.

10          A child may score if he/she has cognitive impairment or skilled/medical care needs that  
11          affect toileting, such as ostomy, suppositories, or frequent infections. Children younger  
12          than 4 years old may still require diapers or need to have intermittent supervision, cueing,  
13          or minor physical assistance, or they may have occasional night time bedwetting or  
14          accidents during waking hours. Children should have an awareness of being wet or  
15          soiled and show interest in toilet training and/or appliances such as ostomies or urinary  
16          catheters.

17          4.     **MOBILITY**

18          Definition: The ability to move between locations in the child's environment inside and  
19          outside the home.

20          This includes the ability to safely maneuver (ambulate) without assistance, go up/down  
21          the stairs, kneel without support, and assume a standing position.

22          A child should be able to physically and/or cognitively perform all essential components  
23          of the task safely and without assistance at 3 years of age or older.

24          Consider what the parent or other caregiver is doing that is above and beyond the  
25          requirements of another child the same age without a disability or impairment.

26          Considerations for a Child from Birth to 59 Months:

- 27          a.     A child younger than 6 months is dependent on a caregiver for mobility.
- 28          b.     A child 6-12 months can typically maintain a sitting position, may begin to move  
29          by rolling or crawling, and may begin to pull self up using furniture.
- 30          c.     A child 12-18 months can typically pull self to standing position, sit or stand  
31          alone, and move by crawling and/or walking with or without the use of furniture  
32          for balance.
- 33          d.     A child 18-59 months can typically stand and walk without assistance.

34          Considerations for a Child from 5 to 18 Years:

- 35          a.     A child age 5-18 years old should be totally mobile and have the ability to move  
36          between locations without assistance.

1 A child may score if the child is unable to maintain seated balance, unable to bear weight  
2 on one or both legs, has a high risk of falling and/or uses mobility devices. Consideration  
3 is given to safety and the need to assist with mobility due to visual concerns, seizure  
4 activity, frequent falls, and/or lack of balance.

## 5 5. *TRANSFERS*

6 Definition: The physical ability to move between surfaces.

7 This includes the physical ability to get in/out of bed or usual sleeping place; to transfer  
8 from a bed/chair to a wheelchair, walker or standing position; to transfer on/off the toilet;  
9 and the ability to use assisted devices for transfers.

10 A child should be able to physically and/or cognitively perform all essential components  
11 of the task safely and without assistance at 3 years of age or older.

12 Consider what the parent or other caregiver is doing that is above and beyond the  
13 requirements of another child without a disability or impairment at the same age.

14 Considerations for a Child from Birth to 59 Months:

- 15 a. A child younger than 12 months is dependent on a caregiver for transfers.  
16 b. A child 12-36 months may require physical assistance with transfers.  
17 c. A child 36-59 months should require minimal assistance with transfers.

18 Considerations for a Child from 5 to 18 Years:

- 19 a. A child age 5-6 years old may still require minimal assistance with transfers.  
20 b. A child age 7-18 years old should be independent and be able to transfer without  
21 physical assistance.

22 A child may score if the child has limited ability to independently move between two  
23 nearby surfaces and/or use assisted devices to transfer. Consideration is given to safety  
24 and the need to assist with transfer due to visual concerns, seizure activity, and  
25 awareness to surrounding and/or lack of balance.

## 26 6. *EATING*

27 Definition: The ability to eat and drink using routine or adaptive utensils.

28 This includes the ability to cut, regulate the amount of intake, chew, swallow foods, and  
29 use utensils. Note other forms of feeding such as a tube or intravenous on the  
30 assessment.

31 A child should typically be able to physically and cognitively perform all essential  
32 components of the task safely and without assistance if 5 years of age or older.

33 Consider what the parent or caregiver is doing that is above and beyond the  
34 requirements of another child without a disability or impairment at the same age.

35 Considerations for a Child from Birth to 59 Months:

- 1 a. A child younger than 12 months is dependent on a caregiver for feeding.
- 2 b. A child 12-24 months can typically eat finger foods and begin to use a utensils  
3 and cup.
- 4 c. A child 24-47 months can typically feed self solid foods and begin to try new  
5 flavors of foods.
- 6 d. A child 48-59 months can typically use spoon, fork, and dinner knife  
7 independently.

8 Considerations for a Child from 5 to 18 Years:

- 9 a. A child age 5-6 years old should physically participate in eating, and may need  
10 some supervision and/or assistance.
- 11 b. A child age 7-18 years old should have the ability to eat without assistance.

12 A child may score if the child requires more than one hour per feeding, tube feedings (or  
13 TPN), or requires more than three hours per day for feeding or eating. Consideration is  
14 given to safety and the need to assist with eating due to choking, dietary restrictions,  
15 allergies and eating disorders. Children younger than 5 years of age may require verbal  
16 prompting and assistance with cutting food.

17 7. *SUPERVISION: (Behavioral)*

18 Definition: The ability to engage in safe actions and interactions and refrain from unsafe  
19 actions and interactions.

20 Considerations for a Child from Birth to 59 Months:

- 21 a. A child younger than 48 months requires supervision and surveillance.
- 22 b. A child 18-36 months often gets physically aggressive when frustrated.
- 23 c. A child 36-59 months should begin to understand and refrain from unsafe actions  
24 and interactions.

25 Considerations for a Child from 5 to 18 Years:

- 26 a. A child 5-18 years old should begin to understand and refrain from unsafe  
27 actions and interactions with occasional reminders.

28 A child may score if the ultimate responsibility for the safety, care, wellbeing, and  
29 behavior of dependent children remains with the parent or caregiver. Consideration  
30 should be given if the child is not able to manage appropriate behaviors and requires  
31 constant supervision/prompting.

32 Examples of behaviors that may justify scoring a functional deficiency for children over 36  
33 months include:

- 34 a. Verbal or physical threats and/or actions against self and/or others.
- 35 b. Socially inappropriate or sexually aggressive behaviors.

1 c. Wandering with little safety awareness.

2 d. Removing or destroying property.

3 8. *SUPERVISION: (Memory/Cognition)*

4 Definition: The ability to acquire and use information, communicate, reason, complete  
5 tasks, and problem-solve needs in order to care for oneself safely.

6 Considerations for a Child from Birth to 59 Months:

7 a. A child 12-18 months typically says 8-20 words, identifies objects in a book, and  
8 follows simple one step directions.

9 b. A child 18-24 months typically uses two to three word phrases, refers to self by  
10 name, and points to parts of face when asked.

11 c. A child 25-36 months typically enjoys simple make-believe games and enjoys  
12 simple stories or songs.

13 d. A child 36-59 months typically begins counting; identifying colors and letters; and  
14 can follow simple rules of a game.

15 Considerations for a Child from 5 to 18 years:

16 a. A child 5-9 years old may require occasional supervision necessary to acquire  
17 and use information, reason, problem-solve, complete tasks, or communicate  
18 needs in order to care for oneself safely.

19 b. A child 5-18 years old has the ability to recognize and adjust to daily routines,  
20 interact with peers and others appropriately, understand directions, understand  
21 basic home safety and stranger awareness.

22 A child may score if the child requires consistent reminding, planning or adjusting for both  
23 new and familiar routines; if the child needs preparation and assistance when  
24 transitioning between activities; or if the child has impaired ability to assure his or her  
25 safety in a strange environment (for example, the child cannot give name or address or  
26 would not be aware of dangerous situations).

27 Examples of behaviors that may justify scoring a functional deficiency for children over 59  
28 months include:

29 a. Failure to recognize and adjust to daily routines.

30 b. Inappropriate interactions with peers and other.

31 c. Lack of basic home safety understanding and stranger awareness.

32 **HF. Activities of Daily Living Scores**

33 *To be eligible for waiver services a child must have deficits in a minimum of two out of six ADLs (2+  
34 score) or a moderate score (2+ score) in Behaviors or Memory/Cognition under Supervision category.*

35 **GI. Assessment Demographic**

1 Check the appropriate box that best identifies the client situation. If one of the categories does not apply,  
2 select 'Other' and enter a description for the different categories in Assessment Demographics.

3 **JF. Summary**

4 Summarize the assessment findings and enter any additional comments that provide more information  
5 about the client's situation such as background information, current status, hospital visits, surgeries,  
6 seizure activities/frequency or police interactions. Comments can address issues not already identified by  
7 the assessment or expand on information presented in the assessment document. Please do not copy  
8 and paste entire assessment in this space.

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15 **8.500 HOME AND COMMUNITY-BASED SERVICES FOR INDIVIDUALS WITH INTELLECTUAL OR**  
16 **DEVELOPMENTAL DISABILITIES(HCBS-DD) WAIVER**

17 **8.500.1** This Section hereby incorporates the terms and provisions of the federally approved Home and  
18 Community-based Services for Individuals with Intellectual or Developmental Disabilities (HCBS-  
19 DD) waiver. To the extent that the terms of that federally approved waiver are inconsistent with  
20 the provisions of this Section, the waiver will control.

21 **8.500.1 DEFINITIONS**

- 22 A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel  
23 and bladder control, dressing, eating, independent ambulation, and needing supervision to  
24 support behavior, medical needs and memory/cognition.
- 25 B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-DD  
26 waiver or a HCBS waiver service.
- 27 C. APPLICANT means ~~an individual who is seeking a long term services and supports eligibility~~  
28 ~~determination and who has not affirmatively declined to apply for Medicaid or participate in an~~  
29 ~~assessment as defined in Section 8.390.1.~~
- 30 D. AUDITABLE means the information represented on the wavier cost report can be verified by  
31 reference to adequate documentation as required by generally accepted auditing standards.
- 32 E. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent  
33 or guardian of the Client receiving services, if appropriate, to assist the Client receiving services  
34 in acquiring or utilizing services and supports, this does not include the duties associated with an  
35 Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as  
36 defined at Section 8.510.1.

- 1 F. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit  
2 agency that meets all applicable state and federal requirements and is certified by the  
3 Department to provide case management services for Home and Community-Based Services  
4 waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation  
5 agreement with the state department.
- 6 G. CLIENT means an individual who meets long-term services and support eligibility requirements  
7 and has been approved for and agreed to receive Home and Community-Based Services  
8 (HCBS).
- 9 H. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the  
10 Client's behalf. A Client Representative may be: (A) a legal representative including, but not  
11 limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual,  
12 family member or friend selected by the Client to speak for or act on the Client's behalf.
- 13 I. COMMUNITY CENTERED BOARD means a private corporation, for-profit or not-for-profit that is  
14 designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting  
15 Developmental Disability determinations, waiting list management Level of Care Evaluations for  
16 Home and Community-Based Service waivers specific to individuals with intellectual and  
17 developmental disabilities, and management of State Funded programs for individuals with  
18 intellectual and developmental disabilities.
- 19 J. COST CONTAINMENT means limiting the cost of providing care in the community to less than or  
20 equal to the cost of providing care in an institutional setting based on the average aggregate  
21 amount. The cost of providing care in the community shall include the cost of providing home and  
22 community-based services and Medicaid state plan benefits including long-term home health  
23 services and targeted case management.
- 24 K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified  
25 need of the Client.
- 26 L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single  
27 State Medicaid agency.
- 28 M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.
- 29 N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.
- 30 O. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means as  
31 defined in 8.280.1.
- 32 P. FAMILY means a relationship as it pertains to the Client and is defined as:
- 33 A mother, father, brother, sister; or,
- 34 Extended blood relatives such as grandparent, aunt, uncle, cousin; or
- 35 An adoptive parent; or,
- 36 One or more individuals to whom legal custody of a Client with an intellectual or developmental  
37 disability has been given by a court; or,
- 38 A spouse; or,

1 The Client's children.

2 ~~Q.~~ ~~FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for long term services and~~  
3 ~~supports as determined by the Department's prescribed instrument.~~

4 ~~R.~~ ~~FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the~~  
5 ~~Uniform Long-term Care instrument and medical verification on the Professional Medical Information~~  
6 ~~Page to determine if the Client meets the institutional Level of Care (LOC).~~

7

8 ~~S.Q.~~ GROUP RESIDENTIAL SERVICES AND SUPPORTS (GRSS) means residential habilitation  
9 provided in group living environments of four (4) to eight (8) Clients receiving services who live in  
10 a single residential setting, which is licensed by the Colorado Department of Public Health and  
11 Environment as a residential care facility or residential community home for persons with  
12 developmental disabilities.

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

17 ~~U.S.~~ GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of  
18 a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963,"  
19 set forth in Article 33 of Title 22, C.R.S.

20 ~~V.T.~~ HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports  
21 authorized through a 1915(c) waiver of the Social Security Act and provided in community  
22 settings to a Client who requires a level of institutional care that would otherwise be provided in a  
23 hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities  
24 (ICF-IDD)

25 ~~W.U.~~ INDIVIDUAL RESIDENTIAL SERVICES AND SUPPORTS (IRSS) means residential habilitation  
26 services provided to three (3) or fewer Clients in a single residential setting or in a host home  
27 setting that does not require licensure by the Colorado Department of Public Health and  
28 Environment.

29 ~~V.X.~~ INSTITUTION means a hospital, nursing facility or intermediate care facility for individuals with  
30 intellectual disabilities (ICF-IDD) for which the Department makes Medicaid payment under the  
31 Medicaid State Plan.

32 ~~W.W.~~ INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES  
33 (ICF-IID) means a publicly or privately-operated facility that provides health and habilitation  
34 services to a Client with an intellectual or developmental disability or related conditions.

35 ~~Z.X.~~ LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.

36 ~~A.A.Y.~~ LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Client must  
37 require in order to receive services in an institutional setting under the Medicaid State Plan.

38 ~~B.B.Z.~~ LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by  
39 individuals of all ages with functional limitations and chronic illnesses who need assistance to  
40 perform routine daily activities.



- 1 ~~CCAA~~. MEDICAID ELIGIBLE means an ~~A~~applicant or Client meets the criteria for Medicaid benefits  
2 based on the ~~A~~applicant's financial determination and disability determination when applicable.
- 3 ~~DBBB~~. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility  
4 groups that a state serves through its Medicaid program, the benefits that the state covers, and  
5 how the state addresses additional federal Medicaid statutory requirements concerning the  
6 operation of its Medicaid program.
- 7 ~~EECC~~. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or  
8 inhalation of medication, including prescription and non-prescription drugs, according to the  
9 directions of the attending physician or other licensed health practitioner and making a written  
10 record thereof.
- 11 ~~FFDD~~. NATURAL SUPPORTS means non-paid informal relationships that provide assistance and occur  
12 in the Client's everyday life including, but not limited to, community supports and relationships  
13 with family members, friends, co-workers, neighbors and acquaintances.
- 14 ~~GGEE~~. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCD) means a public or privately  
15 managed service organization that is designated as a Community Centered Board and contracts  
16 with other qualified providers to furnish services authorized in the Home and Community-Based  
17 Services for Persons with Developmental Disabilities (HCBS-DD), HCBS-Supported Living  
18 Services (HCBS-SLS) and HCBS-Children's Extensive Supports (HCBS-CES) waivers.
- 19 ~~HHFF~~. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1  
20 DEFINITIONS.
- 21 GG. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance  
22 either from the Department, a State fiscal agent or the Case Management Agency.
- 23 ~~HHH~~. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means ~~the medical information form~~  
24 ~~signed by a licensed medical professional used to certify the client's medical necessity for long-~~  
25 ~~term care services as defined in Section 8.390.1 DEFINITIONS.~~
- 26 ~~JJ~~II PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency  
27 or typical community service agency as defined Section 8.600.4 et seq., that has received  
28 program approval to provide HCBS-DD waiver services.
- 29 ~~KKJJ~~. PUBLIC CONVEYANCE means public passenger transportation services that are available for  
30 use by the general public as opposed to modes for private use, including vehicles for hire.
- 31 ~~LLKK~~. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or  
32 common law marriage.
- 33 ~~MMLL~~. RETROSPECTIVE REVIEW means the Department or the Department's contractor's review after  
34 services and supports are provided to ensure the Client received services according to the  
35 support plan and that the Case Management Agency complied with the requirements set forth in  
36 statute, waiver and regulation.
- 37 ~~NSERVICE PLAN~~ Person-Centered Support Plan (PCSP) means as defined in Section 8.390.1  
38 DEFINITIONS. ~~the written document that specifies identified and needed services, to include~~  
39 ~~Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain~~  
40 ~~safely in the community and developed in accordance with the Department's rules.~~

1 ~~QQMM~~. STATE AND LOCAL GOVERNMENT HCBS WAIVER PROVIDER means the state owned and  
2 operated agency providing HCBS waiver services to Clients enrolled in the HCBS-DD waiver.

3 ~~PPNN~~. SUPPORT is any task performed for the Client where learning is secondary or incidental to the  
4 task itself or an adaptation is provided.

5 ~~QQOO~~. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers  
6 information from a semi-structured interview of respondents who know the Client well. It is  
7 designed to identify and measure the practical support requirements of adults with developmental  
8 disabilities.

9 ~~PPRR~~. TARGETED CASE MANAGEMENT (TCM) means case management services provided to  
10 individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP),  
11 HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case  
12 management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS  
13 waiver services and coordinating with other non-waiver resources, including, but not limited to  
14 medical, social, educational and other resources to ensure non-duplication of waiver services and  
15 the monitoring of effective and efficient provision of waiver services across multiple funding  
16 sources. Targeted case management includes the following activities; ~~comprehensive~~  
17 ~~a~~assessment and periodic ~~R~~eassessment, development and periodic revision of a ~~Service~~  
18 ~~Plan~~PCSP, referral and related activities, and monitoring.

19 ~~SSQQ~~. THIRD PARTY RESOURCES means services and supports that a Client may receive from a  
20 variety of programs and funding sources beyond natural supports or Medicaid. That may include,  
21 but are not limited to, community resources, services provided through private insurance, non-  
22 profit services and other government programs.

23 ~~TTTT~~. WAIVER SERVICE means optional services defined in the current federally approved HCBS  
24 waiver documents and do not include Medicaid State Plan benefits.

## 25 **8.500.2 HCBS-DD WAIVER ADMINISTRATION**

26 8.500.2.A HCBS-DD shall be provided in accordance with the federally approved waiver document  
27 and these rules and regulations.

28 8.500.2.B The HCBS-DD waiver provides the necessary support to meet the daily living needs of a  
29 Client who requires access to 24-hour support in a community-based residential setting.

30 8.500.2.C HCBS-DD Waiver services are available only to address those needs identified in the  
31 ~~functional needs assessment~~LOC Screen and authorized in the ~~service plan~~PCSP and when the  
32 service or support is not available through the Medicaid state plan, EPSDT, natural supports or  
33 third-party resources.

## 34 **8.500.4 CLIENT ELIGIBILITY**

35 8.500.4.A To be eligible for the HCBS-DD waiver, an individual shall meet the target population  
36 criteria as follows:

- 37 1. Be determined to have an intellectual or developmental disability,
- 38 2. Be eighteen (18) years of age or older,
- 39 3. Require access to services and supports twenty-four (24) hours a day,

- 1 4. Meet ICF-IID level of care as determined by the ~~functional needs assessment~~LOC  
2 Screen, and
- 3 5. Meet the Medicaid financial determination for LTC eligibility as specified in Section 8.100,  
4 *et seq.*

#### 5 8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

6 The section hereby incorporates the terms and provisions of the federally approved Home and  
7 Community-Based Supported Living Services (HCBS-SLS) waiver. To the extent that the terms of the  
8 federally approved waiver are inconsistent with the provisions of this section, the waiver shall control.

9 HCBS-SLS services and supports which are available to assist persons with intellectual or developmental  
10 disabilities to live in the person's own home, apartment, family home, or rental unit that qualifies as an  
11 HCBS-SLS setting. HCBS-SLS waiver services are not intended to provide twenty-four (24) hours of paid  
12 support or meet all identified Client needs and are subject to the availability of appropriate services and  
13 supports within existing resources.

#### 14 8.500.90 DEFINITIONS

- 15 A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel  
16 and bladder control, dressing, eating, independent ambulation, and needing supervision to  
17 support behavior, medical needs and memory/cognition.
- 18 B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-SLS  
19 waiver or a specific HCBS-SLS waiver service(s).
- 20 C. APPLICANT means ~~an individual who is seeking a long-term services and supports eligibility~~  
21 ~~determination and who has not affirmatively declined to apply for Medicaid or participate in an~~  
22 ~~assessment as defined in Section 9.390.1.~~
- 23 D. AUTHORIZED REPRESENTATIVE means an individual designated by a Client, or by the parent  
24 or guardian of the Client receiving services, if appropriate, to assist the Client receiving service in  
25 acquiring or utilizing services and supports, this does not include the duties associated with an  
26 Authorized Representative for Consumer Directed Attendant Support Services (CDASS) as  
27 defined at Section 8.510.1.
- 28 E. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit  
29 agency that meets all applicable state and federal requirements and is certified by the  
30 Department to provide case management services for Home and Community-Based Services  
31 waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation  
32 agreement with the state department.
- 33 F. CLIENT means an individual who meets long-term services and supports eligibility requirements  
34 and has been approved for and agreed to receive Home and Community-Based Services  
35 (HCBS).
- 36 G. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the  
37 Client's behalf. A Client representative may be: (A) a legal representative including, but not  
38 limited to a court-appointed guardian, a parent of a minor child, or a spouse; or, (B) an individual,  
39 family member or friend selected by the Client to speak for and/or act on the Client's behalf.
- 40 H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit  
41 that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to

- 1 conducting Developmental Disability determinations, waiting list management Level of Care  
 2 Evaluations for Home and Community-Based Service waivers specific to individuals with  
 3 intellectual and developmental disabilities, and management of State Funded programs for  
 4 individuals with intellectual and developmental disabilities.
- 5 I. CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service  
 6 delivery option for services that assist an individual in accomplishing activities of daily living when  
 7 included as a waiver benefit that may include health maintenance, personal care and homemaker  
 8 activities.
- 9 J. COST CONTAINMENT means limiting the cost of providing care in the community to less than or  
 10 equal to the cost of providing care in an institutional setting based on the average aggregate  
 11 amount. The cost of providing care in the community shall include the cost of providing Home and  
 12 Community-Based Services, and Medicaid State Plan Benefits including long-term home health  
 13 services, and targeted case management.
- 14 K. COST EFFECTIVENESS means the most economical and reliable means to meet an identified  
 15 need of the Client.
- 16 L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single  
 17 State Medicaid agency.
- 18 M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.
- 19 N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.
- 20 O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as  
 21 defined in Section 8.280.1.
- 22 P. FAMILY means a relationship as it pertains to the Client and includes the following:  
 23 A mother, father, brother, sister; or,  
 24 Extended blood relatives such as grandparent, aunt, uncle, cousin; or  
 25 An adoptive parent; or,  
 26 One or more individuals to whom legal custody of a Client with an intellectual or developmental  
 27 disability has been given by a court; or,  
 28 A spouse; or  
 29 The Client's children.
- 30 ~~Q. FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for long term services and~~  
 31 ~~supports as determined by the Department's prescribed instrument.~~
- 32 ~~R. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face to face evaluation using the~~  
 33 ~~Uniform Long term Care instrument and medical verification on the professional medical~~  
 34 ~~information page to determine if the applicant or Client meets the institutional Level of Care~~  
 35 ~~(LOC).~~
- 36 Q. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who  
 37 has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a

