Title of Rule: Revision to the Medical Assistance Act Rule concerning At-Risk Diversion for Case Management Agencies, Section 8.7200
Rule Number: MSB 24-06-03-A
Division / Contact / Phone: Office of Community Living / Victoria Lewis

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 rule revision is necessary to ensure compliance and consistency while ensuring that Medicaid Members that have been identified as At-Risk for institutionalization are connected to support, resources, and services. This is essential to ensure that these individuals have the services they may need to remain safely in the community setting of their choice. This revision will also align with rule revision 8.519.27-8.763 Transition Coordination, which will allow Medicaid members that have been identified as At-Risk for institutionalization by the Department to be eligible for transition coordination. Transition coordination can assist these individuals with housing needs to get housing support, housing navigation services to obtain a housing voucher and assistance to locate housing, and/or any additional support through major life events. This revision is intended to target Medicaid members enrolled in HCBS that will likely need nursing facility care in the near future.

   The rule is being revised through 8.7200 Case Management Agency Overall Requirements; At-Risk Diversion will align with 8.7202.K Monitoring responsibilities. Under 8.7202.K, the Case Management Agency is responsible to monitor the overall provision of services and supports authorized by Case Managers to ensure the rights, health, safety and welfare of Members, quality services, and that service provision practices promote Member's ability to engage in self-determination, self-representation, and self-advocacy. Monitoring is required for all waivers in accordance with federal waiver requirements and C.R.S. §§ 25.5-6-1701 — 25.5-6-1709; §§ 25.5-6-1702(3).

   Currently, there is minimal documentation and evidence within the Department's preferred system to validate that members receiving HCBS are being assessed adequately for Community-Based support and services.

   Case Management Agencies will use the Department's preferred system (Care and Case Management) for documentation of all Case Management activity and At-Risk outreaches as it relates to At-Risk individuals. The Case Management Agency will be responsible for completion, and documentation, and appropriate referrals to Transition Services, Regional Accountable Agencies and/or other applicable agencies (as needed).

   Case Management