- 1 parent or by the court. The term includes a limited, emergency, and temporary substitute  
2 guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.
- 3 R. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of  
4 a child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963,"  
5 set forth in Article 33 of Title 22, C.R.S.
- 6 S. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports  
7 authorized through a 1915(c) waiver of the Social Security Act and provided in community  
8 settings to a Client who requires a level of institutional care that would otherwise be provided in a  
9 hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities  
10 (ICF-IID).
- 11 T. INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for Individuals with  
12 Intellectual Disabilities (ICF-IID) for which the Department makes Medicaid payment under the  
13 Medicaid State Plan.
- 14 U. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES  
15 (ICF-IID) means a public or private facility that provides health and habilitation services to a Client  
16 with intellectual or developmental disabilities or related conditions.
- 17 V. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse.
- 18 W. LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a Client must  
19 require in order to receive services in an institutional setting under the state plan.
- 20 X. LEVEL OF CARE SCREEN means as defined in Section 8.390.1.
- 21 Y. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by  
22 individuals of all ages with functional limitations and chronic illness who need assistance to  
23 perform routine daily activities such as bathing, dressing, preparing meals, and administering  
24 medications.
- 25 YZ. MEDICAID ELIGIBLE means an Aapplicant or Client meets the criteria for Medicaid benefits  
26 based on the Aapplicant's financial determination and disability determination when applicable.
- 27 ZAA. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility  
28 groups that a state serves through its Medicaid program, the benefits that the State covers, and  
29 how the State addresses additional Federal Medicaid statutory requirements concerning the  
30 operation of its Medicaid program.
- 31 AABB. MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or  
32 inhalation of medication, including prescription and non-prescription drugs, according to the  
33 directions of the attending physician or other licensed health practitioner and making a written  
34 record thereof.
- 35 BBCC. NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur  
36 in a Client's everyday life including, but not limited to, community supports and relationships with  
37 family members, friends, co-workers, neighbors and acquaintances.
- 38 CCDD. ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCDs) means a public or privately  
39 managed service organization that is designated as a Community Centered Board and contracts  
40 with other qualified providers to furnish services authorized in the Home and Community-Based  
41 Services for Persons with Developmental Disabilities (HCBS-DD), Home and Community-Based

- 1 Services Supported Living Services (HCBS-SLS) and Home and Community-Based Services  
2 Children's Extensive Support (HCBS-CES) waivers.
- 3 ~~DBEE~~. PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1  
4 DEFINITIONS.
- 5 ~~EEFF~~. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance  
6 either from the Department, a State fiscal agent or the Case Management Agency.
- 7 ~~FFGG~~. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means ~~the medical information form~~  
8 ~~signed by a licensed medical professional used to certify the Applicant's or Client's need for long-~~  
9 ~~term care services.~~ as defined in Section 8.390.1 DEFINITIONS.
- 10 ~~GGHH~~. PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency  
11 or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received  
12 program approval to provide HCBS-SLS services.
- 13 ~~HHII~~. PUBLIC CONVEYANCE means public passenger transportation services that are available for  
14 use by the general public as opposed to modes for private use including vehicles for hire.
- 15 ~~IJJJ~~. REIMBURSEMENT RATES means the maximum allowable Medicaid reimbursement to a provider  
16 for each unit of service.
- 17 ~~JJKK~~. RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or  
18 common law marriage.
- 19 ~~KKLL~~. RETROSPECTIVE REVIEW means the Department or the Department's contractor review after  
20 services and supports are provided to ensure the Client received services according to the  
21 ~~service plan~~ PCSP and that the Case Management Agency complied with requirements set forth  
22 in statute, waiver and regulation.
- 23 ~~LLMM~~. SERVICE DELIVERY OPTION means the method by which direct services are provided for a  
24 Client and include a) by an agency and b) Client directed. ~~SERVICE PLAN—the written~~  
25 ~~document that specifies identified and needed services to include Medicaid-eligible and non-~~  
26 ~~Medicaid-eligible services, regardless of funding source, to assist a Client to remain safely in the~~  
27 ~~community and developed in accordance with the Department's rules.~~
- 28 ~~MMNN~~. SERVICE PLAN AUTHORIZATION LIMIT (SPAL) means an annual upper payment limit of total  
29 funds available to purchase services to meet the Client's ongoing needs. Purchase of services  
30 not subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each  
31 of the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department  
32 based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level,  
33 and projected utilization.
- 34 ~~NNOO~~. SUPPORT is any task performed for the Client where learning is secondary or incidental to the  
35 task itself or an adaptation is provided.
- 36 ~~OOPP~~. SUPPORTS INTENSITY SCALE (SIS) means the standardized assessment tool that gathers  
37 information from a semi- structured interview of respondents who know the Client well. It is  
38 designed to identify and measure the practical support requirements of adults with developmental  
39 disabilities.
- 40 ~~PPQQ~~. SUPPORT LEVEL means a numeric value determined using an algorithm that places Clients into  
41 groups with other Clients who have similar overall support needs.



1 **QQRR.** TARGETED CASE MANAGEMENT (TCM) means case management services provided to  
 2 individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP),  
 3 HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case  
 4 management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS  
 5 waiver services and coordinating with other non-waiver resources, including, but not limited to  
 6 medical, social, educational and other resources to ensure non-duplication of waiver services and  
 7 the monitoring of effective and efficient provision of waiver services across multiple funding  
 8 sources. Targeted case management includes the following activities: **comprehensive**  
 9 **Assessment** and periodic **R** reassessment, development and periodic revision of a **Service**  
 10 **Plan, PCSP** referral and related activities, and monitoring.

11 **RRSS.** THIRD PARTY RESOURCES means services and supports that a Client may receive from a  
 12 variety of programs and funding sources beyond natural supports or Medicaid that may include,  
 13 but are not limited to community resources, services provided through private insurance, non-  
 14 profit services and other government programs.

15 **SSTT.** WAIVER SERVICE means optional services defined in the current federally approved HCBS  
 16 waiver documents and do not include Medicaid State plan benefits.

#### 17 **8.500.91 HCBS-SLS WAIVER ADMINISTRATION**

18 8.500.91.A HCBS-SLS shall be provided in accordance with the federally approved waiver document  
 19 and these rules and regulations, and the rules and regulations of the Colorado Department of  
 20 Human Services, Division for Developmental Disabilities, 2 CCR 503-1 and promulgated in  
 21 accordance with the provision of Section 25.5-6-404 (4), C.R.S.

22 8.500.91.B In the event a direct conflict arises between the rules and regulations of the Department  
 23 and the Operating Agency, the provisions of Section 25.5-6-404(4), C.R.S. shall apply and the  
 24 regulations of the Department shall control.

25 8.500.10.C The HCBS-SLS waiver is operated by the Department of Health Care Policy and  
 26 Financing.

27 8.500.910.E HCBS-SLS services are available only to address those needs identified in the **functional**  
 28 **needs assessment-LOC Screen** and authorized in the **service plan PCSP** when the service or  
 29 support is not available through the Medicaid State plan, EPSDT, natural supports, or third party  
 30 payment resources.

31 8.500.91.F The HCBS-SLS Waiver:

- 32 1. Shall not constitute an entitlement to services from either the Department or the  
 33 Operating Agency,
- 34 2. Shall be subject to annual appropriations by the Colorado General Assembly,
- 35 3. Shall ensure enrollments into the HCBS-SLS waiver do not exceed the federally  
 36 approved waiver capacity, and
- 37 4. May limit the enrollment when utilization of the HCBS-SLS waiver program is projected to  
 38 exceed the spending authority.

#### 39 **8.500.93 CLIENT ELIGIBILITY**

- 1 8.500.93. A To be eligible for the HCBS-SLS waiver an individual shall meet the target population  
2 criteria as follows:
- 3 1. Be determined to have an intellectual or developmental disability
  - 4 2. Be eighteen (18) years of age or older,
  - 5 3. Does not require twenty-four (24) hour supervision on a continuous basis which is  
6 reimbursed as a HCBS-SLS service,
  - 7 4. Is served safely in the community with the type or amount of HCBS-SLS waiver services  
8 available and within the federally approved capacity and cost containment limits of the  
9 waiver,
  - 10 5. Meet ICF-IID level of care as determined by the ~~Functional Needs Assessment~~LOC  
11 Screen.
  - 12 6. Meet the Medicaid financial determination for LTC eligibility as specified at Section 8.100;  
13 and,
  - 14 7. Reside in an eligible HCBS-SLS setting. SLS settings are the Client's residence, which is  
15 defined as the following:
    - 16 a. A living arrangement, which the Client owns, rents or leases in own name,
    - 17 b. The home where the Client lives with the Client's family or legal guardian, or
    - 18 c. A living arrangement of no more than three (3) persons receiving HCBS-SLS  
19 residing in one household, unless they are all members of the same family.
  - 20 8. The Client shall maintain eligibility by continuing to meet the HCBS-SLS eligibility  
21 requirements and the following:
    - 22 a. Receives at least one (1) HCB-SLS waiver service each calendar month,
    - 23 b. Is not simultaneously enrolled in any other HCBS waiver, and
    - 24 c. Is not residing in a hospital, nursing facility, ICF-IID, correctional facility or other  
25 institution.
  - 26 9. When the HCBS-SLS waiver reaches capacity for enrollment, a Client determined eligible  
27 for a waiver shall be placed on a wait list in accordance with these rules at Section  
28 8.500.96.

### 29 **8.500.103 RETROSPECTIVE REVIEW PROCESS**

- 30 8.500.103.A Services provided to a Client are subject to a retrospective review by the Department and  
31 the Operating Agency. This retrospective review shall ensure that services:
- 32 1. Identified in the ~~service plan~~PCSP are based on the Client's identified needs as stated in  
33 the ~~functional needs assessment~~LOC Screen.
  - 34 2. Have been requested and approved prior to the delivery of services,



3. Provided to a Client are in accordance with the ~~service plan~~, PCSP and
4. Provided are within the specified HCBS service definition in the federally approved HCBS-SLS waiver,

#### 8.501 State Funded Supported Living Services Program

The State Funded Supported Living Services (State-SLS) program is funded through an allocation from the Colorado General Assembly. The State-SLS program is designed to provide supports to individuals with an intellectual or developmental disability to remain in their community. The State-SLS program shall not supplant Home and Community-Based services for those who are currently eligible.

##### 8.501.A Definitions

1. APPLICANT means an individual who is seeking supports from State-SLS program.
2. 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 Home and Community-Based Services waivers pursuant to section 25.5-10-209.5, C.R.S., has a valid provider participation agreement with the Department, and has a valid contract with the Department to provide these services.
3. CCB CASE MANAGER means the staff member of the Community Centered Board that works with individuals seeking services to develop and authorize services under the State-SLS program.
4. CLIENT means an individual who meets the DD Determination criteria and other State-SLS eligibility requirements and has been approved for and agreed to receive services in the State-SLS program.
5. 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, 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.
6. CORRECTIVE ACTION PLAN means a written plan, which includes the detailed description of actions to be taken to correct non-compliance with State-SLS requirements, regulations, and direction from the Department, and includes the date by which each action shall be completed and the individuals responsible for implementing the action.
7. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit that meets the requirements set forth in Section 25.5.-10-209, C.R.S. and is responsible for conducting level of care evaluations and determinations for State-SLS services specific to individuals with intellectual and developmental disabilities.
8. COMMUNITY RESOURCE means services and supports that a Client may receive from a variety of programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not limited to, services provided through private insurance, non-profit services and other government programs.
9. COST EFFECTIVENESS means the most economical and reliable means to meet an identified need of the Client.

- 1 10. DEVELOPMENTAL DISABILITY (DD) DETERMINATION means the determination of a  
2 Developmental Disability as defined in section 8.607.2
- 3 11. DEPARTMENT means the Colorado Department of Health Care Policy and Financing,  
4 the single State Medicaid agency.
- 5 12. DEVELOPMENTAL DISABILITY means a disability that is defined in section 8.600.4.
- 6 13. EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT) means  
7 the child health component of Medicaid State Plan for Medicaid eligible children up to the  
8 age of twenty-one (21).
- 9 14. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and  
10 supports authorized through a 1915(c) waiver of the Social Security Act and provided in  
11 community settings to a Client who requires a level of institutional care that would  
12 otherwise be provided in a hospital, nursing facility or intermediate care facility for  
13 individuals with intellectual disabilities (ICF-IID).
- 14 15. LONG-TERM CARE SERVICES AND SUPPORTS (LTSS) means the services and  
15 supports utilized by individuals of all ages with functional limitations and chronic illnesses  
16 who need assistance to perform routine daily activities such as bathing, dressing,  
17 preparing meals, and administering medications.
- 18 16. MEDICAID ELIGIBLE means an Applicant or Client meets the criteria for Medicaid  
19 benefits based on a financial determination and disability determination.
- 20 17. MEDICAID STATE PLAN means the federally approved document that specifies the  
21 eligibility groups that a state serves through its Medicaid program, the benefits that the  
22 state covers, and how the state addresses federal Medicaid statutory requirements  
23 concerning the operation of its Medicaid program.
- 24 18. NATURAL SUPPORTS means an informal relationship that provides assistance and  
25 occurs in the Client's everyday life including, but not limited to, community supports and  
26 relationships with family members, friends, co-workers, neighbors and acquaintances.
- 27 19. PERFORMANCE AND QUALITY REVIEW means a review conducted by the  
28 Department or its contractor at any time to include a review of required case  
29 management services performed by the CCB to ensure quality and compliance with all  
30 statutory and regulatory requirements.
- 31 20. PLAN YEAR mean a twelve (12) month period starting from the date when State-SLS  
32 Supports and Services where authorized.
- 33 21. PRIOR AUTHORIZATION means approval for an item or service that is obtained in  
34 advance either from the Department, a State fiscal agent.
- 35 22. PROGRAM APPROVED SERVICE AGENCY (PASA) means a developmental disabilities  
36 service agency or a service agency as defined in 8.602, that has received program  
37 approval, by the Department, to provide Medicaid Wavier services.
- 38 23. RELATIVE means a person related to the Client by virtue of blood, marriage, or adoption.
- 39 24. RETROSPECTIVE REVIEW means the Department's review after services and supports  
40 are provided and the PASA is reimbursed for the service, to ensure the Client received

1 services according to the ~~service-plan~~PCSP and standards of economy, efficiency and  
2 quality of service.

3 25. STATE-SLS INDIVIDUAL SUPPORT PLAN means the written document that identifies  
4 an individual's need and specifies the State-SLS services being authorized, to assist a  
5 Client to remain safely in the community.

6 26. STATE FISCAL YEAR means a 12-month period beginning on July 1 of each year and  
7 ending June 30 of the following calendar year. If a single calendar year follows the term,  
8 then it means the State Fiscal Year ending in the calendar year.

9 27. Services and Supports or Supports and Services means one or more of the following:  
10 Education, training, independent or supported living assistance, therapies, identification  
11 of natural supports, and other activities provided to

12 a. To enable persons with intellectual and developmental disabilities to make  
13 responsible choices, exert greater control over their lives, experience presence  
14 and inclusion in their communities, develop their competencies and talents,  
15 maintain relationships, foster a sense of belonging, and experience person  
16 security and self-respect.

17 28. SUPPORT SERVICE means the service(s) established in the State SLS program that a  
18 CCB Case Manager may authorize to support an eligible Client to complete the identified  
19 tasks identified in the Client's Individualized Support Plan.

20 29. WAIVER SERVICE means optional services and supports defined in the current federally  
21 approved HCBS waiver documents and do not include Medicaid State Plan benefits.

## 22 8.503 CHILDREN'S EXTENSIVE SUPPORT WAIVER PROGRAM (HCBS-CES)

### 23 8.503 DEFINITIONS

24 A. ACTIVITIES OF DAILY LIVING (ADL) means basic self-care activities including bathing, bowel  
25 and bladder control, dressing, eating, independent ambulation, transferring, and needing  
26 supervision to support behavior, medical needs and memory cognition.

27 B. ADVERSE ACTION means a denial, reduction, termination or suspension from the HCBS-CES  
28 waiver or a HCBS waiver service.

29 C. APPLICANT means ~~an individual who is seeking a long-term services and supports eligibility~~  
30 ~~determination and who has not affirmatively declined to apply for Medicaid or participate in an~~  
31 ~~assessment-s defined in Section 8.390.1.~~

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

37 E. CASE MANAGEMENT AGENCY (CMA) means a public or private not-for-profit or for-profit  
38 agency that meets all applicable state and federal requirements and is certified by the  
39 Department to provide case management services for Home and Community Based Services  
40 waivers pursuant to Section 25.5-10-209.5, C.R.S. and pursuant to a provider participation  
41 agreement with the Department.

- 1 F. CLIENT means an individual who meets long-term services and supports eligibility requirements  
2 and has been approved for and agreed to receive Home and Community-based Services  
3 (HCBS).
- 4 G. CLIENT REPRESENTATIVE means a person who is designated by the Client to act on the  
5 Client's behalf. A Client representative may be: (A) a legal representative including, but not  
6 limited to a court-appointed guardian, a parent of a minor child, or a spouse; or (B) an individual,  
7 family member or friend selected by the Client to speak for or act on the Client's behalf.
- 8 H. COMMUNITY CENTERED BOARD (CCB) means a private corporation, for-profit or not-for-profit  
9 that is designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to  
10 conducting Developmental Disability determinations, waiting list management Level of Care  
11 Evaluations for Home and Community-based Service waivers specific to individuals with  
12 intellectual and developmental disabilities, and management of State Funded programs for  
13 individuals with intellectual and developmental disabilities.
- 14 I. COST CONTAINMENT means limiting the cost of providing care in the community to less than or  
15 equal to the cost of providing care in an institutional setting based on the average aggregate  
16 amount. The cost of providing care in the community shall include the cost of providing Home and  
17 Community-based Services, and Medicaid State Plan benefits including long-term home health  
18 services and targeted case management.
- 19 J. COST EFFECTIVENESS means the most economical and reliable means to meet an identified  
20 need of the Client.
- 21 K. CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES (CDASS) means the service  
22 delivery option for services that assist an individual in accomplishing activities of daily living when  
23 included as a waiver benefit that may include health maintenance, personal care and homemaker  
24 activities.
- 25 L. DEPARTMENT means the Colorado Department of Health Care Policy and Financing, the single  
26 state Medicaid agency.
- 27 M. DEVELOPMENTAL DELAY means as defined in Section 8.600.4.
- 28 N. DEVELOPMENTAL DISABILITY means as defined in Section 8.600.4.
- 29 O. EARLY AND PERIODIC SCREENING DIAGNOSIS AND TREATMENT (EPSDT) means as  
30 defined in Section 8.280.1.
- 31 P. FAMILY means a relationship as it pertains to the Client and is defined as:
- 32 A mother, father, brother, sister,
- 33 Extended blood relatives such as grandparent, aunt, uncle, cousin,
- 34 An adoptive parent,
- 35 One or more individuals to whom legal custody of a person with a developmental disability has  
36 been given by a court,
- 37 A spouse or,
- 38 The Client's child.

- 1 Q. FISCAL MANAGEMENT SERVICE (FMS) means the entity contracted with the Department to  
2 complete employment related functions for CDASS attendants and track and report on individual  
3 Client allocations for CDASS.
- 4 ~~FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for long-term services  
5 and supports as determined by the Department~~
- 6 ~~S. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the  
7 Uniform Long-term Care instrument and medical verification on the Professional Medical  
8 Information Page to determine if the applicant or Client meets the institutional Level of Care  
9 (LOC).~~
- 10 R. GUARDIAN means an individual at least twenty-one years of age, resident or non-resident, who  
11 has qualified as a guardian of a minor or incapacitated person pursuant to appointment by a  
12 parent or by the court. The term includes a limited, emergency, and temporary substitute  
13 guardian but not a guardian ad litem Section 15-14-102 (4), C.R.S.
- 14 S. GUARDIAN AD LITEM or GAL means a person appointed by a court to act in the best interests of  
15 a child involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963,"  
16 set forth in Article 33 of Title 22, C.R.S.
- 17 T. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVERS means services and supports  
18 authorized through a 1915 (c) waiver of the Social Security Act and provided in community  
19 settings to a Client who requires a level of institutional care that would otherwise be provided in a  
20 hospital, nursing facility or Intermediate Care Facility for Individuals with Intellectual Disabilities  
21 (ICF-IID).
- 22 U. INSTITUTION means a hospital, nursing facility, or ICF-IID for which the Department makes  
23 Medicaid payments under the state plan.
- 24 V. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES  
25 (ICF-IID) means a publicly or privately operated facility that provides health and habilitation  
26 services to a Client with developmental disabilities or related conditions.
- 27 W. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse
- 28 X. LEVEL OF CARE (LOC) means the specified minimum amount of assistance a Client must  
29 require in order to receive services in an institutional setting under the Medicaid State Plan.
- 30 ~~Y. LEVEL OF CARE SCREEN means as defined in Section 8.391.1.~~
- 31 ~~YZ. LICENSED MEDICAL PROFESSIONAL means a person who has completed a 2-year or longer  
32 program leading to an academic degree or certificate in a medically related profession. This is  
33 limited to those who possess the following medical licenses: physician, physician assistant and  
34 nurse governed by the Colorado Medical License Act and the Colorado Nurse Practice Act.~~
- 35 ~~ZAA. LONG-TERM SERVICES AND SUPPORTS (LTSS) means the services and supports used by  
36 individuals of all ages with functional limitations and chronic illnesses who need assistance to  
37 perform routine daily activities.~~
- 38 ~~AABB. MEDICAID ELIGIBLE means the Applicant or Client meets the criteria for Medicaid benefits  
39 based on the Applicant's financial determination and disability determination when applicable.~~

- 1 **BBCC.** MEDICAID STATE PLAN means the federally approved document that specifies the eligibility  
2 groups that a state serves through its Medicaid program, the benefits that the state covers, and  
3 how the state addresses additional federal Medicaid statutory requirements concerning the  
4 operation of its Medicaid program.
- 5 **CCDD.** MEDICATION ADMINISTRATION means assisting a Client in the ingestion, application or  
6 inhalation of medication, including prescription and non-prescription drugs, according to the  
7 directions of the attending physician or other licensed health practitioner and making a written  
8 record thereof.
- 9 **DEEE.** NATURAL SUPPORTS means non paid informal relationships that provide assistance and occur  
10 in the Client's everyday life such as, but not limited to, community supports and relationships with  
11 family members, friends, co-workers, neighbors and acquaintances.
- 12 **EEFF.** ORGANIZED HEALTH CARE DELIVERY SYSTEM (OHCD) means a public or privately  
13 managed service organization that is designated as a Community Centered Board and contracts  
14 with other qualified providers to furnish services authorized in Home and Community Services for  
15 persons with Developmental Disabilities (HCBS-DD), HCBS- Supported Living Services (HCBS-  
16 SLS) and HCBS- Children's Extensive Supports (HBCS-CES) waivers.
- 17 **FFGG.** PERSON-CENTERED SUPPORT PLAN (PCSP) means as defined in Section 8.390.1  
18 DEFINITIONS.
- 19 **GGHH.** PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance  
20 either from the Department, a state fiscal agent or the Case Management Agency.
- 21 **HHII.** PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means as defined in Section 8.390.1  
22 DEFINITIONS.
- 23 **IJJJ.** PROGRAM APPROVED SERVICE AGENCY means a developmental disabilities service agency  
24 or typical community service agency as defined in Section 8.600.4 *et seq.*, that has received  
25 program approval to provide HCBS-CES waiver services.
- 26 **JJKK.** RELATIVE means a person related to the Client by virtue of blood, marriage, adoption or  
27 common law marriage.
- 28 **KKLL.** RETROSPECTIVE REVIEW means the Department or the Department's contractor review after  
29 services and supports are provided to ensure the Client received services according to the  
30 ~~service plan~~ PCSP and that the Case Management Agency complied with the requirements set  
31 forth in statute, waiver and regulation.
- 32 ~~SERVICE PLAN the written document that specifies identified and needed services, regardless of~~  
33 ~~funding source, to assist a Client to remain safely in the community and developed in accordance~~  
34 ~~with the Department's rules~~
- 35 **LLMM.** SUPPORT is any task performed for the Client where learning is secondary or incidental to the  
36 task itself or an adaptation is provided.
- 37 **MMNN.** TARGETED CASE MANAGEMENT (TCM) means case management services provided to  
38 individuals enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP),  
39 HCBS-DD, and HCBS-SLS waivers in accordance with Section 8.760 *et seq*, Targeted case  
40 management includes facilitating enrollment, locating, coordinating and monitoring needed HCBS  
41 waiver services and coordinating with other non-waiver resources, including, but not limited to  
42 medical, social, educational and other resources to ensure non-duplication of waiver services and

1 the monitoring of effective and efficient provision of waiver services across multiple funding  
 2 sources. Targeted case management includes the following activities; ~~comprehensive~~  
 3 ~~A~~assessment and periodic ~~R~~reassessment, development and periodic revision of a ~~Service~~  
 4 ~~Plan, PCSP~~, referral and related activities, and monitoring.

5 ~~NNOO~~. THIRD PARTY RESOURCES means services and supports that a Client may receive from a  
 6 variety of programs and funding sources beyond natural supports or Medicaid. They may include,  
 7 but are not limited to community resources, services provided through private insurance, non-  
 8 profit services and other government programs.

9 ~~OOPP~~. UTILIZATION REVIEW CONTRACTOR (URC) means the agency contracted with the  
 10 Department to review the HCBS-CES waiver applications for determination of eligibility based on  
 11 the additional targeting criteria.

12 ~~PPQQ~~. WAIVER SERVICE means optional services defined in the current federally approved waivers  
 13 and do not include Medicaid State Plan benefits.

#### 14 **8.503.30 CLIENT ELIGIBILITY**

15 A. To be eligible for the HCBS-CES waiver, an individual shall meet the target population criteria as  
 16 follows:

- 17 1. Is unmarried and less than eighteen years of age,
- 18 2. Be determined to have a Developmental Disability which includes Developmental Delay if  
 19 under five (5) years of age,
- 20 3. Can be safely served in the community with the type and amount of HCBS-CES waiver  
 21 services available and within the federally approved capacity and Cost Containment limits  
 22 of the HCBS-CES waiver,
- 23 4. Meet ICF-IID Level ~~o~~Of Care as determined by the ~~Functional Needs Assessment, LOC~~  
 24 ~~Screen~~.
- 25 5. Meet the Medicaid financial determination for Long-term Care (LTC) eligibility as  
 26 specified at Section 8.100 *et seq.* and,
- 27 6. Reside in an eligible HCBS-CES waiver setting as defined as the following:
  - 28 a. With biological, adoptive parent(s), or legal Guardian,
  - 29 b. In an out-of-home placement and can return home with the provision of HCBS-  
 30 CES waiver services with the following requirement:
    - 31 i. The case manager will work in conjunction with the residential caregiver  
 32 to develop a transition plan that includes timelines and identified services  
 33 or Supports requested during the time the Client is not residing in the  
 34 Family home. The case manager will submit the transition plan to the  
 35 Department for approval prior to the start of services.
- 36 7. Be determined to meet the Federal Social Security Administration's definition of disability,
- 37 8. Be determined by the Department or its agent to meet the additional targeting criteria  
 38 eligibility for HCBS-CES waiver. The additional targeting criterion includes the following:



- 1 a. The individual demonstrates a behavior or has a medical condition that requires  
 2 direct human intervention, more intense than a verbal reminder, redirection or  
 3 brief observation of status, at least once every two hours during the day and on a  
 4 weekly average of once every three hours during the night. The behavior or  
 5 medical condition must be considered beyond what is typically Age Appropriate  
 6 and due to one or more of the following conditions:
- 7 i. A significant pattern of self-endangering behavior or medical condition  
 8 which, without intervention will result in a life-threatening condition or  
 9 situation. Significant pattern is defined as the behavior or medical  
 10 condition that is harmful to self or others as evidenced by actual events  
 11 occurring within the past six (6) months,
- 12 ii. A significant pattern of serious aggressive behavior toward self, others or  
 13 property. Significant pattern is defined as the behavior is harmful to self  
 14 or others, is evidenced by actual events occurring within the past six (6)  
 15 months, or
- 16 iii. Constant vocalizations such as screaming, crying, laughing or verbal  
 17 threats which cause emotional distress to caregivers. The term constant  
 18 is defined as on the average of fifteen (15) minutes each waking hour.
- 19 b. In the instance of an annual **R**eassessment, the **R**eassessment must  
 20 demonstrate in the absence of the existing interventions or preventions provided  
 21 through Medicaid that the intensity and frequency of the behavior or medical  
 22 condition would resume to a level that would meet the criterion listed above.
- 23 B. The Client shall maintain eligibility by meeting the HCBS-CES waiver eligibility as set forth in  
 24 Section 8.503 and the following:
- 25 1. Receives at least one (1) HCBS-CES waiver service each calendar month,  
 26 2. Is not simultaneously enrolled in any other HCBS waiver, and  
 27 3. Is not residing in a hospital, nursing facility, ICF-IID, other Institution or correctional  
 28 facility.

### 29 **8.503.60 WAITING LIST PROTOCOL**

- 30 A. When the HCBS-CES waiver reaches capacity for enrollment, a Client determined eligible for  
 31 HCBS-CES waiver benefits shall be placed on a statewide waiting list in accordance with these  
 32 rules and the Department's procedures.
- 33 1. The Community Centered Board shall determine if an Applicant has Developmental  
 34 Delay if under age five (5), or Developmental Disability if over age five (5) , prior to  
 35 submitting the HCBS-CES waiver application to the Department or its agent. Only a  
 36 Client who is determined to have a Developmental Delay or Developmental Disability  
 37 may apply for HCBS-CES waiver.
- 38 2. In the event a Client who has been determined to have a Developmental Delay is placed  
 39 on the wait list prior to age five (5), and that Client turns five (5) while on the HCBS-CES  
 40 waiver wait list, a determination of Developmental Disability must be completed in order  
 41 for the Client to remain on the wait list.



3. The Case Management Agency shall complete the Functional Needs Assessment, LOC Screen as defined in Department rules, to determine the Client's Level of Care.
4. The Case Management Agency shall complete the HCBS-CES waiver application (for use with the ULTC 100.2 only) with the participation of the Family. The completed application and a copy of the Functional Needs Assessment, LOC Screen that determines the Client meets the ICF-IID Level of Care shall be submitted to the Department or its agent within fourteen (14) calendar days of parent signature.
5. Supporting documentation provided with the HCBS-CES waiver application shall not be older than six (6) months at the time of submission to the Department or its agent.
6. The Department or its agent shall review the HCBS-CES waiver application. In the event the Department or its agent needs additional information; the Case Management Agency shall respond within two (2) business days of request.
7. Any Client determined eligible for services under the HCBS-CES waiver when services are not immediately available within the federally approved capacity limits of the HCBS-CES waiver, shall be eligible for placement on a single statewide waiting list in the order in which the Department or its agent received the eligible HCBS-CES waiver application. Applicants denied program enrollment shall be informed of the Client's appeal rights in accordance with Section 8.057.
8. The Case Management Agency will create or update the consumer record to reflect the Client is waiting for the HCBS-CES waiver with the waiting list date as determined by the Department or its agent.

#### 8.503.70 ENROLLMENT

- A. When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.
  1. The Case Management Agency shall complete the HCBS-CES waiver application (with ULTC 100.2 only) and the Functional Needs Assessment, LOC Screen in the Family home with the participation of the Family. The completed application, as applicable, and a copy of the Functional Needs Assessment, LOC Screen shall be submitted to the Department or its agent within thirty (30) days of the authorized initial enrollment date.
    - a. If it has been less than six (6) months since the review to determine waiting list eligibility by the URC and there has been no change in the Client's condition, the Case Management Agency shall complete the Functional Needs Assessment, LOC Screen and the parent may submit a letter to the Case Management Agency in lieu of the HCBS-CES waiver application stating there has been no change.
    - b. If there has been any change in the Client's condition the Case Management Agency shall complete a Functional Needs Assessment, LOC Screen and the HCBS-CES waiver application, as applicable, which shall be submitted to the Department or its agent.
  2. Services and Supports shall be implemented pursuant to the Service Plan, PCSP within 90 days of the parent or Guardian signature.

- 1           3.       All continued stay review enrollments shall be completed and submitted to the  
2           Department or its agent at least thirty (30) days and not more than ninety (90) days prior  
3           to the end of the current enrollment period.

4   **8.503.80       CLIENT RESPONSIBILITIES**

- 5   A.       The parent or legal Guardian of a Client is responsible to assist in the enrollment of the Client and  
6       cooperate in the provision of services. Failure to do so shall result in the Client's termination from  
7       the HCBS-CES waiver. The parent or legal Guardian shall:

- 8           1.       Provide accurate information regarding the Client's ability to complete activities of daily  
9           living, daily and nightly routines and medical and behavioral conditions;
- 10          2.       Cooperate with providers and Case Management Agency requirements for the HCBS-  
11       CES waiver enrollment process, ~~Reassessment continued stay review~~ process and  
12       provision of services;
- 13          3.       Cooperate with the local Department of Human Services in the determination of financial  
14       eligibility;
- 15          4.       Complete the HCBS-CES waiver application with fifteen (15) calendar days of the  
16       authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or  
17       in the event of a ~~continued stay review~~ Reassessment, at least thirty (30) days prior to the  
18       end of the current certification period;
- 19          5.       Complete the ~~Service Plan~~ PCSP within thirty (30) calendar days of determination of  
20       HCBS-CES waiver additional targeting criteria eligibility as determined by the Department  
21       or its agent.
- 22          6.       Notify the case manager within thirty (30) days after changes:
- 23           a.       In the Client's Support system, medical condition and living situation including  
24           any hospitalizations, emergency room admissions, nursing home placements or  
25           ICF-IID placements;
- 26           b.       That may affect Medicaid financial eligibility such as prompt report of changes in  
27           income or resources;
- 28           c.       When the Client has not received an HCBS-CES waiver service for one calendar  
29           month;
- 30           d.       In the Client's care needs; and,
- 31           e.       In the receipt of any HCBS-CES waiver services.
- 32
- 33

1 **8.504 HOME AND COMMUNITY BASED SERVICES for CHILDREN WITH LIFE LIMITING ILLNESS**  
 2 **WAIVER**

3 **8.504.05 Legal Basis**

4 The Home and Community-based Services for Children with Life Limiting Illness program (HCBS-CLLI) in  
 5 Colorado is authorized by a waiver of the amount, duration and scope of services requirements contained  
 6 in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States  
 7 Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-  
 8 CLLI program is also authorized under state law at Section 25.5-5-305 C.R.S.

9 **8.504.1 DEFINITIONS**

10 A. ~~Assessment means a comprehensive evaluation with the individual seeking services and~~  
 11 ~~appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted~~  
 12 ~~by the case manager, with supporting diagnostic information from the individual's medical~~  
 13 ~~provider to determine the individual's level of functioning, service needs, available resources, and~~  
 14 ~~potential funding resources. Case managers shall use the Department approved assessment tool~~  
 15 ~~to complete assessments. Assessment shall be as defined at Section 8.390.1.DEFINITIONS.~~

16 B. Bereavement Counseling means counseling provided to the Client and/or family members in  
 17 order to guide and help them cope with the Client's illness and the related stress that  
 18 accompanies the continuous, daily care required by a child with a life-threatening condition.  
 19 Enabling the Client and family members to manage this stress improves the likelihood that the  
 20 child with a life-threatening condition will continue to be cared for at home, thereby preventing  
 21 premature and otherwise unnecessary institutionalization. Bereavement activities offer the family  
 22 a mechanism for expressing emotion and asking questions about death and grieving in a safe  
 23 environment thereby potentially decreasing complications for the family after the child dies.

24 C. Case Management means ~~as defined in Section 8.390.1 DEFINITIONS. the assessment of an~~  
 25 ~~individual receiving long-term services and supports' needs, the development and implementation~~  
 26 ~~of a support plan for such individual, referral and related activities, the coordination and~~  
 27 ~~monitoring of long-term service delivery, the evaluation of service effectiveness and the periodic~~  
 28 ~~reassessment of such individual's needs.~~

29 D. Continued Stay Review (CSR) means a ~~Reassessment by the Single Entry Point case manager~~  
 30 ~~to determine the Client's continued eligibility and functional level of care.~~as defined in Section  
 31 8.390.1 DEFINITIONS.

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

35 F. Curative Treatment means medical care or active treatment of a medical condition seeking to  
 36 affect a cure.

37 G. Expressive Therapy means creative art, music or play therapy which provides children the ability  
 38 to creatively and kinesthetically express their medical situation for the purpose of allowing the  
 39 Client to express feelings of isolation, to improve communication skills, to decrease emotional  
 40 suffering due to health status, and to develop coping skills.

41 H. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point  
 42 agency and shall include, but not be limited to, a preliminary screening in the following areas: an  
 43 individual's need for long-term services and supports; an individual's need for referral to other

1 programs or services; an individual's eligibility for financial and program assistance; and the need  
2 for a comprehensive functional assessment of the individual seeking services.

3 I. Level of Care Screen means as defined in Section 8.391.1.

4 J. Life Limiting Illness means a medical condition that, in the opinion of the medical specialist  
5 involved, has a prognosis of death that is highly probable before the child reaches adulthood at  
6 age 19.

7 K. Massage Therapy means the physical manipulation of muscles to ease muscle contractures,  
8 spasms, extension, muscle relaxation and muscle tension.

9 L. Palliative/Supportive Care is a specific program offered by a licensed health care facility or  
10 provider that is specifically focused on the provision of organized palliative care services.  
11 Palliative care is specialized medical care for people with life limiting illnesses. This type of care is  
12 focused on providing Clients with relief from the symptoms, pain, and stress of serious illness,  
13 whatever the diagnosis. The goal is to improve the quality of life for both the Client and the family.  
14 Palliative care is appropriate at any age (18 and under for this waiver) and at any stage in a life  
15 limiting illness and can be provided together with curative treatment. The services are provided by  
16 a Hospice or Home Care Agency who have received additional training in palliative care concepts  
17 such as adjustment to illness, advance care planning, symptom management, and grief/loss. For  
18 the purpose of this waiver, Palliative Care includes Care Coordination and Pain and Symptom  
19 Management.

20 1. Care Coordination includes development and implementation of a care plan, home visits  
21 for regular monitoring of the health and safety of the Client and central coordination of  
22 medical and psychological services. The Care Coordinator will organize the multifaceted  
23 array of services. This approach will enable the Client to receive all medically necessary  
24 care in the community with the goal of avoiding institutionalization in an acute care  
25 hospital. Additionally, a key function of the Care Coordinator will be to assume the  
26 majority of responsibility, otherwise placed on the parents, for condensing, organizing,  
27 and making accessible to providers, critical information that is related to care and  
28 necessary for effective medical management. The activities of the Care Coordinator will  
29 allow for a seamless system of care. Care Coordination does not include utilization  
30 management, that is review and authorization of service requests, level of care  
31 determinations, and waiver enrollment, provided by the case manager at the Single Entry  
32 Point.

33 2. Pain and Symptom Management means nursing care in the home by a registered nurse  
34 to manage the Client's symptoms and pain. Management includes regular, ongoing pain  
35 and symptom assessments to determine efficacy of the current regimen and available  
36 options for optimal relief of symptoms. Management also includes as needed visits to  
37 provide relief of suffering, during which, nurses assess the efficacy of current pain  
38 management and modify the regimen if needed to alleviate distressing symptoms and  
39 side effects using pharmacological, non-pharmacological and complementary/supportive  
40 therapies.

41 M. Person-Centered Support Planning means ~~the process of working with the individual receiving~~  
42 ~~services and people chosen by the individual to identify goals, needed services, individual~~  
43 ~~choices and preferences, and appropriate service providers based on the individual seeking or~~  
44 ~~receiving services' assessment and knowledge of the individual and of community resources.~~  
45 ~~Support planning informs the individual seeking or receiving services of his or her rights and~~  
46 ~~responsibilities as defined in Section 8.390.1 DEFINITIONS.~~

1 Prior Authorization Request (PAR) means the Department's prescribed form to authorize  
2 services.

3 NM. Professional Medical Information Page (PMIP) ~~Client means the medical information form signed~~  
4 ~~by a licensed medical professional used to verify the Client needs institutional Level of Care~~  
5 ~~means as defined in Section 8.390.1 DEFINITIONS.~~

6 ON. Respite Care means services provided to an eligible Client who is unable to care for  
7 himself/herself on a short-term basis because of the absence or the need for relief of those  
8 persons normally providing care. Respite Care may be provided through different levels of care  
9 depending upon the needs of the Client. Respite care may be provided in the Client's residence,  
10 in the community, or in an approved respite center location.

11 PO. Therapeutic Life Limiting Illness Support means grief/loss or anticipatory grief counseling that  
12 assist the Client and family to decrease emotional suffering due to the Client's health status, to  
13 decrease feelings of isolation or to cope with the Client's life limiting diagnosis. Support is  
14 intended to help the child and family in the disease process. Support is provided to the Client to  
15 decrease emotional suffering due to health status and develop coping skills. Support is provided  
16 to the family to alleviate the feelings of devastation and loss related to a diagnosis and prognosis  
17 for limited lifespan, surrounding the failing health status of the Client, and impending death of a  
18 child. Support is provided to the Client and/or family members in order to guide and help them  
19 cope with the Client's illness and the related stress that accompanies the continuous, daily care  
20 required by a terminally ill child. Support will include but is not limited to counseling, attending  
21 physician visits, providing emotional support to the family/caregiver if the child is admitted to the  
22 hospital or having stressful procedures, and connecting the family with community resources  
23 such as funding or transportation.

24 QP. Utilization Review means approving or denying admission or continued stay in the waiver based  
25 on level of care needs, clinical necessity, amount and scope, appropriateness, efficacy or  
26 efficiency of health care services, procedures or settings.

## 27 **8.504.5 WAIT LIST**

28 8.504.5.A. The number of Clients who may be served through the waiver at any one time during a  
29 year shall be limited by the federally approved HCBS-CLLI waiver document.

30 8.504.5.B. Applicants who are determined eligible for benefits under the HCBS-CLLI waiver, who  
31 cannot be served within the capacity limits of the federally approved waiver, shall be eligible for  
32 placement on a wait list maintained by the Department.

33 8.504.5.C. The SEP case manager shall ensure the Aapplicant meets all criteria as set forth in  
34 Section 8.504.4.A prior to notifying the Department to place the Aapplicant on the wait list.

35 8.504.5.D. The SEP case manager shall enter the Client's ~~Assessment LOC Screen~~ and  
36 Professional Medical Information Page data in the ~~Benefits Utilization System (BUS) IMS~~ and  
37 notify the Department by sending the Client's enrollment information, utilizing the Department's  
38 approved form, to the program administrator.

39 8.504.5.E. The date and time of notification from the SEP case manager shall be used to establish  
40 the order of an Aapplicant's place on the wait list.

41 8.504.5.F. Within five working days of notification from the Department that an opening for the  
42 HCBS-CLLI waiver is available, the SEP case manager shall:

- 1 1. Reassess the Aapplicant for ~~functional~~ level of care using the Department  
2 ~~approved~~prescribed assessment tool- Level of Care Screen if the date of the last  
3 aAssessment is more than six months old.
- 4 2. Update the current LOC Screen if the date is less than six months old.
- 5 3. Reassess for the target population criteria.
- 6 4. Notify the Department of the Aapplicant's eligibility status.

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DRAFT

1 **8.506 CHILDREN'S HOME AND COMMUNITY-BASED SERVICES WAIVER PROGRAM**

2 **8.506.1 Legal Basis:**

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

8 **8.506.2 Definitions of Services Provided**

9 8.506.2.A Case Management means services as defined at Section 8.390.1 DEFINITIONS ~~506.3.B~~  
 10 and the additional operations specifically defined for this waiver in Section 8.506.4.B.

11 8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and  
 12 Section 8.552

13 **8.506.3 General Definitions**

14 A. ~~Assessment means a comprehensive evaluation with the individual seeking services and~~  
 15 ~~appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted~~  
 16 ~~by the case manager, with supporting diagnostic information from the individual's medical~~  
 17 ~~provider to determine the individual's level of functioning, service needs, available resources, and~~  
 18 ~~potential funding resources. Case managers shall use the Department approved instrument to~~  
 19 ~~complete assessments. Assessment shall be means as defined at Section 8.390.1.DEFINITIONS.~~

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

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

27 C. Continued Stay Review means a Reassessment by the case manager to determine the Client's  
 28 continued eligibility and functional level of care as defined in Section 8.390.1 DEFINITIONS.

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

32 E. County Department means the Department of Human or Social Services in the county where the  
 33 resident resides.

34 F. Department means the Department of Health Care Policy and Financing.

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

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



- 1 H. Institutional Placement means residing in an acute care hospital or nursing facility.
- 2 I. Intake/Screening/Referral means the initial contact with individuals by the Case Management  
3 Agency and shall include, but not be limited to, a preliminary screening in the following areas: an  
4 individual's need for long-term services and supports; an individual's need for referral to other  
5 programs or services; an individual's eligibility for financial and program assistance; and the need  
6 for a comprehensive functional assessment of the individual seeking services.
- 7 ~~J. Level of Care Screen means as defined in Section 8.390.1.~~
- 8 ~~K. Level of Care Eligibility Determination means as defined in Section 8.390.1.~~
- 9 ~~L. Performance and Quality Review means a review conducted by the Department or its contractor  
10 at any time to include a review of required case management services performed by a Case  
11 Management Agency to ensure quality and compliance with all statutory and regulatory  
12 requirements.~~
- 13 ~~MK. Person-Centered Support Planning means ~~the process of working with the individual receiving  
14 services and people chosen by the individual to identify goals, needed services, individual  
15 choices and preferences, and appropriate service providers based on the individual seeking or  
16 receiving services' assessment and knowledge of the individual and of community resources.  
17 Support planning informs the individual seeking or receiving services of his or her rights and  
18 responsibilities.~~ as defined in Section 8.390.1 DEFINITIONS.~~
- 19 ~~N. Prior Authorization Request (PAR) means the Department prescribed form to authorize delivery  
20 and utilization of services.~~
- 21 ~~OM. Professional Medical Information Page (PMIP) ~~Client means the medical information form signed  
22 by a licensed medical professional used to certify Level of Care.~~ means as defined in Section  
23 8.390.1 DEFINITIONS.~~
- 24 ~~PN. Targeting Criteria means the criteria set forth in Section 8.506.6.A.1~~
- 25 ~~QQ. Utilization Review Contractor (URC) means the agency or agencies contracted with the  
26 Department to review the CHCBS waiver application for confirmation that ~~functional eligibility  
27 Level of Care eligibility~~ and targeting criteria are met.~~

#### 28 **8.506.4 Benefits**

- 29 8.506.4.A Home and Community-based Services under the CHCBS waiver shall be provided within  
30 Cost Containment, as demonstrated in Section 8.506.12.
- 31 8.506.4.B Case Management:
- 32 1. Case Management Agencies must follow requirements and regulations in accordance  
33 with state statutes on Confidentiality of Information at Section 26-1-114, C.R.S.
- 34 2. Case Management Agencies will complete all administrative functions of a Client's  
35 benefits as described in HCBS-EBD Case Management Functions, Section 8.486.
- 36 3. Initial Referral:
- 37 a. The Case Management Agency shall begin assessment activities within ten (10)  
38 calendar days of receipt of Client's information. Assessment activities shall



1 consist of at least one (1) face-to-face contact with the child, or document  
2 reason(s) why such contact was not possible. Upon Department approval,  
3 contact may be completed by the case manager at an alternate location, via the  
4 telephone or using virtual technology methods. Such approval may be granted  
5 for situations in which face-to-face meetings would pose a documented safety  
6 risk to the case manager or Client (e.g., natural disaster, pandemic, etc.

7 b. At the time of making the initial in person contact with the child and their  
8 parent/guardian, assess child's health and social needs to determine whether or  
9 not program services are both appropriate and cost effective. Upon Department  
10 approval, contact may be completed by the case manager at an alternate  
11 location, via the telephone or using virtual technology methods. Such approval  
12 may be granted for situations in which face-to-face meetings would pose a  
13 documented safety risk to the case manager or Client (e.g., natural disaster,  
14 pandemic, etc.

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

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

21 e. Submit the ~~assessment-LOC Screen~~ and documentation to the URC to ensure  
22 the targeting criteria and ~~functional eligibility~~level of care eligibility criteria are  
23 met. Minimum documents required:

24 ii. Department prescribed Professional Medical Information Page

25 f. Submit a copy of the Level of Care Determination to the County Department for  
26 activation of a Medicaid State Identification Number.

27 g. Develop the Person-Centered Support Planning ~~document~~ in accordance with  
28 Section 8.506.4.B.7.

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

31 4. Continued Stay Review

32 a. Complete a ~~new-Assessment-LOC Screen Reassessment~~ of each child, at a  
33 minimum, every twelve (12) months and before the end of the eligibility period  
34 approved. Upon Department approval, assessment may be completed by the  
35 case manager at an alternate location, via the telephone or using virtual  
36 technology methods. Such approval may be granted for situations in which face-  
37 to-face meetings would pose documented safety risk to the case manager or  
38 Client (e.g., natural disaster, pandemic, etc.).

39 b. Submit the ~~assessment-LOC Screen~~ and documentation to the URC to ensure  
40 the targeting criteria and ~~functional-Level of Care~~ eligibility criteria are met.

41 c. Review and revise the Person-Centered Support Planning ~~document~~ in  
42 accordance with Section 8.506.4.B.7.

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

2 5. Discharge/Withdrawal

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

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

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

10 iv. Notify County Department of termination.

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

13 6. Transfers

14 a. Sending agency responsibilities:

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

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

19 2) Negotiate an appropriate transfer date.

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

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

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

30 This rule incorporates by reference the Colorado Department of Human  
31 Services, Income Maintenance Staff Manual, Case Transfer Section at 9  
32 CCR 2503-5, Section 3.560 is available at Pursuant to Section 24-4-103  
33 (12.5), C.R.S., the Department maintains copies of the incorporated text  
34 in its entirety, available for public inspection during regular business  
35 hours at: Colorado Department of Health Care Policy and Financing,  
36 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated  
37 materials are provided at cost upon request.

38 b. Receiving agency responsibilities

- i. Conduct an in person visit with the child within ten (10) working days of the child's transfer. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g., natural disaster, pandemic, etc.), and
- ii. Review and revise the Person-Centered Support Plan ~~ning document~~ and change or coordinate services and providers as necessary.

## 8.506.6 Client Eligibility

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

1. Targeting Criteria:

- a. Not have reached his/her eighteenth (18th) birthday.
- b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.
- c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.
- d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Functional Level of Care Eligibility:

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

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

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

## 8.506.7 Waiting List

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

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

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

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

- 1 8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case  
2 Manager shall provide a written notice of the action in accordance with section 8.057 et seq.
- 3 8.506.7.F As openings become available within the capacity limits of the federally approved waiver,  
4 individuals shall be considered for CHCBS services in the order of the individual's placement on  
5 the waiting list.
- 6 8.506.7.G When an opening for the CHCBS waiver becomes available the URC will provide written  
7 notice to the Case Management Agency.
- 8 8.506.7.H Within ten business days of notification from the URC that an opening for the CHCBS  
9 waiver is available the Case Management Agency shall:
- 10 1. Reassess the individual using the Department's prescribed LOC Screen instrument if  
11 more than six months has elapsed since the previous assessment.
- 12 2. Update the existing ~~functional~~-Level of Care Screen in the official Client record.
- 13 3. Reassess for eligibility criteria as set forth at 8.506.6.
- 14 4. Notify the URC of the individual's eligibility status.
- 15 8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of  
16 the following criteria:
- 17 1. Have been in a hospital for 30 or more days and require waiver services in order to be  
18 discharged from the hospital.
- 19 2. Are on the waiting list for an organ transplant.
- 20 3. Are dependent upon mechanical ventilation or prolonged intravenous administration of  
21 nutritional substances.
- 22 4. Have received a terminally ill prognosis from their physician.
- 23 8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the  
24 child's case manager prior to prioritization on the waiting list.
- 25 **8.506.10 Prior Authorization Requests**
- 26 8.506.10.A The Case Manager shall complete and submit a PAR form within one calendar month of  
27 determination of eligibility for the waiver.
- 28 8.506.10.B All units of service requested shall be listed on the Person-Centered Support Planning  
29 document.
- 30 8.506.10.C The first date for which services can be authorized is the latest date of the following:
- 31 1. The financial eligibility start date, as determined by the financial eligibility site.
- 32 2. The assigned start date on the ~~certification page of the Assessment~~.Level of Care  
33 Eligibility Determination.

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

4 8.506.10.D The PAR shall not cover a period of time longer than the certification period assigned on  
5 the certification page of the Assessment Level of Care Eligibility Determination.

6 8.506.10.E The Case Manager shall submit a revised PAR if a change in the Person-Centered  
7 Support Planning document results in a change in services.

8 8.506.10.F The revised Person-Centered Support Plan ning document shall list the service being  
9 changed and state the reason for the change. Services on the revised Person-Centered Support  
10 Plan ning document, plus all services on the original document, shall be entered on the revised  
11 PAR.

12 8.506.10.G Revisions to the Person-Centered Support Planning document requested by providers  
13 after the end date on a PAR shall be disapproved.

14 8.506.10.H The Long-Term Care Notice of Action Form (LTC-803) shall be completed in the  
15 Information Management System (IMS), (as defined at 8.549.1.Z) as defined in Section 8.390.1  
16 DEFINITIONS for all applicable programs at the time of initial eligibility, when there is a significant  
17 change in the individual's payment or services, an adverse action, or at the time of  
18 discontinuation.

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## 1 8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

### 2 8.508.10 LEGAL BASIS

3 The Home and Community based Services- Children's Habilitation Residential Program (HCBS-CHRP) is  
 4 authorized by waiver of the amount, duration, and scope of services requirements contained in Section  
 5 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. § 1396a. The waiver is granted by the United States  
 6 Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. §  
 7 1396n.

### 8 8.508.20 DEFINITIONS

- 9 A. Abuse: As defined at § 16-22-102 (9) C.R.S., § 19-1-103, C.R.S., § 25.5-10-202 (1) (a)-(c),  
 10 C.R.S., and § 26.3.1-101 C.R.S.
- 11 B. Adverse Action: A denial, reduction, termination, or suspension from a Long-Term Services and  
 12 Supports (LTSS) program or service.
- 13 C. Applicant: A child or youth who is seeking a Long-Term Care eligibility determination and who has  
 14 not affirmatively declined to apply for Medicaid or participate in an assessment.

### 15 ~~D.~~ Assessment: As defined in Section 8.390.1 DEFINITIONS.

16 ~~ED.~~ Caretaker: As defined at Section 25.5-10-202 (1.6)(a)-(c), C.R.S.

17 ~~EF.~~ Caretaker neglect: As defined at Section 25.5-10-202 (1.8)(a)-(c), C.R.S.

18 ~~FG.~~ Case Management Agency (CMA): A public or private not-for-profit for-profit agency that meets  
 19 all applicable state and federal requirements and is certified by the Department to provide case  
 20 management services for Home and Community-based Services waivers pursuant to sections  
 21 25.5-10-209.5 C.R.S. and pursuant to a provider participation agreement with the state  
 22 department.

23 ~~GH.~~ Child Placement Agency: As defined at 12 CCR 2509-8; Section 7.701.2 (F).

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

26 ~~J.~~ Client Representative: A person who is designated to act on the Client's behalf. A Client  
 27 Representative may be: (a) a legal representative including, but not limited to a court-appointed  
 28 guardian, or a parent of a minor child; or (b) an individual, family member or friend selected by the  
 29 Client to speak for an/or act on the Client's behalf.

30 ~~KJ.~~ Community Centered Board: A private corporation, for-profit or not-for-profit that is designated  
 31 pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting  
 32 Developmental Disability determinations, waiting list management Level of Care Evaluations for  
 33 Home and Community-based Service waivers specific to individuals with intellectual and  
 34 developmental disabilities, and management of state funded programs for individuals with  
 35 intellectual and developmental disabilities.

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

- 1 ML. Complex Medical Needs: Needs that occur as a result of a chronic medical condition as  
2 diagnosed by a licensed physician that has lasted or is expected to last at least twelve (12)  
3 months, requires skilled care, and that without intervention may result in a severely life altering  
4 condition.
- 5 ~~M.~~ ~~Comprehensive Assessment: An initial assessment or periodic reassessment of individual needs~~  
6 ~~to determine the need for any medical, educational, social or other services and completed~~  
7 ~~annually or when the Client experiences significant change in need or in level of support.~~
- 8 NN. Cost Containment: Limiting the cost of providing care in the community to less than or equal to  
9 the cost of providing care in an institutional setting based on the average aggregate amount. The  
10 cost of providing care in the community shall include the cost of providing Home and Community-  
11 based Services, and Medicaid State Plan benefits including long- term home health services and  
12 targeted case management.
- 13 OO. Criminal Activity: A criminal offense that is committed by a person; a violation of parole or  
14 probation; and any criminal offense that is committed by a person receiving services that results  
15 in immediate incarceration.
- 16 PP. Crisis: An event, series of events, and/or state of being greater than normal severity for the Client  
17 and/or family that becomes outside the manageable range for the Client and/or their family and  
18 poses a danger to self, family, and/or the community. Crisis may be self-identified, family  
19 identified, and/or identified by an outside party.
- 20 QQ. Critical Incident: Incidents of Mistreatment; Abuse; Neglect; Exploitation, Criminal Activity;  
21 Damage to Client's Property/Theft; Death unexpected or expected; Injury/Illness to Client;  
22 Medication Mismanagement; Missing Person; Unsafe Housing/Displacement; and/or Other  
23 Serious Issues.
- 24 RR. Department: The Colorado Department of Health Care Policy and Financing the single state  
25 Medicaid agency.
- 26 SS. Damage to Client's Property/Theft: Deliberate damage, destruction, theft or use a Client's  
27 belongings or money. If the incident involves Mistreatment by a Caretaker that results in damage  
28 to Client's property or theft in the incident shall be listed as Mistreatment.
- 29 T. Developmental Delay: A child who is:
- 30 1. Birth up to age five (5) and has a developmental delay defined as the existence of at  
31 least one of the following measurements:
- 32 i. Equivalence of twenty-five percent (25%) or greater delay in one (1) or more of  
33 the five domains of development when compared with chronological age;
- 34 ii. Equivalence of 1.5 standard deviations or more below the mean in one (1) or  
35 more of the five domains of development;
- 36 iii. Has an established condition defined as a diagnosed physical or mental  
37 condition that, as determined by a qualified health professional utilizing  
38 appropriate diagnostic methods and procedures, has a high probability of  
39 resulting in significant delays in development, or
- 40 2. Birth up to age three (3) who lives with a parent who has been determined to have a  
41 developmental disability by a CCB.

- 1 ~~UT~~. Early and Periodic Screening Diagnosis and Treatment (EPSDT): As defined in Section 8.280.1.
- 2 ~~VU~~. Exploitation: As defined in Sections 25.5-10-202(15.5)(a)-(d) and 26.3.1-101 C.R.S.
- 3 ~~WV~~. Extraordinary Needs: A level of care due to Complex Behavior and/or Medical Support Needs  
4 that is provided in a residential child care facility or that is provided through community-based  
5 programs, and without such care, would place a child at risk of unwarranted child welfare  
6 involvement or other system involvement.
- 7 ~~XW~~. Family: As defined at Section 25.5-10-202 (16)(a)(I)-(IV)(b), C.R.S.
- 8 ~~YX~~. Foster Care Home: A family care home providing 24-hour care for a child or children and certified  
9 by either a County Department of Social/Human Services or a child placement agency. A Foster  
10 Care Home, for the purposes of this waiver, shall not include a family member as defined in  
11 Section 25.10-202 (16)(a)(I)-(IV)(b), C.R.S.
- 12 ~~ZY~~. Guardian: An individual at least twenty-one years of age, resident or non-resident, who has  
13 qualified as a guardian of a minor or incapacitated person pursuant to appointment by a court.  
14 Guardianship may include a limited, emergency, and temporary substitute court appointed  
15 guardian but not guardian ad litem.
- 16 ~~ZA.A~~. Guardian ad litem or GAL: A person appointed by a court to act in the best interests of a child  
17 involved in a proceeding under Title 19, C.R.S., or the "School Attendance Law of 1963", set forth  
18 in Article 33 of Title 22, C.R.S.
- 19 ~~BBAA~~. Harmful Act: as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.
- 20 ~~BBCC~~. Home and Community-based Services (HCBS) Waivers: Services and supports authorized  
21 through a 1915 (c) waiver of the Social Security Act and provided in community settings to a  
22 Client who requires a level of institutional care that would otherwise be provided in a hospital,  
23 nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).
- 24 ~~CCDD~~. Increased Risk Factors: Situations or events that when occur at a certain frequency or pattern  
25 historically have led to Crisis.
- 26 ~~DDEE~~. Informed Consent: An assent that is expressed in writing, freely given, and preceded by the  
27 following:
- 28 1. A fair explanation of the procedures to be followed, including an identification of those  
29 which are experimental;
  - 30 2. A description of the attendant discomforts and risks;
  - 31 3. A description of the expected benefits;
  - 32 4. A disclosure of appropriate alternative procedures together with an explanation of the  
33 respective benefits, discomforts and risks;
  - 34 5. An offer to answer any inquiries regarding the procedure(s);
  - 35 6. An instruction that the person giving consent is free to withdraw such consent and  
36 discontinue participation in the project or activity at any time; and,



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

3 EEFF. Injury/Illness to Client: An injury or illness that requires treatment beyond first aid which includes  
4 lacerations requiring stitches or staples, fractures, dislocations, loss of limb, serious burns, and  
5 skin wounds; an injury or illness requiring immediate emergency medical treatment to preserve  
6 life or limb; an emergency medical treatment that results in admission to the hospital; and a  
7 psychiatric crisis resulting in unplanned hospitalization.

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

10 GGHH. Intellectual and Developmental Disability: A disability that manifests before the person reaches  
11 twenty-two (22) years of age, that constitutes a substantial disability to the affected person, and  
12 that is attributable to an intellectual and developmental disability or related conditions, including  
13 Prader-Willi syndrome, cerebral palsy, epilepsy, autism, or other neurological conditions when the  
14 condition or conditions result in impairment of general intellectual functioning or adaptive behavior  
15 similar to that of a person with an intellectual and developmental disability. Unless otherwise  
16 specifically stated, the federal definition of "developmental disability" found in 42 U.S.C. sec.  
17 15001 et seq., does not apply.

18 "Impairment of general intellectual functioning" The person has been determined to have an  
19 intellectual quotient equivalent which is two or more standard deviations below the mean (70 or  
20 less assuming a scale with a mean of 100 and a standard deviation of 15), as measured by an  
21 instrument which is standardized, appropriate to the nature of the person's disability, and  
22 administered by a qualified professional. the standard error of measurement of the instrument  
23 should be considered when determining the intellectual quotient equivalent. when an individual's  
24 general intellectual functioning cannot be measured by a standardized instrument, then the  
25 assessment of a qualified professional shall be used.

26 "Adaptive behavior similar to that of a person with intellectual and developmental disabilities" The  
27 person has overall adaptive behavior which is two or more standard deviations below the mean in  
28 two or more skill areas (communication, self-care, home living, social skills, community use, self-  
29 direction, health and safety, functional academics, leisure, and work), as measured by an  
30 instrument which is standardized, appropriate to the person's living environment, and  
31 administered and clinically determined by a qualified professional. These adaptive behavior  
32 limitations are a direct result of, or are significantly influenced by, the person's substantial  
33 intellectual deficits and may not be attributable to only a physical or sensory impairment or mental  
34 illness.

35 "Substantial intellectual deficits" An intellectual quotient that is between 71 and 75 assuming a  
36 scale with a mean of 100 and a standard deviation of 15, as measured by an instrument which is  
37 standardized, appropriate to the nature of the person's disability, and administered by a qualified  
38 professional. the standard error of measurement of the instrument should be considered when  
39 determining the intellectual quotient equivalent.

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

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

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

- 1 **KKLL**. Level of Care (LOC): The specified minimum amount of assistance a Client must require in order  
2 to receive services in an institutional setting under the Medicaid State Plan.
- 3 **LLMM**. Level of Care Eligibility Determination: ~~An eligibility determination by a CGB of an Individual for a~~  
4 ~~Long-Term Services and Supports (LTSS) program. As defined in Section 8.390.1.~~
- 5 **MMNN**. Level of Care Eligibility Determination Screen: As defined in Section 8.390.1.
- 6 ~~Level of Care Evaluation: A comprehensive evaluation with the Individual seeking services and others~~  
7 ~~chosen by the Individual to participate, conducted by the case manager utilizing the Department's~~  
8 ~~prescribed tool, with supporting diagnostic information from the Individual's medical providers, for~~  
9 ~~the purpose of determining the Individual's level of functioning for admission or continued stay in~~  
10 ~~Long-Term Services and Supports (LTSS) programs.~~
- 11 **NNOO**. Licensed Child Care Center (less than 24 hours): As defined in Section 26-6-102 (5), C.R.S. and  
12 as described in 12 CCR 2509-8; Section 7.701.
- 13 **OOPP**. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced  
14 practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by  
15 Clients of all ages with functional limitations and chronic illnesses who need assistance to  
16 perform routine daily activities such as bathing, dressing, preparing meals, and administering  
17 medications.
- 18 **PPQQ**. Medicaid Eligible: The Applicant or Client meets the criteria for Medicaid benefits based on the  
19 financial determination and disability determination.
- 20 **QQRR**. Medicaid State Plan: The federally approved document that specifies the eligibility groups that a  
21 state serves through its Medicaid program, the benefits that the state covers, and how the state  
22 addresses additional federal Medicaid statutory requirements concerning the operation of its  
23 Medicaid program.
- 24 **RRSS**. Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up,  
25 compliance and administration or monitoring which results in harm or an adverse effect which  
26 necessitates medical care.
- 27 **SSTT**. Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or  
28 there is a risk to public safety.
- 29 **TTUU**. "Mistreated" or "Mistreatment": As defined at Section 25.5-10-202(29.5)(a)-(d) and 26.3.1-101.
- 30 **UUVV**. Natural Supports: Unpaid informal relationships that provide assistance and occur in the Client's  
31 everyday life such as, but not limited to, community supports and relationships with family  
32 members, friends, co-workers, neighbors and acquaintances.
- 33 **VVWW**. Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.
- 34 **WWXX**. Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or  
35 lesser likelihood of success of Crisis interventions.
- 36 **XXYY**. Prior Authorization: Approval for an item or service that is obtained in advance either from the  
37 Department, a state fiscal agent or the CMA.
- 38 **YYZZ**. Professional: Any person, not including family, performing an occupation that is regulated by the  
39 State of Colorado and requires state licensure and/or certification.

- 1 ~~AAAZZ~~. Professional Medical Information Page (PMIP): ~~The medical information form signed by a~~  
2 ~~Licensed Medical Professional used to certify Level of Care as defined in Section 8.390.1~~  
3 DEFINITIONS.
- 4 ~~BBBAAA~~. Relative: A person related to the Client by blood, marriage, adoption or common law  
5 marriage.
- 6 ~~BBBGGG~~. Residential Child Care Facility: As defined in 12 CCR 2509-8, Section 7.705.1.
- 7 ~~DDDDCCC~~. Retrospective Review: The Department's review after services and supports are provided  
8 to ensure the Client received services according to the ~~service plan~~PCSP and standards of  
9 economy, efficiency and quality of service.
- 10 ~~DDDEEE~~. Separation: The restriction of a Client for a period of time to a designated area from  
11 which the is not physically prevented from leaving, for the purpose of providing the Client an  
12 opportunity to regain self-control.
- 13 ~~EEEEFFF~~. Service Provider: A Specialized Group Facility, Residential Child Care Facility, Foster  
14 Care Home, Kinship Foster Care Home, Child Placement Agency, Licensed Child Care Facility  
15 (non-24 hours), and/or Medicaid enrolled provider.
- 16 ~~GGGFFF~~. Person-Centered Support Plan (PCSP)~~Service Plan: The written document that specifies~~  
17 ~~identified and needed services, to include Medicaid and non-Medicaid covered services~~  
18 ~~regardless of funding source, to assist a Client to remain safely in the community and developed~~  
19 ~~in accordance with Department regulations. Defined in Section 8.390.1 DEFINITIONS.~~
- 20 ~~GGGHHH~~. Person-Centered Support~~service~~ Planning (PCSP): ~~The process of working with the Client~~  
21 ~~receiving services and people chosen by the Individual, to identify goals, needed services, and~~  
22 ~~appropriate service providers based on the Comprehensive Assessment and knowledge of the~~  
23 ~~available community resources. Service planning informs the Individual seeking or receiving~~  
24 ~~services of his or her rights and responsibilities. Defined in Section 8.390.1 DEFINITIONS.~~
- 25 ~~HHHHH~~. Specialized Group Facility: As defined in 12 CCR 2509-8; Section 7.701.2(B).
- 26 ~~JJJJJ~~. Support: Any task performed for the Client where learning is secondary or incidental to the task  
27 itself or an adaptation is provided.
- 28 ~~KKKJJJ~~. Support Level: A numeric value determined by the Support Need Level Assessment that  
29 places Clients into groups with other Clients who have similar overall support needs.
- 30 ~~KKKLLL~~. Support Need Level Assessment: The standardized assessment tool used to identify and  
31 measure the support requirements for HCBS-CHRP waiver participants.
- 32 ~~LLLMMM~~. Targeted Case Management (TCM): Has the same meaning as in Section 8.761.
- 33 ~~NNNMMM~~. Third Party Resources: Services and supports that a Client may receive from a variety of  
34 programs and funding sources beyond Natural Supports or Medicaid. This may include, but is not  
35 limited to community resources, services provided through private insurance, non-profit services  
36 and other government programs.
- 37 ~~NNNQQQ~~. Unsafe Housing/Displacement: An individual residing in an unsafe living condition due to  
38 a natural event (such as fire or flood) or environmental hazard (such as infestation) and is at risk  
39 of eviction or homelessness.

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

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

9 Trauma informed care.

10 Youth mental health first aid.

11 Crisis supports and planning.

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

13 Cultural and linguistic competency.

14 Family and youth serving systems.

15 Family engagement.

16 Child and adolescent development.

17 Accessing community resources and services.

18 Conflict resolution.

19 Intellectual and developmental disabilities.

20 Mental health topics and services.

21 Substance abuse topics and services.

22 Psychotropic medications.

23 Motivational interviewing.

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

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

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

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

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

5  
6  
7  
8 **8.508.40 ELIGIBILITY**

9 A. Services shall be provided to Clients with an Intellectual and Developmental Disability who meet  
 10 all of the following eligibility requirements:

- 11 1. A determination of developmental disability by a CCB which includes developmental  
 12 delay if under five (5) years of age.
- 13 2. The Client has Extraordinary Needs that put the Client at risk of, or in need of, out of  
 14 home placement.
- 15 3. Meet ICF-IID Level of Care as determined by a ~~LOC Screen~~Level of Care Evaluation.
- 16 4. The income of the Client does not exceed 300% of the current maximum SSI standard  
 17 maintenance allowance.
- 18 5. Enrollment of the Client in the HCBS- CHRP waiver will result in an overall savings when  
 19 compared to the ICF/IID cost as determined by the State.
- 20 6. The Client receives at least one waiver service each month.

21 B. A Support Need Level Assessment must be completed upon determination of eligibility. The  
 22 Support Need Level Assessment is used to determine the level of reimbursement for Habilitation  
 23 and per diem Respite services.

24 C. Clients must first access all benefits available under the Medicaid State Plan and/or EPSDT for  
 25 which they are eligible, prior to accessing funding for those same services under the HCBS-  
 26 CHRP waiver.

27 D. Pursuant to the terms of the HCBS-CHRP waiver, the number of individuals who may be served  
 28 each year is based on:

- 29 1. The federally approved capacity of the waiver;
- 30 2. Cost Containment requirements under section 8.508.80;
- 31 3. The total appropriation limitations when enrollment is projected to exceed spending  
 32 authority.

33 **8.508.50 WAITING LIST PROTOCOL**

- 1 A. Clients determined eligible for HCBS-CHRP services who cannot be served within the  
 2 appropriation capacity limits of the HCBS-CHRP waiver shall be eligible for placement on a  
 3 waiting list.
- 4 1. The waiting list shall be maintained by the Department.
- 5 2. The date used to establish the Client's placement on the waiting list shall be the date on  
 6 which all other eligibility requirements at Section 8.508.40 were determined to have been  
 7 met and the Department was notified.
- 8 3. As openings become available within the appropriation capacity limits of the federal  
 9 waiver, Clients shall be considered for services based on the date of their waiting list  
 10 placement.

#### 11 **8.508.60 RESPONSIBILITIES OF THE CCB**

- 12 A. The CCB shall make eligibility determinations for developmental disabilities services to include  
 13 the Level of Care ~~Evaluation Determination~~Eligibility Determination for any Applicant or Client  
 14 being considered for enrollment in the HCBS-CHRP waiver.
- 15 B. Additional administrative responsibilities of CCBs as required in 8.601.

#### 16 **8.508.70 CASE MANAGEMENT FUNCTIONS**

- 17 A. Case management services will be provided by a CMA as a Targeted Case Management service  
 18 pursuant to sections 8.761.14 and 8.519 and will include:
- 19 1. Completion of a ~~Comprehensive Assessment~~LOC Screen
- 20 2. Completion of a ~~Person-Centered Support~~Service Plan (PCSP);
- 21 3. Referral for services and related activities;
- 22 4. Monitoring and follow-up by the CMA including ensuring that the SP is implemented and  
 23 adequately addresses the Client's needs.
- 24 5. Monitoring and follow-up actions, which shall
- 25 a. Be performed when necessary to address health and safety and services in the  
 26 PCSP;
- 27 b. Services in the PCSP are adequate; and
- 28 c. Necessary adjustments in the PCSP and service arrangements with providers  
 29 are made if the needs of the Client have changed.
- 30 6. Face to face monitoring to be completed at least once per quarter and to include direct  
 31 contact with the Client in a place where services are delivered. Upon Department  
 32 approval, monitoring may be completed by the case manager at an alternate location, via  
 33 the telephone or using virtual technology methods. Such approval may be granted for  
 34 situations in which face-to-face meetings would pose a documented safety risk to the  
 35 case manager or Client (e.g., natural disaster, pandemic, etc.).

1 **8.508.121 REASSESSMENT AND REDETERMINATION OF ELIGIBILITY**

2 A. The CMA shall conduct a Level of Care Evaluation-Eligibility Determination and redetermine or  
3 confirm a Client's eligibility for the HCBS-CHRP waiver, at a minimum, every twelve (12) months.

4 B. The CMA shall conduct a Comprehensive Assessment/OC Screen to redetermine or confirm a  
5 Client's individual needs, at a minimum, every twelve (12) months.

6 C. The CMA shall verify that the child or youth remains Medicaid Eligible at a minimum, every twelve  
7 (12) months.

8  
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DRAFT



1 **8.509 HOME AND COMMUNITY-BASED SERVICES FOR COMMUNITY MENTAL HEALTH**  
2 **SUPPORTS (HCBS-CMHS)**

3 **8.509.10 GENERAL PROVISIONS**

4 **8.509.11 LEGAL BASIS**

- 5 A. The Home and Community-based Services for COMMUNITY MENTAL HEALTH SUPPORTS  
6 (HCBS-CMHS) program in Colorado is authorized by a waiver of the amount, duration, and scope  
7 of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The  
8 waiver was granted by the United States Department of Health and Human Services, under  
9 Section 1915(c) of the Social Security Act. The HCBS-CMHS program is also authorized under  
10 state law at Sections 25.5-6-601 through 25.5-6-607, C.R.S. The number of recipients served in  
11 the HCBS-CMHS program is limited to the number of recipients authorized in the waiver.
- 12 B. All congregate facilities where any HCBS Client resides must be in possession of a valid Assisted  
13 Living Residence license issued under Section 25-27-105, C.R.S., and regulations of the  
14 Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7.

15 **8.509.14 GENERAL DEFINITIONS**

- 16 A. Assessment shall be defined as a Client evaluation according to requirements at Section  
17 ~~8.509.31~~ 8.390.1 DEFINITIONS.
- 18 B. Case Management shall be defined as administrative functions performed by a case  
19 management agency according to requirements at Section 8.509.30.
- 20 C. Case Management Agency shall be defined as an agency that is certified and has a valid contract  
21 with the state to provide HCBS-CMHS case management.
- 22 D. Categorically Eligible, shall be defined in the HCBS-CMHS Program, as any person who is  
23 eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical  
24 Assistance; and who retains eligibility for Medical Assistance even when the Client is not a  
25 resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible  
26 shall not include persons who are eligible for financial assistance, or persons who are eligible for  
27 HCBS-CMHS as three hundred percent eligible persons, as defined at 8.509.14.S.
- 28 E. Congregate Facility shall be defined as a residential facility that provides room and board to three  
29 or more adults who are not related to the owner and who, because of impaired capacity for  
30 independent living, elect protective oversight, personal services and social care but do not require  
31 regular twenty-four hour medical or nursing care.
- 32 F. Uncertified Congregate Facility is a facility as defined in Section 8.509.14.G that is not certified as  
33 an Alternative Care Facility, which is defined at Section 8.495.1.
- 34 G. Continued Stay Review shall be defined as a ~~Rere~~-assessment as defined in Section 8.390.1 and  
35 conducted as described at Section 8.402.60.
- 36 H. Cost Containment shall be defined at Section 8.485.50(l)
- 37 I. Department shall be defined as the State Agency designated as the Single State Medicaid  
38 Agency for Colorado, or another state agency operating under the authority of a memorandum of  
39 understanding with the Single State Medicaid Agency.

- 1 J. Deinstitutionalized shall be defined as waiver Clients who were receiving nursing facility services  
 2 reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-CMHS waiver.  
 3 These include hospitalized Clients who were in a nursing facility immediately prior to inpatient  
 4 hospitalization and who would have returned to the nursing facility if they had not elected the  
 5 HCBS-CMHS waiver.
- 6 K. Diverted shall be define as HCBS-CMHS waiver recipients who were not deinstitutionalized, as  
 7 defined at Section 8.485.50(K).
- 8 L. Home and Community-based Services for Community Mental Health Supports (HCBS-CMHS)  
 9 shall be defined as services provided in a home or community-based setting to Clients who are  
 10 eligible for Medicaid reimbursement for long-term care, who would require nursing facility care  
 11 without the provision of HCBS-CMHS, and for whom HCBS-CMHS services can be provided at  
 12 no more than the cost of nursing facility care.
- 13 M. Intake/Screening/Referral shall be as defined at Section 8.390.1(M) and as the initial contact with  
 14 Clients by the case management agency. This shall include, but not be limited to, a preliminary  
 15 screening in the following areas: an individual's need for long-term care services; an individual's  
 16 need for referral to other programs or services; an individual's eligibility for financial and program  
 17 assistance; and the need for a comprehensive long-term care Client assessment.
- 18 N. Level Ff Care Screen shall be defined as an assessment conducted in accordance with Section  
 19 8.401.16
- 20 O. Non-Diversion shall be defined as a Client who was certified by the URC as meeting the Llevel of  
 21 Ccare Sscreen and target group for the HCBS-CMHS program, but who did not receive HCBS-  
 22 CMHS services for some other reason.
- 23 P. Person-Centered Support Plan shall be as defined in Section 8.390.1 DEFINITIONS.
- 24 Q. Provider Agency shall be defined as an agency certified by the Department and which has a  
 25 contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER  
 26 AGENCIES, to provide one of the services listed at Section 8.509.13. A case management  
 27 agency may also become a provider if the criteria at Sections 8.390-8.393 and 8.487 are met.
- 28 R. Reassessment shall be as defined as a periodic reevaluation according to the requirements at in  
 29 Section 8.390.1 DEFINITIONS.509.32.C.
- 30 S. Three Hundred Percent (300%) Eligible persons shall be defined as persons:
- 31 1) Whose income does not exceed 300% of the SSI benefit level, and
- 32 2) Who, except for the level of their income, would be eligible for an SSI payment; and
- 33 3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an  
 34 HCBS program or are in a nursing facility or hospitalized for thirty (30) consecutive days.

### 35 **8.509.15 ELIGIBLE PERSONS**

- 36 A. HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements  
 37 below:
- 38 1. Financial Eligibility

1 Clients shall meet the eligibility criteria as specified in 9 CCR 2503-5, and the Section  
2 8.100.

3 2. Level of Care AND Target Group.

4 Clients who have been determined to meet the level of care AND target group criteria  
5 shall be determined by the Utilization Review Contractor (URC) as meeting the level of  
6 care eligibility for HCBS-CMHS. The URC shall only determine HCBS-CMHS eligibility for  
7 those Clients:

8 a. Determined to meet the target group definition, defined as a person experiencing  
9 a severe and persistent mental health need that requires assistance with one or  
10 more Activities of Daily Living (ADL);

11 i. A person experiencing a severe and persistent mental health need is  
12 defined as someone who:

13 1) Is 18 years of age or older with a severe and persistent mental  
14 health need; and

15 2) Currently has or at any time during the past year leading up to  
16 assessment has a diagnosable mental, behavioral, or emotional  
17 disorder of sufficient duration to meet diagnostic criteria specified  
18 within the Diagnostic and Statistical Manual of Mental Disorders  
19 (DSM -5); and

20 a) Has a disorder that is episodic, recurrent, or has  
21 persistent features, but may vary in terms of severity and  
22 disabling effects; and

23 b) Has resulted in functional impairment which substantially  
24 interferes with or limits one or more major life activities.

25 ii. A severe and persistent mental health need does not include:

26 1) Intellectual or developmental disorders; or

27 2) Substance use disorder without a co-occurring diagnosis of a  
28 severe and persistent mental health need.

29 b. Determined by a formal level-of-care-assessment/LOC Screen to require the level  
30 of care available in a nursing facility, according to Section 8.401.11-15; and

31 c. A length of stay shall be assigned by the URC for approved admissions,  
32 according to guidelines at Section 8.402.50.

33 3. Receiving Services

34 a. Only Clients who receive HCBS-CMHS services, or who have agreed to accept  
35 HCBS-CMHS services as soon as all other eligibility criteria have been met, are  
36 eligible for the HCBS-CMHS program.

37 b. Case management is not a service and shall not be used to satisfy this  
38 requirement.

- 1 c. Desire or need for home health services or other Medicaid services that are not  
2 HCBS-CMHS services, as listed at Section 8.509.12, shall not satisfy this  
3 eligibility requirement.
- 4 d. HCBS-CMHS Clients who have not received HCBS-CMHS services for thirty (30)  
5 days shall be discontinued from the program.

6 4. Institutional Status

- 7 a. Clients who are residents of nursing facilities or hospitals are not eligible for  
8 HCBS-CMHS services while residing in such institutions.
- 9 b. A Client who is already an HCBS-CMHS recipient and who enters a hospital may  
10 not receive HCBS-CMHS services while in the hospital. If the hospitalization  
11 continues for 30 days or longer, the case manager must terminate the Client from  
12 the HCBS-CMHS program.
- 13 c. A Client who is already an HCBS-CMHS recipient and who enters a nursing  
14 facility may not receive HCBS-CMHS services while in the nursing facility;
- 15 1) The case manager must terminate the Client from the HCBS-CMHS  
16 program if Medicaid pays for all or part of the nursing facility care, or if  
17 there is a URC-certified ULTC-100.2-LOC Eligibility Determination for the  
18 nursing facility placement, as verified by telephoning the URC.
- 19 2) A Client receiving HCBS-CMHS services who enters a nursing facility for  
20 Respite Care as a service under the HCBS-CMHS program shall not be  
21 required to obtain a nursing facility ULTC-100.2-LOC Screen and shall  
22 be continued as an HCBS-CMHS Client in order to receive the HCBS-  
23 CMHS service of Respite Care in a nursing facility.

24 **8.509.16 START DATE**

25 The start date of eligibility for HCBS-CMHS services shall not precede the date that all of the  
26 requirements at Section 8.509.15, have been met. The first date for which HCBS-CMHS services can be  
27 reimbursed shall be the LATER of any of the following:

- 28
- 29 A. Financial The financial eligibility start date shall be the effective date of eligibility, as  
30 determined by the income maintenance technician, according to Section 8.100. This may  
31 be verified by consulting the income maintenance technician, or by looking it up on the  
32 eligibility system.
- 33 B. Level of Care This date is determined by the official URC-assigned start date on the  
34 ULTC-100.2 form-LOC Eligibility Determination.
- 35 C. Receiving Services This date shall be determined by the date on which the Client signs  
36 either a case plan form, or a preliminary case plan (Intake) form, as prescribed by the  
37 state, agreeing to accept HCBS-CMHS services.
- 38 D. Institutional Status HCBS-CMHS eligibility cannot precede the date of discharge from the  
39 hospital or nursing facility.

1 **8.509.30 CASE MANAGEMENT FUNCTIONS**

2 8.509.31 NEW HCBS-CMHS CLIENTS

3 A. INTAKE/SCREENING/REFERRAL

- 4 1. Case management agency staff shall complete a State-prescribed Intake form in  
5 accordance with the Single Entry Point Intake Procedures at Section 8.393.2 for each  
6 potential HCBS-CMHS Aapplicant. The Intake form must be completed before an  
7 assessment is initiated. The Intake form may also be used as a preliminary case plan  
8 form when signed by the Aapplicant for purposes of establishing a start date. Additionally,  
9 at intake, Clients shall be offered an opportunity to identify a third party to receive Client  
10 notices. This information shall be included on the intake form. This designee shall be sent  
11 copies of all notices sent to Clients.
- 12 2. Case management agency staff shall verify the individual's current financial eligibility  
13 status or refer the Client to the county department of social services of the Client's county  
14 of residence for application. This verification shall include whether the Aapplicant is in a  
15 category of assistance that includes financial eligibility for long-term care.
- 16 3. Based upon information gathered on the Intake form, the case manager shall determine  
17 the appropriateness of a referral for a ~~comprehensive uniform long-term care Client~~  
18 ~~assessment (ULTC-100.2), Level of Care Eligibility Determination Screen~~ and shall  
19 explain the reasons for the decision on the Intake form. The Client shall be informed of  
20 the right to request an ~~assessment~~ LOC Screen if the Client disagrees with the case  
21 manager's decision.
- 22 4. If the case management agency staff has determined that a ~~comprehensive uniform long-~~  
23 ~~term care client assessment (ULTC-100.2)~~ LOC Screen is needed, or if the Client  
24 requests ~~an assessment, one~~ a case manager shall be assigned to schedule the  
25 assessment.

26 B. ASSESSMENT

- 27 1. The URC/SEP case manager shall complete the ~~Uniform Long-term Care Client~~  
28 ~~Assessment Instrument (ULTC-100.2)~~ LOC Screen in accordance with Section  
29 ~~8.393.2.C-D~~ ASSESSMENT.
- 30 2. The URC/SEP case manager shall begin and complete the LOC Screen within ten (10)  
31 days of notification of Client's need for assessment.
- 32 3. The URC/SEP case manager shall complete the following activities for a LOC Screen:
- 33 a. Obtain all required information from the Client's medical provider including  
34 information required for target group determination;
- 35 b. Determine the Client's level of care needs during a face-to-face interview,  
36 preferably with the observation of the Client in his or her residential setting. Upon  
37 Department approval, the assessment may be completed by the case manager  
38 at an alternate location, via the telephone or using virtual technology methods.  
39 Such approval may be granted for situations in which face-to-face meetings  
40 would pose a documented safety risk to the case manager or Client (e.g. natural  
41 disaster, pandemic, etc.);

- 1 c. Determine the ability and appropriateness of the Client's caregiver, family, or  
 2 others and other collateral, to provide the Client assistance in activities of daily  
 3 living;
- 4 d. Determine the Client's service needs, including the Client's need for services not  
 5 provided under HCBS-CMHS
- 6 e. If the Client is a resident of a nursing facility, determine the feasibility of  
 7 deinstitutionalization;
- 8 f. Review service options based on the Client's needs, the potential funding  
 9 sources, and the availability of resources;
- 10 g. Explore the Client's eligibility for publicly funded programs, based on the eligibility  
 11 criteria for each program, in accordance with state rules;
- 12 h. View and document the current Assisted Living Residence license, if the Client  
 13 lives, or plans to live, in a congregate facility as defined at Section 8.509.14 in  
 14 order to assure compliance with the regulation at Section 5.509.11(B).
- 15 i. Determine and document Client preferences in program selection;
- 16 j. Complete documentation on the ~~ULTC 100.2 form~~ LOC Screen.
- 17 k. To de-institutionalize a Client who is in a nursing facility under payment by  
 18 Medicaid, and with an existing -nursing facility Level of Care Eligibility  
 19 Determination with a completion date older than six (6) months, current ULTC  
 20 100.2 already certified by the URC/SEP agency for the nursing facility level of  
 21 ULTC 100.2 completion date is older than six (6) months, the URC/SEP case  
 22 manager shall complete a new LOC Screen and determine whetherif the client  
 23 continues to meet the nursing facility level of care. The nursing facility staff shall  
 24 notify the URC/SEP agency of the planned date of discharge and shall assign a  
 25 new length of stay for HCBS if eligibility criteria are met. If a client leaves a  
 26 nursing facility, and no one has notified the URC/SEP agency of the client's intent  
 27 to apply for HCBS-CMHS, the case manager must ~~obtain a new~~ complete a new  
 28 ULTC 100.2 LOC Screen and the Client shall be treated as an Applicant from  
 29 the community rather than as a de-institutionalized Client.
- 30 l. It is the URC/SEP case manager's responsibility to assess the behaviors of the  
 31 Client and assure that community placement is appropriate.

### 32 C. HCBS-CMHS DENIALS AND/OR DISCONTINUATIONS

- 33 1. If a Client is determined, at any point in the level of care assessment eligibility  
 34 determination process, to be ineligible for HCBS-CMHS according to any of the  
 35 requirements at Section 8.509.15, the case manager shall refer the Client or the Client's  
 36 designated representative to other appropriate services. Clients who are denied HCBS-  
 37 CMHS services shall be notified of denials and appeal rights as follows:
- 38 a. Financial Eligibility
- 39 The income maintenance technician at the county department of social services  
 40 shall notify the Applicant of denial for reasons of financial eligibility and shall  
 41 inform the Applicant of appeal rights in accordance with Sections 3.840 and



1 3.850 of the Colorado Department of Human Services' Staff Manual Volume III at  
2 9 CCR 2503-1. The case manager shall not attend the appeal bearing for a  
3 denial based on financial eligibility, unless subpoenaed, or unless requested by  
4 the state.

5 b. Level of Care AND Target Group

6 The URC shall notify the applicantApplicant of denial for reasons related to  
7 determination of level of care AND target group eligibility and shall inform the  
8 applicantApplicant of appeal rights in accordance with Section 8.057. The case  
9 manager shall not make judgments as to eligibility regarding level of care or  
10 target group and shall refer all applicantApplicants who request a URC review to  
11 the URC, independently of any action that may be taken by the case manager in  
12 regard to other eligibility requirements, in accordance with the rest of this section.  
13 The case manager shall not attend the appeal hearing for a denial based on level  
14 of care or target group determination, unless subpoenaed, or unless requested  
15 by the state.

16 c. Receiving Services

17 The case manager shall notify the applicantApplicant of denial, on Department-  
18 prescribed form, when the case manager determines that the applicantApplicant  
19 does not meet the HCBS-CMHS eligibility requirements at Section 8.509.15 and  
20 shall inform the applicantApplicant of appeal rights in accordance with Section  
21 8.057, et. seq. The case manager shall also attend the appeal hearing to defend  
22 this denial action. A denial and appeal for this reason is independent of any  
23 action that may be taken by the URC in regard to level of care and target group  
24 determination.

25 d. Institutional Status

26 The case manager shall notify the applicantApplicant of denial, on a Department-  
27 prescribed form, when the case manager determines that the applicantApplicant  
28 does not meet the eligibility requirement at Section 8.509.15 and shall inform the  
29 applicantApplicant of appeal rights in accordance with Section 8.057, et. seq.  
30 The case manager shall also attend the appeal hearing to defend this denial  
31 action. A denial and appeal for this reason is independent of any action that may  
32 be taken by the URC in regard to level of care and target group determination.

33 e. Cost-effectiveness

34 The case manager shall notify the applicantApplicant of denial, on Department-  
35 prescribed form, when the case manager determines that the applicantApplicant  
36 does not meet the eligibility requirement 8.509.15 and shall inform the  
37 applicantApplicant of appeal rights in accordance with Section 8.057, et.seq. The  
38 case manager shall also attend the appeal hearing to defend this denial action. If  
39 the applicantApplicant requests to receive less than the needed amount of  
40 services in order to become cost-effective, the case manager must assess the  
41 safety of the applicantApplicant, and the competency of the applicantApplicant to  
42 choose to live in an unsafe situation. If the case manager determines that the  
43 applicantApplicant will be unsafe with the amount of services available and is not  
44 competent to choose to live in an unsafe situation, the case manager may deny  
45 HCBS-CMHS eligibility. To support a denial for safety reasons related to cost-  
46 effectiveness, the case manager must document the results of an Adult  
47 Protective Services assessment, a statement from the Client's physician attesting



1 to the Client's mental competency status, and all other available information  
 2 which will support the determination that the Client is unsafe and incompetent to  
 3 make a decision to live in an unsafe situation; and, which will satisfy the burden  
 4 of proof required of file case manager making the denial. Denials and appeals for  
 5 reasons of cost-effectiveness, or safety related to cost-effectiveness, are  
 6 independent of any action that may be taken by the URC in regard to level of  
 7 care and target group determination.

8 f. Waiver Cap

9 The case manager shall notify the ~~applicant~~Applicant of denial, on a Department-  
 10 prescribed form, when the waiver cap limiting the number of Clients who may be  
 11 served under the terms of the approved waiver has been reached.

12 **8.509.32 ONGOING HCBS-CMHS CLIENTS**

13 A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

- 14 1. The coordination, monitoring, and evaluation of services for HCBS-CMHS Clients shall  
 15 be in accordance with Section 8.393.2. In addition, the case manager shall:
- 16 a. Contact each Client quarterly, or more frequently, as determined by the Client's  
 17 assessed needs. Contact may be at the Client's place of residence, by  
 18 telephone, or other appropriate setting as determined by the Client's needs.
- 19
- 20 b. Review the ~~ULTC.100.2- LOC Screen~~ and the ~~Service Plan-PCSP~~ with the client  
 21 every six (6) months in person. Upon Department approval, contact may be  
 22 completed by the case manager at an alternate location, via the telephone or  
 23 using virtual technology methods. Such approval may be granted for situations in  
 24 which face-to-face meetings would pose a documented safety risk to the case  
 25 manager or Client (e.g. natural disaster, pandemic, etc.).
- 26 2. The case manager shall refer the Client for mental health services taking into account  
 27 Client choice. The case manager shall coordinate case management activities for those  
 28 Clients who are receiving mental health services from the Behavioral Health  
 29 Organizations (BHO).
- 30 3. On-going case management shall include, but not be limited to the following tasks:
- 31 a. Review of the Client's case plan and service agreements;
- 32 b. Contact with the Client concerning whether services are being delivered  
 33 according to the plan; and the Client's satisfaction with services provided;
- 34 c. Contact with service providers concerning service delivery, coordination,  
 35 effectiveness, and appropriateness;
- 36 d. Contact with appropriate parties in the event any issues or complaints have been  
 37 presented by the Client or others;
- 38 e. Conflict resolution and/or crisis intervention, as needed;

- 1 f. Informal assessment of changes in Client functioning, service effectiveness,  
2 service appropriateness, and service cost-effectiveness;
- 3 g. Notification of appropriate enforcement agencies, as needed; and
- 4 h. Referral to community resources, and arrangement for non-HCBS-CMHS  
5 services, as needed.
- 6 4. In the event, at any time throughout the case management process, the case manager  
7 suspects an individual to be a victim of abuse, neglect/self-neglect or exploitation, the  
8 case manager shall immediately refer the individual to the protective services section of  
9 the county department of social services of the individual's county of residence or the  
10 local law enforcement agency.
- 11 5. The case manager shall immediately report, to the appropriate agency, any information  
12 which indicates an overpayment, incorrect payment, or mis-utilization of any public  
13 assistance or Medicaid benefit. The case manager shall cooperate with the appropriate  
14 agency in any subsequent recovery process, in accordance with the Colorado  
15 Department of Human Services' Staff Manual Volume 3, Section 3.810.

16 C. REASSESSMENT

- 17 1. The case manager shall complete a ~~level of care R~~ reassessment of each HCBS-CMHS  
18 Client before the end of the length of stay assigned by the URC at the ~~st level of care~~  
19 ~~determination-Level of Care Eligibility Determination~~. The case manager shall initiate a  
20 ~~R~~ reassessment more frequently when warranted by significant changes that may affect  
21 HCBS-CMHS eligibility.
- 22 2. The case manager shall complete the ~~R~~ reassessment, utilizing the ~~Uniform Long-term~~  
23 ~~Care Client Assessment Instrument (ULTC 100.2)-Department prescribed instrument~~.
- 24 3. Reassessment shall include, but not be limited to, the following activities:
- 25 a. Verify continuing Medicaid eligibility, including verification of an aid category that  
26 includes eligibility for long-term care benefits;
- 27 b. Evaluate service effectiveness, quality of care, appropriateness of services, and  
28 cost effectiveness;
- 29 c. Evaluate continuing need for the HCBS-CMHS program, and clearly document  
30 reasons for continuing HCBS; or terminate the Client's eligibility according to  
31 Section 8.509.32(E);
- 32 d. Ensure that all information needed from the medical provider for the ~~URC level of~~  
33 ~~care review is included on the ULTC 100.2 form;LOC Screen is included~~.
- 34 e. Reassess the Client's ~~functional~~ level of care status, according to the procedures  
35 in Section 8.509.31(B);
- 36 f. Review the PCSP, including verification of whether services have been delivered  
37 according to the PCSP, and write a new PCSP, according to procedures at  
38 Section 8.509.31(D);
- 39 g. Refer the Client to community resources, as needed;

- 1 h. Submit a continued stay review PAR, in accordance with requirements at Section  
2 8.509.31(G). For Clients who have been denied by the URC at continued stay  
3 review, and are eligible for services during the appeal, written documentation that  
4 an appeal is in progress may be used as a substitute for the ~~approved ULTC~~  
5 ~~400.2~~Level of Care Eligibility Determination. Acceptable documentation of an  
6 appeal include: (a) a copy of the request for reconsideration, or the request for  
7 appeal, signed by the Client and sent to the URC or to the Office of  
8 Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by  
9 the URC or the Office of Administrative Courts to the Client; or (c) a copy of the  
10 notice of a scheduled court date.

11 Copies of denial letters, and written statements from case managers, are not  
12 acceptable documentation that an appeal was actually filed and shall not be  
13 accepted as a substitute for ~~the approved ULTC 400.2~~the Level of Care Eligibility  
14 Determination. The length of the PAR on appeal cases may be up to one year,  
15 with the PAR being revised to the correct dates of eligibility at the time the appeal  
16 is resolved.

### 18 8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

#### 19 A. COMMUNICATION

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

- 22 1. The case manager shall inform the income maintenance technician of any and all  
23 changes in the Client's participation in HCBS-CMHS and shall provide the technician with  
24 copies ~~of the first page of all URC approved ULTC 400.2 forms~~the Level of Care  
25 Eligibility Determination.  
26

## 1 8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

### 2 8.510.1 DEFINITIONS

- 3 A. Adaptive Equipment means one or more devices used to assist with completing activities of daily  
4 living.
- 5 B. Allocation means the funds determined by the Case Manager in collaboration with the Client and  
6 made available by the Department through the Financial Management Service (FMS) vendor for  
7 Attendant support services available in the Consumer Directed Attendant Support Services  
8 (CDASS) delivery option.
- 9 C. ~~Assessment means a comprehensive evaluation with the Client seeking services and appropriate~~  
10 ~~collaterals (such as family members, advocates, friends and/or caregivers) conducted by the~~  
11 ~~Case Manager, with supporting diagnostic information from the Client's medical provider to~~  
12 ~~determine the Client's level of functioning, service needs, available resources, and potential~~  
13 ~~funding sources. Case Managers shall use the Department's prescribed tool to complete~~  
14 ~~assessments. Assessment shall be as defined at Section 8.390.1.DEFINITIONS.~~
- 15 D. Attendant means the individual who meets qualifications in 8.510.8 who provides CDASS as  
16 described in 8.510.3 and is hired by the Client or Authorized Representative through the  
17 contracted FMS vendor.
- 18 E. Attendant Support Management Plan (ASMP) means the documented plan described in 8.510.5,  
19 detailing management of Attendant support needs through CDASS.
- 20 F. Authorized Representative (AR) means an individual designated by the Client or the Client's legal  
21 guardian, if applicable, who has the judgment and ability to direct CDASS on a Client's behalf and  
22 meets the qualifications contained in 8.510.6 and 8.510.7.
- 23 G. Case Management Agency (CMA) means a public or private entity that meets all applicable state  
24 and federal requirements and is certified by the Department to provide case management  
25 services for Home and Community-based Services waivers pursuant to §§ 25.5-10-209.5 and  
26 25.5-6-106, C.R.S., and has a current provider participation agreement with the Department.
- 27 H. Case Manager means an individual employed by a Case Management Agency who is qualified to  
28 perform the following case management activities: determination of an individual Client's  
29 functional eligibility for one or more Home and Community-based Services (HCBS) waivers,  
30 development and implementation of an individualized and person-centered care plan for the  
31 Client, coordination and monitoring of HCBS waiver services delivery, evaluation of service  
32 effectiveness, and periodic R reassessment of Client needs.
- 33 I. Consumer-Directed Attendant Support Services (CDASS) means the service delivery option that  
34 empowers Clients to direct their care and services to assist them in accomplishing activities of  
35 daily living when included as a waiver benefit. CDASS benefits may include assistance with  
36 health maintenance, personal care, and homemaker activities.
- 37 J. CDASS Certification Period Allocation means the funds determined by the Case Manager and  
38 made available by the Department for Attendant services for the date span the Client is approved  
39 to receive CDASS within the annual certification period.
- 40 K. CDASS Task Worksheet: A tool used by a Case Manager to indicate the number of hours of  
41 assistance a Client needs for each covered CDASS personal care services, homemaker services,  
42 and health maintenance activities.

- 1 L. CDASS Training means the required CDASS training and comprehensive assessment provided  
2 by the Training and Operations Vendor to a Client or Authorized Representative.
- 3 M. Department means the Colorado Department of Health Care Policy and Financing, the Single  
4 State Medicaid Agency.
- 5 N. Electronic Visit Verification (EVV) means the use of technology, including mobile device  
6 technology, telephony, or Manual Visit Entry, to verify the required data elements related to the  
7 delivery of a service mandated to be provided using EVV by the "21st Century Cures Act," P.L.  
8 No. 114-255, or this rule.
- 9 O. Family Member means any person related to the Client by blood, marriage, adoption, or common  
10 law as determined by a court of law.
- 11 P. Financial Eligibility means the Health First Colorado financial eligibility criteria based on Client  
12 income and resources.
- 13 Q. Financial Management Services (FMS) vendor means an entity contracted with the Department  
14 and chosen by the Client or Authorized Representative to complete employment-related functions  
15 for CDASS Attendants and to track and report on individual Client CDASS Allocations.
- 16 R. Fiscal/Employer Agent (F/EA) provides FMS by performing payroll and administrative functions  
17 for Clients receiving CDASS benefits. The F/EA pays Attendants for CDASS services and  
18 maintains workers' compensation policies on the Client-employer's behalf. The F/EA withholds,  
19 calculates, deposits and files withheld Federal Income Tax and both Client-employer and  
20 Attendant-employee Social Security and Medicare taxes. ~~Functional Eligibility means the~~  
21 ~~physical and cognitive functioning criteria a Client must meet to qualify for a Medicaid waiver~~  
22 ~~program, as determined by the Department's functional eligibility assessment tool.~~
- 23 S. Home and Community-based Services (HCBS) means a variety of supportive services delivered  
24 in conjunction with Colorado Medicaid Waivers to Clients in community settings. These services  
25 are designed to help older persons and persons with disabilities to live in the community.
- 26 T. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the  
27 Training and Operations Vendor or the FMS, and which includes documented verbal, sexual  
28 and/or physical abuse. Verbal abuse may include threats, insults or offensive language.
- 29 U. Licensed Medical Professional means the primary care provider of the Client, who possesses one  
30 of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing  
31 Nurse (APN), as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice  
32 Act.
- 33 V. Prior Authorization Request (PAR) means the Department-prescribed process used to authorize  
34 HCBS waiver services before they are provided to the Client.
- 35 W. Notification means a communication from the Department or its designee with information about  
36 CDASS. Notification methods include but are not limited to announcements via the Department's  
37 CDASS web site, Client account statements, Case Manager contact, or FMS vendor contact.
- 38 X. Stable Health means a medically predictable progression or variation of disability or illness.
- 39 Y. Training and Operations Vendor means the organization contracted by the Department to provide  
40 training and customer service for self-directed service delivery options to Clients, Authorized  
41 Representatives, and Case Managers.  
42

1 **8.515 HOME AND COMMUNITY BASED SERVICES FOR PERSONS WITH BRAIN INJURY (HCBS-**  
2 **BI)**

3 **8.515.1 LEGAL BASIS**

4 The Home and Community-based Services for Persons with Brain Injury (HCBS-BI) program is  
5 authorized by waiver of the amount, duration, and scope of services requirements contained in Section  
6 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. Section 1396a(a)(10)(B) (2018). This waiver is  
7 granted by the United States Department of Health and Human Services under Section 1915(c) of the  
8 Social Security Act, 42 U.S.C. Section 1396n (2018). This regulation is adopted pursuant to the authority  
9 in Section 25.5-1-303, C.R.S. and is intended to be consistent with the requirements of the State  
10 Administrative Procedures Act, Sections 24-4-101 et seq., C.R.S. and the Home and Community-based  
11 Services for Persons with Brain Injury Act, Sections 25.5-6-701 et seq., C.R.S.

12 **8.515.3 GENERAL DEFINITIONS**

13 Brain Injury means an injury to the brain of traumatic or acquired origin which results in residual physical,  
14 cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the following  
15 broad diagnoses found within the most current version of the International Classification of Diseases  
16 (ICD) at the time of assessment:

- 17 1. Nonpsychotic mental disorders due to brain damage; or
- 18 2. Anoxic brain damage; or
- 19 3. Compression of the brain; or
- 20 4. Toxic encephalopathy; or
- 21 5. Subarachnoid and/or intracerebral hemorrhage; or
- 22 6. Occlusion and stenosis of precerebral arteries; or
- 23 7. Acute, but ill-defined cerebrovascular disease; or
- 24 8. Other and ill-defined cerebrovascular disease; or
- 25 9. Late effects of cerebrovascular disease; or
- 26 10. Fracture of the skull or face; or
- 27 11. Concussion resulting in an ongoing need for assistance with activities of daily living; or
- 28 12. Cerebral laceration and contusion; or
- 29 13. Subarachnoid, subdural, and extradural hemorrhage, following injury; or
- 30 14. Other unspecified intracranial hemorrhage following injury; or
- 31 15. Intracranial injury; or
- 32 16. Late effects of musculoskeletal and connective tissue injuries; or
- 33 17. Late effects of injuries to the nervous system; or

1 18. Unspecified injuries to the head resulting in ongoing need for assistance with activities of  
2 daily living.

3 Case Management Agency means the agency designated by the Department to provide the Single Entry  
4 Point Functions detailed at Section 8.393.

5 Individual Cost Containment Amount means the average cost of services for a comparable population  
6 institutionalized at the appropriate level of care, as determined annually by the Department.

7 ~~Service Plan means the plan developed by the case manager in coordination with the HCBS-BI Client  
8 and/or the legal guardian to identify and document the HCBS-BI services, other Medicaid services, and  
9 any other non-Medicaid services or supports that the HCBS-BI Client requires in order to live successfully  
10 in the community.~~ Person-Centered Support Plan means as defined in Section 8.390.1 DEFINITIONS.

#### 11 8.515.4 SCOPE AND PURPOSE

12 The HCBS-BI program provides those services listed at Section 8.515.2.A to eligible individuals with brain  
13 injury that require long-term supports and services in order to remain in a community-based setting.

#### 14 8.515.5 ELIGIBLE PERSONS

15 HCBS-BI program enrollment and services shall be offered only to individuals determined by the  
16 Department or its agent to have met all eligibility requirements in this Section 8.515.5.

17

18

#### 19 8.515.5.A LEVEL OF CARE

20 Eligible individuals shall be determined by the Department or its agent to require one of the following  
21 levels of care:

22 1. Hospital Level of Care as evidenced by:

23 a. The individual shall have been:

24 i. Referred to the Case Management Agency while receiving inpatient care  
25 in an acute care or rehabilitation hospital for the treatment of the  
26 individual's brain injury; or

27 ii. Determined by the Department or its agent to have ~~a significant  
28 functional impairment~~ require a hospital level of care as determined  
29 using the Department prescribed LOC Screens ~~evidenced by a  
30 comprehensive functional assessment using the Uniform Long-term Care  
31 100.2 (ULTC 100.2) assessment tool that results in at least the minimum  
32 scores required by Section 8.401.1.15; and~~

33 c. The individual shall require goal-oriented therapy with medical management by a  
34 physician; and

35 d. The individual cannot be therapeutically managed in a community-based setting  
36 without significant supervision and structure, specialized therapy, and support  
37 services.



- 1           2.     Nursing Facility Level of Care as evidenced by all the following:
- 2           a.     The individual shall have been determined by the Department or its agent to
- 3           ~~have a significant functional impairment as evidenced by a comprehensive~~
- 4           ~~functional assessment using the Uniform Long-term Care 100.2 (ULTC 100.2)~~
- 5           ~~assessment tool that results in at least the minimum scores required by Section~~
- 6           ~~8.401.1-15; require nursing facility level of care as determined using the~~
- 7           ~~Department prescribed LOC Screen.~~
- 8           b.     The individual shall require long-term support services at a level comparable to
- 9           those services typically provided in a nursing facility.

10   8.515.5.B    TARGET GROUP

11   Eligible individuals shall be determined by the Department or its agent to meet all the following target

12   group criteria:

- 13           1.     The individual shall have a diagnosis of Brain Injury. This diagnosis must be documented
- 14           on the individual's Professional Medical Information Page (PMIP) and the ~~ULTC 100.2~~
- 15           ~~assessment tool~~ OC Screen.
- 16           2.     Age Limit
- 17           a.     Individuals enrolled in the Brain Injury waiver shall be aged 16 years and older
- 18           and shall have sustained the brain injury prior to the age of 65.

19   8.515.5.C    FINANCIAL ELIGIBILITY

20   Individuals must meet the financial requirements for long-term care medical assistance eligibility specified

21   at Section 8.100.7.

22   8.515.5.D    NEED FOR HCBS-BI SERVICES

- 23           1.     Only Clients that currently receive HCBS-BI services, or that have agreed to accept
- 24           HCBS-BI services as soon as all other eligibility criteria have been met, are eligible for
- 25           the HCBS-BI program.
- 26           a.     Case management is provided as an administrative function, not an HCBS-BI
- 27           service, and shall not be used to satisfy this requirement.
- 28           b.     The desire or need for any Medicaid services other than HCBS-BI services, as
- 29           listed at Section 8.515.1, shall not satisfy this eligibility requirement.

- 30           2.     Clients that have not received an HCBS-BI service for a period greater than 30
- 31           consecutive days shall be discontinued from the program.

32   8.515.5.E    EXCLUSIONS FROM ELIGIBILITY

- 33           1.     Individuals who are residents of nursing facilities, hospitals, or other institutional settings
- 34           are not eligible to receive HCBS-BI services.
- 35           2.     HCBS-BI Clients that enter a nursing facility or hospital may not receive HCBS-BI
- 36           services while admitted to the nursing facility or hospital.

- 1 a. HCBS-BI Clients admitted to a nursing facility or hospital for 30 consecutive days  
2 or longer shall be discontinued from the HCBS-BI program.
- 3 b. HCBS-BI Clients entering a nursing facility for Respite Care as an HCBS-BI  
4 service shall not be discontinued from the HCBS-BI program.

#### 5 8.515.6 START DATE FOR SERVICES

6 8.515.6.A. The start date of eligibility for HCBS-BI services shall not precede the date that all of the  
7 requirements in Section 8.515.5, have been met. The first date for which HCBS-BI services may  
8 be reimbursed shall be the later the following:

- 9 1. The date at which financial eligibility is effective.
- 10 2. The date at which the Department or its agent has made a Level of Care Determination  
11 ~~determined~~ that the Client has met all level of care eligibility requirements at Section  
12 8.515.5.
- 13 3. The date at which the Client agrees to accept services and signs all necessary intake and  
14 Person-Centered Support Planning ~~service planning~~ forms.
- 15 4. The date of discharge from an institutional setting.

#### 16 8.515.7 PRIOR AUTHORIZATION OF SERVICES

17 8.515.7.A. All HCBS-BI services must be prior authorized by the Department or its agent.

18 8.515.7.B. The Department shall develop the Prior Authorization Request (PAR) form to be used by  
19 case managers in compliance with all applicable regulations.

20 8.515.7.C. The Department or its agent shall determine if the services requested are:

- 21 1. Consistent with the Client's documented medical condition and functional capacity;
- 22 2. Reasonable in amount, scope, frequency, and duration;
- 23 3. Not duplicative of the other services or supports included in the Client's Service  
24 Plan; PCSP;
- 25 4. Not for services for which the Client is receiving funds to purchase; and
- 26 5. Do not total more than 24 hours per day of care.

27 8.515.7.D. Revisions to the PAR that are requested six months or more after the end date shall be  
28 disapproved.

29 8.515.7.E. Approval of the PAR by the Department or its agent shall authorize providers of HCBS-BI  
30 services to submit claims to the fiscal agent and to receive payment for authorized services  
31 provided during the period of time covered by the PAR.

- 32 1. Payment for HCBS-BI services is also conditional upon:
- 33 a. The Client's eligibility for HCBS-BI services;

1           b.       The provider's certification status; and

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

3 8.515.7.F.     The prior authorization of services does not constitute an entitlement to those services.  
4           All services provided and reimbursed must be delivered in accordance with regulation and be  
5           necessary to meet the Client's needs.

6 8.515.7.G.     Services requested on the PAR shall be supported by information on the Service  
7           PlanPCSP and the ULTC-100.2 assessment-LOC Screen.

8 8.515.7.H.     The PAR start date shall not precede the start date of HCBS-BI eligibility in accordance  
9           with Section 8.515.6.

10 8.515.7.I.     The PAR end date shall not exceed the end date of the HCBS-BI eligibility certification  
11           period.

## 12 **8.515.8 WAITING LIST**

13 8.515.7.A.     Persons determined eligible for HCBS-BI services that cannot be served within the  
14           capacity limits of the HCBS-BI waiver shall be eligible for placement on a waiting list.

15           1.       The waiting list shall be maintained by the Department.

16           2.       The date used to establish the person's placement on the waiting list shall be the date on  
17           which all other eligibility requirements at Section 8.515.5 were determined to have been  
18           met and the HCBS-BI Program Administrator was notified.

19           3.       As openings become available within the capacity limits of the federal waiver, persons  
20           shall be considered for services based on the date of their waiting list placement.

## 21 **8.515.85 SUPPORTIVE LIVING PROGRAM**

### 22 8.515.85.A DEFINITIONS

23           1.       Activities of Daily Living (ADLs) mean basic self-care activities, including mobility,  
24           bathing, toileting, dressing, eating, transferring, support for memory and cognition, and  
25           behavioral supervision.

26           2.       Assistance means the use of manual methods to guide or assist with the initiation or  
27           completion of voluntary movement or functioning of an individual's body through the use  
28           of physical contact by others, except for the purpose of providing physical restraint.

29           3.       Assistive Technology Devices means any item, piece of equipment, or product system  
30           that is used to increase, maintain, or improve functional capabilities of individuals with  
31           disabilities.

32           4.       Authorized Representative means an individual designated by the Client or the legal  
33           guardian, if appropriate, who has the judgment and ability to assist the Client in acquiring  
34           and utilizing supports and services.

35           5.       Behavioral Management and Education means services as defined in § 8.516.40.A, and  
36           Inclusions as defined at § 8.516.40.B, provided as an individually developed intervention

- 1 designed to decrease/control the Client's severe maladaptive behaviors which, if not  
2 modified, will interfere with the Client's ability to remain integrated in the community.
- 3 6. Case Management Agency (CMA) means an agency within a designated service area  
4 where an ~~applicant~~Applicant or Client can obtain Case Management services. CMAs  
5 include Single Entry Points (SEPs), Community Centered Boards (CCBs), and private  
6 case management agencies.
- 7 7. Case Manager means an individual employed by a CMA who is qualified to perform the  
8 following case management activities: determination of an individual Client's  
9 ~~functional~~Level of Care Eligibility Determination for the Home and Community-based  
10 Services – Brain Injury (HCBS-BI) waiver, development and implementation of an  
11 individualized and ~~P~~person-Centered Service-Support Plan for the Client, coordination  
12 and monitoring of HCBS-BI waiver services delivery, evaluation of service effectiveness,  
13 and the periodic R reassessment of such Client's needs.
- 14 8. Critical Incident means an actual or alleged event or situation that creates a significant  
15 risk of substantial or serious harm to the health or welfare of a Client that could have, or  
16 has had, a negative impact on the mental and/or physical well-being of a Client in the  
17 short or long-term. A critical incident includes accidents, a suspicion of, or actual abuse,  
18 neglect, or exploitation, and criminal activity.
- 19 9. Department means the Department of Health Care Policy and Financing.
- 20 10. Health Maintenance Activities means those routine and repetitive health-related tasks  
21 which are necessary for health and normal bodily functioning, that an individual with a  
22 disability would carry out if he/she were physically able, or that would be carried out by  
23 family members or friends if they were available. These activities include, but are not  
24 limited to, catheter irrigation, administration of medication, enemas, suppositories, and  
25 wound care.
- 26 11. Independent Living Skills Training means services designed and directed toward the  
27 development and maintenance of the Client's ability to independently sustain  
28 himself/herself physically, emotionally, and economically in the community.
- 29 12. Instrumental Activities of Daily Living (IADLs) means activities related to independent  
30 living, including preparing meals, managing money, shopping for groceries or personal  
31 items, performing light or heavy housework and communication.
- 32 13. Interdisciplinary Team means a group of people responsible for the implementation of a  
33 Client's individualized care plan, which includes the Client receiving services, the parent  
34 or guardian of a minor, a guardian or an authorized representative, as appropriate, the  
35 person who coordinates the provision of services and supports, and others as determined  
36 by the Client's needs and preferences, who are assembled in a cooperative manner to  
37 develop or review the person-centered care plan.
- 38 14. Personal Care Services includes providing assistance with eating, bathing, dressing,  
39 personal hygiene or other activities of daily living. When specified in the service plan,  
40 Personal Care Services may also include housekeeping chores such as bed making,  
41 dusting, and vacuuming. Housekeeping assistance must be incidental to the care  
42 furnished or essential to the health and welfare of the individual rather than for the benefit  
43 of the individual's family.

1 15. Person-Centered Care Support Plan is ~~a service plan created by a process that is driven~~  
 2 ~~by the individual and can also include people chosen by the individual pursuant to 42~~  
 3 ~~C.F.R. § 441.540. It provides necessary information and support to the individual to~~  
 4 ~~ensure that the individual directs the process to the maximum extent possible. It~~  
 5 ~~documents Client choice, establishes goals, identifies potential risks, assures health and~~  
 6 ~~safety, and identifies the services and supports the Client needs to function safely in the~~  
 7 ~~community as defined in Secqtion 8.390.1 DEFINITIONS.~~

8 16. Protective Oversight is defined as monitoring and guidance of a Client to assure his/her  
 9 health, safety, and well-being. Protective oversight includes, but is not limited to:  
 10 monitoring the Client while on the premises, monitoring ingestion and reactions to  
 11 prescribed medications, if appropriate, reminding the Client to carry out activities of daily  
 12 living, and facilitating medical and other health appointments. Protective oversight  
 13 includes the Client's choice and ability to travel and engage independently in the wider  
 14 community and providing guidance on safe behavior while outside the Supportive Living  
 15 Program.

16 17. Room and Board is defined as a comprehensive set of services that include lodging,  
 17 routine or basic supplies for comfortable living, and nutritional and healthy meals and  
 18 food for the Client, all of which are provided by the Supportive Living Program provider,  
 19 and are not included in the per diem.

20 18. Supportive Living Program (SLP) certification means documentation from the Colorado  
 21 Department of Public Health and Environment (CDPHE) recommending certification to  
 22 the Department after the SLP provider has met all licensing requirements found in 6  
 23 C.C.R. 1011-1; Chapter 2, and either Chapter 7 or 26, in addition to all requirements in §  
 24 8.515.85.

25 8.515.85.B CLIENT ELIGIBILITY

26 1. SLP services are available to individuals who meet all of the following requirements:

27 a. Clients are determined ~~functionally eligible to meet level of care eligibility~~ for  
 28 HCBS-BI waiver by a certified case management agency ~~as outlined in Section~~  
 29 ~~8.515.5;~~

30 b. Clients are enrolled in the HCBS-BI waiver; and

31 c. Clients require the specialized services provided under the SLP as determined  
 32 by assessed need.

33 2. Person-Centered Care Planning

34 SLP providers must comply with the Person-Centered Care Planning process. Providers  
 35 must work with CMAs to ensure coordination of a Client's Person-Centered Care Plan.  
 36 Additionally, SLP providers must provide the following actionable plans for all HCBS-BI  
 37 waiver Clients, updated every six (6) months:

38 a. Transition Planning; and

39 b. Goal Planning.

1           These elements of a Person-Centered Care Plan are intended to ensure the Client  
2 actively engages in his or her care and activities, as is able to transition to any other type  
3 of setting or service at any given time.

4           3.       Exclusions

5           The following are not included as components of the SLP:

6           a.       Room and board; and

7           b.       Additional services which are available as a State Plan benefit or other HCBS-BI  
8 waiver service. Examples include, but are not limited to physician visits, mental  
9 health counseling, substance abuse counseling, specialized medical equipment  
10 and supplies, physical therapy, occupational therapy, long-term home health, and  
11 private duty nursing.  
12

DRAFT

1 **8.517 HOME AND COMMUNITY-BASED SERVICES FOR THE COMPLEMENTARY AND**  
2 **INTEGRATIVE HEALTH WAIVER**

3 **8.517.1 HCBS-CIH WAIVER SERVICES**

4 **8.517.2 GENERAL DEFINITIONS**

- 5 A. Acupuncture (CIHS) means the insertion of needles and/or manual, mechanical, thermal,  
6 electrical, and electromagnetic treatment to stimulate specific anatomical tissues for the  
7 promotion, maintenance and restoration of health and prevention of disease both physiological  
8 and psychological. During an acupuncture treatment, dietary advice and therapeutic exercises  
9 may be recommended in support of the treatment.
- 10 B. Chiropractic (CIHS) means the use of manual adjustments (manipulation or mobilization) of the  
11 spine or other parts of the body with the goal of correcting and/or improving alignment,  
12 neurological function, and other musculoskeletal problems. During a chiropractic treatment,  
13 nutrition, exercise, and rehabilitative therapies may be recommended in support of the  
14 adjustment.
- 15 C. Complementary and Integrative Health Care Plan means the plan developed prior to the delivery  
16 of Complementary and Integrative Health Services in accordance with Section 8.517.11.D.
- 17 D. Complementary and Integrative Health Provider means an individual or agency certified annually  
18 by the Department to have met the certification standards listed at Section 8.517.11.
- 19 E. Complementary and Integrative Health Services (CIHS) means Acupuncture, Chiropractic, and  
20 Massage Therapy.
- 21 F. Emergency Systems means procedures and materials used in emergent situations and may  
22 include, but are not limited to, an agreement with the nearest hospital to accept patients; an  
23 Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.
- 24 G. Individual Cost Containment Amount means the average cost of services for a comparable  
25 population institutionalized at the appropriate level of care, as determined annually by the  
26 Department.
- 27
- 28 H. Massage Therapy (CIHS) means the systematic manipulation of the soft tissues of the body,  
29 (including manual techniques of gliding, percussion, compression, vibration, and gentle  
30 stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or  
31 psychological changes.

32 **8.517.5 CLIENT ELIGIBILITY**

33 **8.517.5.A. ELIGIBLE PERSONS**

34 Home and Community-based Services for Complementary and Integrative Health (HCBS-CIH)  
35 waiver services shall be offered only to individuals who meet all of the following eligibility  
36 requirements:

- 37 1. Individuals shall be aged 18 years or older.



- 1           2.       Individuals shall have a qualifying condition of a spinal cord injury (traumatic or  
2                   nontraumatic), multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or  
3                   cerebral palsy with the inability for independent ambulation directly resulting from one of  
4                   these conditions as defined by broad diagnoses related to each condition within the most  
5                   current version of the International Classification of Diseases (ICD) at the time of  
6                   assessment.
- 7           3.       Individuals must have been determined to have an inability for independent ambulation  
8                   resulting from the qualifying condition as identified by the case manager through the  
9                   assessment process. The inability for independent ambulation means:
- 10           a.       The individual does not walk, and requires use of a wheelchair or scooter in all  
11                   settings, whether or not they can operate the wheelchair or scooter safely, on  
12                   their own, OR;
- 13           b.       The individual does walk, but requires use of a walker or cane in all settings,  
14                   whether or not they can use the walker or cane safely, on their own, OR;
- 15           c.       The individual does walk, but requires “touch” or “stand-by” assistance to  
16                   ambulate safely in all settings.

#### 17   8.517.5.C       LEVEL OF CARE CRITERIA

18           Individuals shall require long-term support services at a level of care comparable to services  
19                   typically provided in a nursing facility or hospital.

#### 20   8.517.6 WAITING LIST

- 21           9.       Within ten business days of notification from the Department that an opening for the  
22                   HCBS-CIH waiver is available the Case Management Agency shall:
- 23           a.       Reassess the individual for ~~functional~~ level of care using the Department’s  
24                   prescribed instrument if more than six months has elapsed since the previous  
25                   assessment.
- 26           b.       Update the existing ~~functional~~ level of care assessment in the official Client  
27                   record if less than six months has elapsed since the date of the previous  
28                   assessment.
- 29           c.       Reassess for eligibility criteria as set forth at 8.517.5.
- 30           d.       Notify the Department of the individual’s eligibility status.  
31

## 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. Agency Applicant means an entity seeking approval to be a provider of case management services for Home and Community-Based Services.~~
- BC. 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.
- CD. 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.
- F. Case Manager means a person who provides case management services and meets all regulatory requirements for Case Managers.
- ~~G. Case Management means the assessment of an individual's needs receiving long term services and supports, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long term service delivery, the evaluation of services effectiveness, and the periodic reassessment of such individual's needs 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.
- 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.

- 1
- 2 L. Community Centered Board means a private corporation, for-profit or not-for-profit that is  
3 designated pursuant to Section 25.5-10-209, C.R.S., responsible for, but not limited to conducting  
4 Developmental Disability determinations, waiting list management Level of Care Evaluations for  
5 Home and Community-Based Service waivers specific to individuals with intellectual and  
6 developmental disabilities, and management of State Funded programs for individuals with  
7 intellectual and developmental disabilities.
- 8 M. ~~Comprehensive Assessment means as defined in Section 8.390.1 DEFINITIONS, an initial  
9 assessment or periodic reassessment of individual needs to determine the need for any medical,  
10 educational, social or other services and completed annually or when the Client experiences  
11 significant change in need or in level of support.~~
- 12 ~~N.~~ Conflict-Free Case Management means, pursuant to 42 CFR § 441.301(c)(1)(vi), case  
13 management services provided to a Client enrolled in a Home and Community-Based Services  
14 waiver that are provided by a Case Management Agency that is not the same agency that  
15 provides services and supports to that person.
- 16 ~~NO.~~ Corrective Action Plan ~~means a written plan by the CMA, which includes a detailed description of  
17 actions to be taken to correct non-compliance with waiver requirements, regulations, and  
18 direction from the Department, and which sets forth the date by which each action shall be  
19 completed and the persons responsible for implementing the action, shall be as defined at  
20 Section 8.390.1.DEFINITIONS.~~
- 21 OP. Critical Incident means incidents or allegations involving Clients receiving services to include  
22 mistreatment, abuse, neglect, exploitation, illness/injury, death, damage to consumer's  
23 property/theft, medication management issues, criminal activity, unsafe housing/displacement,  
24 and missing persons.
- 25 PQ. Department means the Colorado Department of Health Care Policy and Financing, the Single  
26 State Medicaid Agency.
- 27 QR. Developmental Delay means as defined in Section 8.600.4.
- 28 RS. Developmental Disability means as defined in Section 8.600.4.
- 29 ST. Executive Director means the Executive Director of the Colorado Department of Health Care  
30 Policy and Financing unless otherwise indicated.
- 31 TU. Financial Eligibility means the eligibility criteria for a publicly funded program, based on the  
32 individual's financial circumstances, including income and resources, if applicable.
- 33 UV. Guardian means an individual at least twenty-one years of age, resident or non-resident, who has  
34 qualified as a guardian of a minor or incapacitated person pursuant to appointment by a parent or  
35 by the court. The term includes a limited, emergency, and temporary substitute guardian but not a  
36 guardian ad litem Section 15-14-102 (4), C.R.S.
- 37 VW. Guardian ad litem or GAL means a person appointed by a court to act in the best interests of a  
38 child involved in a proceeding under title 19, C.R.S., or the "School Attendance Law of 1963," set  
39 forth in article 33 of title 22, C.R.S.
- 40 WX. Home and Community-based Services (HCBS) waivers means services and supports authorized  
41 through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client

1 who requires a ~~n institutional~~ Level of Care that would otherwise be provided in a hospital,  
2 nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

3

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

11 ~~YZ.~~ Information Management System (IMS) ~~means an automated data management system~~  
12 ~~approved by the Department to enter case management information for each individual seeking~~  
13 ~~or receiving long-term services as well as to compile and generate standardized or custom~~  
14 ~~summary reports.~~ means as defined in Section 8.390.1 DEFINITIONS.

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

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

21 ~~BBGG.~~ Level of Care Eligibility Determination means ~~determining eligibility of an individual for a Long-~~  
22 ~~Term Services and Supports (LTSS) program and determined by a Community Centered Board~~  
23 ~~or Single Entry Point Agency~~ as defined in Section 8.390.1 DEFINITIONS.

24 ~~CCDD.~~ Level of Care Evaluation-Eligibility Determination Screen means as defined in Section 8.390.1  
25 DEFINITIONS. ~~a comprehensive evaluation with the individual seeking services and others~~  
26 ~~chosen by the individual to participate and an evaluation by the Case Manager utilizing the~~  
27 ~~Department prescribed tool, with supporting diagnostic information from the Client's medical~~  
28 ~~provider, and to determine the Client's level of functioning for admission or continued stay in~~  
29 ~~certain Long-Term Services and Supports (LTSS) programs.~~

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

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

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

41 ~~GGHH.~~ Parent means the biological or adoptive parent.

- 1 ~~HH.##~~ Performance and Quality Review means a review conducted by the Department or its contractor  
2 at any time but no less than the frequency as specified in the approved waiver application. To  
3 include a review of required case management services performed by the agency to ensure  
4 quality and compliance with all requirements. The agency shall provide all requested information  
5 and documents as requested by the Department or by its contractor.
- 6 ~~II.##~~ Person-Centered Support Plan (PCSP) means as defined in Section 8.390.1 DEFINITIONS.
- 7 JJ. Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS.
- 8 KK. Prior Authorization Requests (PAR) means approval for an item or service that is obtained in  
9 advance either from the Department, a state fiscal agent or the Case Management Agency.
- 10 ~~LLKK.~~ Professional Medical Information Page (PMIP) ~~means the medical information form signed by a~~  
11 ~~licensed medical professional used to certify Level of Care. means as defined in Section 8.390.1~~  
12 ~~DEFINITIONS.~~
- 13 MM ~~LL.~~ Provider for the purpose of this section means any person, group or entity approved to  
14 render services or provide items to a Client enrolled in an HCBS waiver program.
- 15 NNMM. Regional Center means a facility or program operated directly by the Department of Human  
16 Services which provides services and supports to Clients with intellectual and developmental  
17 disabilities.
- 18 OONN. Retrospective Review means the Department or the Department's contractor's review after  
19 services and supports are provided to ensure the Client received services according to the  
20 ~~Service Plan PCSP~~ and that the Case Management Agency complied with the requirements set  
21 forth in statute, waiver, and regulations.
- 22 ~~OO.~~ ~~Person-Centered SupportService Plan (PCSP) means as defined in Section 8.390.1~~  
23 ~~DEFINITIONS. the written document that specifies identified and needed services, to include~~  
24 ~~Medicaid and non-Medicaid services regardless of funding source, to assist a Client to remain~~  
25 ~~safely in the community and developed in accordance with the Department's rules.~~
- 26 PP. Service Plan Authorization Limit (SPAL) means an annual upper payment limit of total funds  
27 available to purchase services to meet the Client's ongoing needs. Purchase of services not  
28 subject to the SPAL are set forth at Section 8.500.102.B. A specific limit is assigned to each of  
29 the six support levels in the HCBS-SLS waiver. The SPAL is determined by the Department  
30 based on the annual appropriation for the HCBS-SLS waiver, the number of Clients in each level,  
31 and projected utilization.
- 32 QQ. Supports Intensity Scale (SIS) means the standardized assessment tool that gathers information  
33 from a semi-structured interview of respondents who know the Client well. It is designed to  
34 identify and measure the practical support requirements of adults with intellectual and  
35 developmental disabilities.
- 36 RR. Support Level means a numeric value determined using an algorithm that places Clients into  
37 groups with other Clients who have similar overall support needs.
- 38 ~~SS.~~ ~~Person-Centered Support Planning means the process of working with an individual receiving~~  
39 ~~services and people chosen by the individual to identify goals, needed services, individual~~  
40 ~~choices and preferences, and appropriate services providers based on the individual's~~  
41 ~~assessment and knowledge of the individual and available community resources. Support~~

1 ~~planning includes informing the individual seeking or receiving services of his or her rights and~~  
 2 ~~responsibilities, as defined in Section 8.390.1 DEFINITIONS.~~

3 ~~SSFF~~. Targeted Case Management (TCM) means case management services provided to Clients  
 4 enrolled in the HCBS-CES, HCBS- Children Habilitation Residential Program (CHRP), HCBS-DD,  
 5 and HCBS-SLS waivers in accordance with Section 8.760 et seq, Targeted case management  
 6 includes facilitating enrollment, locating, coordinating and monitoring needed HCBS waiver  
 7 services and coordinating with other non-waiver resources, including, but not limited to medical,  
 8 social, educational and other resources to ensure non-duplication of waiver services and the  
 9 monitoring of effective and efficient provision of waiver services across multiple funding sources.  
 10 Targeted case management includes the following activities; ~~comprehensive a~~ Assessment and  
 11 periodic ~~R~~ reassessment, development and periodic revision of a ~~Service Plan~~ PCSP, referral and  
 12 related activities, and monitoring.

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

15  
 16 ~~8.519.6 Case Management Agency selection To be implemented no later than January 1, 2021~~

17 ~~8.519.6.A. Clients have the ability to change their Case Management Agency at any time, with the~~  
 18 ~~exception of initial enrollment into a waiver.~~

19 ~~1. Clients must remain with the initial chosen Case Management Agency for at least 60~~  
 20 ~~calendar days or until the service plan is developed, whichever is sooner.~~

21 ~~8.519.6.B. At the time the Client has met all eligibility requirements for an HCBS waiver the~~  
 22 ~~Community Centered Board, shall within two (2) business days send a referral to the~~  
 23 ~~Department's contractor to assist the Client in selecting a CMA.~~

24 ~~1. The Department's contractor shall contact the Client within two (2) business days from~~  
 25 ~~the date of referral from the CCB.~~

26 ~~a. The Client, or the Client's guardian, shall inform the Department's contractor of~~  
 27 ~~their choice of Case Management Agency.~~

28 ~~b. The Department's contractor shall assist the Client in selecting a CMA when~~  
 29 ~~necessary, which may include, but is not limited to:~~

30 ~~i. Providing a list of qualified CMAs.~~

31 ~~ii. Providing the Department's webpage address and information on how to~~  
 32 ~~search for a CMA.~~

33 ~~iii. Providing information regarding the qualified CMAs based on the Client's~~  
 34 ~~preferences.~~

35 ~~iv. In addition to other assistance as requested or needed by the Client.~~

36 ~~2. The Department's contractor shall notify the selected CMA within two (2) business days~~  
 37 ~~from the date of selection by the Client.~~



1 ~~a. The Department's contractor shall send a letter to the Client with the following~~  
2 ~~information:~~

3 ~~i. The selected CMA, address and contact information;~~

4 ~~ii. Information about the Client's right to choose a CMA; and~~

5 ~~iii. Contact information for the Department's contractor.~~

6 ~~3. The selected CMA shall contact the Client within two (2) business days from notification~~  
7 ~~of selection to confirm the choice and schedule a meeting to develop the Service Plan.~~

8 ~~8.519.6.C Case Management Agency transfer~~

9 ~~1. When a Client wishes to change their CMA, the Client must notify the current CMA or~~  
10 ~~contact the Department's contractor directly.~~

11 ~~a. The CMA shall notify the Department's contractor that the Client would like to~~  
12 ~~change their CMA if the Client did not notify the contractor directly.~~

13 ~~b. The Department's contractor shall contact the Client within two (2) business days~~  
14 ~~from the date of referral from the CMA or notification from the Client.~~

15 ~~i. When the Client seeking case management services and/or their~~  
16 ~~guardian, as appropriate, knows which approved CMA the Client wishes~~  
17 ~~to select, the Client will inform the Department's contractor of their~~  
18 ~~choice.~~

19 ~~ii. When the Client seeking case management services and/or their~~  
20 ~~guardian, as appropriate, does not know which approved CMA the Client~~  
21 ~~wishes to select, the Department's contractor shall assist the Client in the~~  
22 ~~selection of a CMA which may include, but is not limited to:~~

23 ~~1. Providing a list of qualified CMAs.~~

24 ~~2. Providing the Department's webpage address and information on~~  
25 ~~how to search for a CMA.~~

26 ~~3. Providing information regarding the qualified CMAs based on the~~  
27 ~~Client's preferences.~~

28 ~~4. Other assistance as requested or needed by the Client~~

29 ~~iii. The Department's contractor shall notify the selected CMA within two (2)~~  
30 ~~business days from the date of selection by the Client. The Department's~~  
31 ~~contractor shall also send a letter to the Client with the following~~  
32 ~~information:~~

33 ~~1. The selected CMA;~~

34 ~~2. Contact information for the CMA;~~

35 ~~3. Information about the right to choose a CMA; and~~



1 ~~4. Contact information for the Department's contractor.~~

2 ~~iv. The selected CMA shall contact the Client within two (2) business days~~  
 3 ~~from notification of selection to confirm the choice and review service~~  
 4 ~~plan and any changes necessitated by the transfer.~~

5 ~~v. The transferring CMA shall continue to provide case management~~  
 6 ~~services until the new CMA has been assigned in the Department's~~  
 7 ~~prescribed system and contacted the Client in accordance with~~  
 8 ~~8.519.6.B(3).~~

9 8.550.6.B. Special Requirements

10 1. Eligibility for, and access to, Hospice Services does not fall within the purview of the long-term care  
 11 Single Entry Point system for prior authorization.

12 2. Nursing facility placement for a Client who has Medicaid and has Elected Hospice Services in a  
 13 nursing facility does not require a ~~ULTC-100.2 assessment~~. LOC Screen. The nursing facility must  
 14 complete a Pre Admission Screening and Resident Review (PASRR).

15 **8.600 Services for Individuals with Intellectual and Developmental Disabilities**

16 **8.600.4 Definitions**

17 As used in these rules, unless the context requires otherwise:

18 "Abuse" is as defined at Sections 16-22-102 (9), 19-1-103, 25.5-10-202 (1) (a)-(c), and 26.3.1-101 C.R.S..

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

23 "Assistive Technology Devices" means any item, piece of equipment, or product system that is used to  
 24 increase, maintain, or improve functional capabilities of individuals with disabilities.

25 "Assistive Technology Services" includes, but is not limited to, the evaluation of a person's need for  
 26 assistive technology; helping to select and obtain appropriate devices; designing, fitting and customizing  
 27 those devices; purchasing, repairing or replacing the devices; and, training the individual, or if appropriate  
 28 a family member, to use the devices effectively.

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

33 "Authorized Services" means those services and supports authorized pursuant to Section 25.5-10-206,  
 34 C.R.S., which the Department shall provide directly or purchase subject to available appropriations for  
 35 persons who have been determined to be eligible for such services and supports and as specified in the  
 36 eligible person's individualized plan.

37 "Caretaker" is as defined at Section 25.5-10-202(1.6)(a)-(c), C.R.S.

38 "Caretaker Neglect" is as defined at Section 25.5-10-202(1.8)(a)-(c), C.R.S.

1 “Case Management Agency” (CMA) means a public or private not-for-profit or for-profit agency that meets  
2 all applicable state and federal requirements and is certified by the Department to provide case  
3 management services for Home and Community Based Services waivers pursuant to Section 25.5-10-  
4 209.5, C.R.S. and pursuant to a provider participation agreement with the state department.

5 “Challenging Behavior” means behavior that puts the person at risk of exclusion from typical community  
6 settings, community services and supports, or presents a risk to the health and safety of the person or  
7 others or a significant risk to property.

8 “Client” means an individual who has met Long-Term Services and Supports (LTSS) eligibility  
9 requirements and has been offered and agreed to receive Home and Community Based Services (HCBS)  
10 in the Children’s Extensive Supports (HCBS-CES) waiver, the HCBS waiver for Children’s Habilitation  
11 Residential Program (CHRP), the HCBS waiver for Persons with Developmental Disabilities (HCBS-DD),  
12 Family Support Services Program (FSSP), or the Supported Living Services (HCBS-SLS) waiver.

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

18 “Comprehensive Review of the Person’s Life Situation” means a thorough review of all aspects of the  
19 person’s current life situation by the program approved service agency in conjunction with other members  
20 of the interdisciplinary team.

21 “Comprehensive Services” means habilitation services and supports that provide a full day (24 hours) of  
22 services and supports to ensure the health, safety and welfare of the individual, and to provide training  
23 and habilitation services or a combination of training and supports in the areas of personal, physical,  
24 mental and social development and to promote interdependence, self-sufficiency and community  
25 inclusion. Services include residential habilitation services and supports, day habilitation services and  
26 supports and transportation.

27 “Consent” means an informed assent, which is expressed in writing and is freely given. Consent shall  
28 always be preceded by the following:

- 29 A. A fair explanation of the procedures to be followed, including an identification of those  
30 which are experimental;
- 31 B. A description of the attendant discomforts and risks;
- 32 C. A description of the benefits to be expected;
- 33 D. A disclosure of appropriate alternative procedures together with an explanation of the  
34 respective benefits, discomforts and risks;
- 35 E. An offer to answer any inquiries regarding the procedure;
- 36 F. An instruction that the person giving consent is free to withdraw such consent and  
37 discontinue participation in the project or activity at any time; and,
- 38 G. A statement that withholding or withdrawal of consent shall not prejudice future provision  
39 of appropriate services and supports to individuals.

40 “Developmental Delay” means that a child meets one or more of the following:

- 1 A. A child who is less than five (5) years of age at risk of having a developmental disability  
2 because of the presence of one or more of the following:
- 3 1. Chromosomal conditions associated with delays in development,
  - 4 2. Congenital syndromes and conditions associated with delays in development,
  - 5 3. Sensory impairments associated with delays in development,
  - 6 4. Metabolic disorders associated with delays in development,
  - 7 5. Prenatal and perinatal infections and significant medical problems associated  
8 with delays in development,
  - 9 6. Low birth weight infants weighing less than 1200 grams, or
  - 10 7. Postnatal acquired problems resulting in delays in development.
- 11 B. A child less than five (5) years of age who is significantly delayed in development in one  
12 or more of the following areas:
- 13 1. Communication,
  - 14 2. Adaptive behavior,
  - 15 3. Social-emotional,
  - 16 4. Motor,
  - 17 5. Sensory, or
  - 18 6. Cognition.
- 19 C. A child less than three (3) years of age who lives with one or both parents who have a  
20 developmental disability.
- 21 “Critical Incident” means an actual or alleged event that creates the risk of serious harm to the health or  
22 welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or  
23 physical well-being of an individual. Critical Incidents include, but are not limited to: Injury/illness;  
24 abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person;  
25 criminal activity; unsafe housing/displacement; or death
- 26 “Developmental Disabilities Professional” means a person who has at least a Bachelor’s Degree and a  
27 minimum of two (2) years’ experience in the field of developmental disabilities or a person with at least  
28 five (5) years of experience in the field of developmental disabilities with competency in the following  
29 areas:
- 30 A. Understanding of civil, legal and human rights;
  - 31 B. Understanding of the theory and practice of positive and non-aversive behavioral  
32 intervention strategies;
  - 33 C. Understanding of the theory and practice of non-violent crisis and behavioral intervention  
34 strategies.

1 “Developmental Disability” means a disability that:

2 A. Is manifested before the person reaches twenty-two (22) years of age;

3 B. Constitutes a substantial disability to the affected individual, as demonstrated by the  
4 criteria below at C, 1 and/or C, 2; and,

5

6 C. Is attributable to an intellectual and developmental disability or related conditions which  
7 include Prader-Willi syndrome, cerebral palsy, epilepsy, autism or other neurological  
8 conditions when such conditions result in impairment of general intellectual functioning or  
9 adaptive behavior similar to that of a person with an intellectual and developmental  
10 disability. Unless otherwise specifically stated, the federal definition of “developmental  
11 disability” found 42 U.S.C. § 15002, et seq., shall not apply.

12 1. “Impairment of general intellectual functioning” means that the person has been  
13 determined to have a full scale intellectual quotient equivalent which is two or  
14 more standard deviations below the mean (70 or less assuming a scale with a  
15 mean of 100 and a standard deviation of 15).

16 a. A secondary score comparable to the General Abilities Index for a  
17 Wechsler Intelligence Scale that is two or more standard deviations  
18 below the mean may be used only if a full scale score cannot be  
19 appropriately derived.

20 b. Score shall be determined using a norm-referenced, standardized test of  
21 general intellectual functioning comparable to a comprehensively  
22 administered Wechsler Intelligence Scale or Stanford-Binet Intelligence  
23 Scales, as revised or current to the date of administration. The test shall  
24 be administered by a licensed psychologist or a school psychologist.

25 c. When determining the intellectual quotient equivalent score, a maximum  
26 confidence level of ninety percent (90%) shall be applied to the full scale  
27 score to determine if the interval includes a score of 70 or less and shall  
28 be interpreted to the benefit of the ~~applicant~~Applicant being determined  
29 to have a developmental disability.

30 2. “Adaptive behavior similar to that of a person with intellectual disability “ means  
31 that the person has an overall adaptive behavior composite or equivalent score  
32 that is two or more standard deviations below the mean.

33 a. Measurements shall be determined using a norm-referenced,  
34 standardized assessment of adaptive behaviors that is appropriate to the  
35 person's living environment and comparable to a comprehensively  
36 administered Vineland Scale of Adaptive Behavior, as revised or current  
37 to the date of administration. The assessment shall be administered and  
38 determined by a professional qualified to administer the assessment  
39 used.

40 b. When determining the overall adaptive behavior score, a maximum  
41 confidence level of ninety percent (90%) shall be applied to the overall  
42 adaptive behavior score to determine if the interval includes a score of

1 70 or less and shall be interpreted to the benefit of the ~~applicant~~Applicant  
2 being determined to have a developmental disability.

- 3 D. A person shall not be determined to have a developmental disability if it can be  
4 demonstrated such conditions are attributable to only a physical or sensory impairment or  
5 a mental illness.

6 “Emergency”, as used in Section 8.608.3 regarding restraint, means a serious, probable, imminent threat  
7 of bodily harm to self or others where there is the present ability to affect such bodily harm.

8 “Emergency Control Procedure” means an unanticipated use of a restrictive procedure or restraint in  
9 order to keep the person receiving services and others safe.

10 “Executive Director” means the Executive Director of the Colorado Department of Health Care Policy and  
11 Financing unless otherwise indicated.

12 “Exploitation” is as defined in Section 25.5-10-202(15.5)(a)-(d) and 26-3.1-101 C.R.S.

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

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

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

21 “Family”, as used in rules pertaining to support services and the Family Support Services Program means  
22 a group of interdependent persons residing in the same household that consists of a family member with  
23 a developmental disability or a child under the age of five (5) years with a developmental delay, and one  
24 or more of the following:

25 A. A mother, father, brother(s), sister(s) or any combination; or,

26 B. Extended blood relatives such as grandparent(s), aunt(s) or uncle(s); or,

27 C. An adoptive parent(s); or,

28 D. One or more persons to whom legal custody of a person with a developmental disability  
29 has been given by a court; or,

30 E. A spouse and/or his/her children.

31 “Family Support Council” means the local group of persons within the Community Centered Board’s  
32 designated service area who have the responsibility for providing guidance and direction to the  
33 Community Centered Board for the implementation of the Family Support Services Program.

34 “Family Support Plan (FSP)” means a plan which is written for the delivery of family support services as  
35 specified in Section 8.613.

36 “Functional Analysis” means a comprehensive analysis of the medical, social, environmental, and  
37 personal factors that may influence current behavior. This analysis shall also investigate the person’s

1 ability to communicate, analyze whether the current behavior is a means to communicate, and identify  
2 historical factors which may contribute to the understanding of the current behavior.

3 “Guardian” means a person who has qualified as a guardian of a minor or incapacitated person by  
4 testamentary or court appointment but excludes a Guardian Ad Litem.

5 “Harmful Act” is as defined at Section 25.5-10-202 (18.5) and 26.3.1-101 C.R.S.

6 “Home and Community-Based Services Waivers (HCBS)” means HCBS waiver programs, including the  
7 Home and Community Based Waiver for the Developmentally Disabled (HCBS-DD), Supported Living  
8 Services (SLS) and Children's Extensive Support (CES). “Host Home Provider” is an individual(s) who  
9 provides residential supports in his/her home to persons receiving comprehensive services who are not  
10 family members as defined in Section 25.5-10-202(16), C.R.S. A host home provider is not a  
11 developmental disabilities service agency pursuant to Section 8.602 of these rules.

12 “Human Rights Committee” means a third-party mechanism to adequately safeguard the legal rights of  
13 persons receiving services by participating in the granting of informed consent, monitoring the suspension  
14 of rights of persons receiving services, monitoring behavioral development programs in which persons  
15 with intellectual and developmental disabilities are involved, monitoring the use of psychotropic  
16 medication by persons with intellectual and developmental disabilities, and reviewing investigations of  
17 allegations of mistreatment of persons with intellectual and developmental disabilities who are receiving  
18 services or supports.

19 “Individual Service and Support Plan (ISSP)” means a plan of intervention or instruction which directly  
20 addresses the needs identified in the person's Individualized Plan and which provides specific direction  
21 and methodology to employees and contractors providing direct service to a person.

22 ~~“Individualized Plan (IP)” means a written plan designed by an interdisciplinary team for the purpose of~~  
23 ~~identifying:~~

24 ~~A. The needs of the person receiving services or family;~~

25 ~~B. The specific services and supports appropriate to meet those needs;~~

26 ~~C. The projected date for initiation of service and supports; and,~~

27 ~~D. The anticipated results to be achieved by receiving the services and supports.~~

28 “Interdisciplinary Team (IDT)” means a group of people convened by a Community Centered Board which  
29 shall include the person receiving services, the parent or guardian of a minor, a guardian or an authorized  
30 representative, as appropriate, the person who coordinates the provision of services and supports, and  
31 others as determined by such person's needs and preferences, who are assembled in a cooperative  
32 manner to develop or review the individualized plan.

33 “Mechanical Restraint” means the use of devices intended to restrict the movement or normal functioning  
34 of a portion of an individual's body. Mechanical restraint does not include the use of protective devices  
35 used for the purpose of providing physical support or prevention of accidental injury.

36 “Minimum Effective Dose” means the smallest medication dosage necessary to produce the intended  
37 effect.

38 “Mistreated” or “Mistreatment” is as defined at Sections 25.5-10-202(29.5)(a)-(d) and 26-3.1-101 C.R.S.:

1 “Notice” means written notification hand delivered to or sent by first class mail that contains at least all of  
2 the following:

3 A. The proposed action;

4 B. The reason or reasons for that action;

5 C. The effective date of that action;

6 D. The specific law, regulation, or policy supporting the action;

7 E. The responsible agency with whom a protest of the action may be filed including the  
8 name and address of the director.

9 F. The dispute resolution procedure, including deadlines, in conformity with Section 8.605  
10 and procedures on accessing agency records:

11 1. For disputes involving individuals as defined in Section 8.605.2, information on  
12 availability of advocacy assistance, including referral to publicly funded legal  
13 services, corporation, and other publicly or privately funded advocacy  
14 organizations, including the protection and advocacy system required under 42  
15 U.S.C. 15001, the Developmental Disabilities Assistance and Bill of Rights Act;  
16 and,

17 2. For disputes involving individuals as defined in Section 8.605.2 an explanation of  
18 how the agency will provide services to a currently enrolled person during the  
19 dispute resolution period, including a statement that services will not be  
20 terminated during the appeal. Such explanation will include a description of  
21 services currently received.

22 “Parent” means the biological or adoptive parent.

23 “Person-Centered Support Plan” means as defined in Section 8.390.1 DEFINITIONS.

24 “Physical Restraint” -means the use of manual methods to restrict the movement or normal functioning of  
25 a portion of an individual's body through direct physical contact by others except for the purpose of  
26 providing assistance/prompts. Assistance/prompts is the use of manual methods to guide or assist with  
27 the initiation or completion of and/or support the voluntary movement or functioning of an individual's body  
28 through the use of physical contact by others except for the purpose of providing physical restraint.

29 “PRN” (Pro Re Nata) means giving drugs on an “as needed” basis through a standing prescription or  
30 standing order.

31 “Program Approved Service Agency” means a developmental disabilities service agency or typical  
32 community service agency as defined in Section 8.602, which has received program approval by the  
33 Department pursuant to Section 8.603 of these rules.

34 “Program Services” means an organized program of therapeutic, habilitative, specialized support or  
35 remedial services provided on a scheduled basis to individuals with developmental disabilities.

36 “Prospective New Service Agency” means an individual or any publicly or privately operated program,  
37 organization or business that has completed and submitted an application with a Community Centered  
38 Board for selection and approval as a service agency to provide comprehensive services.



- 1 "Public Safety Risk-Convicted" means a factor in addition to specific SIS scores that is considered in the  
2 calculation of a Client's support level. This factor shall be identified when a Client has:
- 3 A. Been found guilty through the criminal justice system for a criminal action involving harm  
4 to another person or arson and who continues to pose a current risk of repeating a similar  
5 serious action; and,
  - 6 B. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or  
7 a court order that imposes line of sight supervision unless the Client is in a controlled  
8 environment that limits his or her ability to engage in the behaviors that pose a risk or to  
9 leave the controlled environment unsupervised.
- 10 "Public Safety Risk-Not Convicted" means a factor in addition to specific SIS scores that is considered in  
11 the calculation of a Client's support level. This factor shall be identified when a Client has:
- 12 A. Not been found guilty through the criminal justice system, but who does pose a current  
13 and serious risk of committing actions involving harm to another person or arson; and,
  - 14 B. A rights suspension in accordance with Section 8.604.3 or through parole or probation, or  
15 a court order that imposes line of sight supervision unless the Client is in a controlled  
16 environment that limits his or her ability to engage in the behaviors that pose a risk or to  
17 leave the controlled environment unsupervised.
- 18 "Rate" means the amount of money, determined by a standardized rate setting methodology, reimbursed  
19 for each unit of a defined waiver service provided to a Client by a qualified provider.
- 20 "Referral" means any notice or information (written, verbal, or otherwise) presented to a Community  
21 Centered Board which indicates that a person may be appropriate for services or supports provided  
22 through the developmental disabilities system and for which the Community Centered Board determines  
23 that some type of follow-up activity for eligibility is warranted.
- 24 "Request for Provider (RFP)" means a formal process for case managers to notify Program Approved  
25 Provider Agencies when a Client is seeking authorized services including, but not limited to, a non-  
26 identifying description of the client's support and supervision needs.
- 27 "Regional Center" means a facility or program operated directly by the Department of Human Services,  
28 which provides services and supports to persons with developmental disabilities.
- 29 "Respondent" means a person participating in the SIS assessment who has known the Client for at least  
30 three months and has knowledge of the Client's skills and abilities. The respondent must have recently  
31 observed the Client directly in one or more places such as home, work, or in the community.
- 32 "Restrictive Procedure" means any of the following when the intent or plan is to bring an individual's  
33 behavior into compliance:
- 34 A. Limitations of an individual's movement or activity against his or her wishes; or,
  - 35 B. Interference with an individual's ability to acquire and/or retain rewarding items or engage  
36 in valued experiences.
- 37 "Request for Developmental Disability Determination" means written formal documentation, either  
38 handwritten or a signed standardized form, which is submitted to a Community Centered Board  
39 requesting that a determination of developmental disability be completed.

1 “Safety Control Procedure” means a restrictive procedure or restraint that is used to control a previously  
2 exhibited behavior which is anticipated to occur again and for which the planned method of intervention is  
3 developed in order to keep the person and others safe.

4 “Screening for Early Intervention Services” means a preliminary review of how a child is developing and  
5 learning in comparison to other similarly situated children. “Seclusion” means the placement of a Client  
6 alone in a closed room for the purpose of punishment. Seclusion for any purpose is prohibited.

7 “Service Agency” means an individual or any publicly or privately operated program, organization or  
8 business providing services or supports for persons with developmental disabilities.

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

13 “Statewide Database” means the state web-based system that contains consumer-related demographic  
14 and program data.

15 “Support Coordinating Agency” means a Community Centered Board which has been designated as the  
16 agency responsible for the coordination of support services (supported living services for adults and the  
17 children’s extensive support program) within its service area.

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

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

23 “Undue Influence” means use of influence to take advantage of a person with an intellectual or  
24 developmental disability’s vulnerable state of mind, neediness, pain, or emotional distress.

25 “Waiver Services” means those optional Medicaid services defined in the current federally approved  
26 HCBS waiver document and do not include Medicaid State Plan services.

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## 1 8.615 TELEHEALTH DELIVERY OF HOME AND COMMUNITY-BASED SERVICES

### 2 8.615.1 DEFINITIONS

3 A. ~~Assessment means a comprehensive evaluation with the individual seeking services and~~  
4 ~~appropriate collaterals (such as family members, advocates, friends, and/or caregivers), chosen~~  
5 ~~by the individual, conducted by the case manager, with supporting diagnostic information from the~~  
6 ~~individual's medical provider to determine the individual's level of functioning, service needs,~~  
7 ~~available resources, and potential funding resources. Assessment shall be as defined at Section~~  
8 ~~8.390.1.DEFINITIONS.~~

9 B. Case Management means ~~the assessment of an individual seeking or receiving long term~~  
10 ~~services and supports' needs, the development and implementation of a Support Plan for such~~  
11 ~~individual, referral and related activities, the coordination and monitoring of long term service~~  
12 ~~delivery, the evaluation of service effectiveness and the periodic reassessment of such~~  
13 ~~individual's needs.as defined in Section 8.390.1 DEFINITIONS.~~

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

19 D. Community Centered Board (CCB) means a private corporation, for profit or not for profit, which  
20 when designated pursuant to Section 25.5-10-209, C.R.S., provides case management services  
21 to Members with developmental disabilities, is authorized to determine eligibility of such Members  
22 within a specified geographical area, serves as the single point of entry for Members to receive  
23 services and supports under Section 25.5-10-201, C.R.S. et seq , and provides authorized  
24 services and supports to such Members either directly or by purchasing such services and  
25 supports from service agencies.

26 E. Department means the Department of Health Care Policy and Financing.

27 F. Home and Community-Based Services (HCBS) means services and supports authorized through  
28 a 1915(c) waiver of the Social Security Act and provided in community settings to a Member who  
29 requires a level of institutional care that would otherwise be provided in an institutional setting.

30 G. Home and Community-Based Services Telehealth (HCBS Telehealth) is a method of service  
31 delivery of those HCBS services listed at Section 8.615.2.

32 H. Medicaid State Plan means the federally approved document that specifies the eligibility groups  
33 that a state serves through its Medicaid program, the benefits that the state covers, and how the  
34 state addresses additional federal Medicaid statutory requirements concerning the operation of its  
35 Medicaid program.

36 I. Member means ~~an individual who meets long term services and support eligibility requirements~~  
37 ~~and has been approved for and agreed to receive Home and Community-Based Services~~  
38 ~~(HCBS).as defined in Section 8.390.1.~~

39 J. Prior Authorization Request (PAR) means the Department prescribed form to authorize the  
40 reimbursement for services.

41 K. Person-Centered Support Plan means as defined in Section 8.390.1 DEFINITIONS. ~~the~~  
42 ~~document used for Support Planning.~~

1

2 L. ~~Person-Centered Support Planning means as defined in Section 8.390.1 DEFINITIONS, the~~  
3 ~~process of working with the individual receiving services and people chosen by the individual to~~  
4 ~~identify goals, needed services, individual choices and preferences, and appropriate service~~  
5 ~~providers based on the individual seeking or receiving services' assessment and knowledge of~~  
6 ~~the individual and of community resources. Support planning informs the individual seeking~~  
7 ~~services of his or her rights and responsibilities.~~

8 M. Telehealth means the broad use of technologies to provide services and supports through HCBS  
9 waivers, when the Member is in a different location from the provider.

10 N. Waiver Service means optional services defined in the current federally approved waiver  
11 documents and do not include Medicaid State Plan benefits.

12

DRAFT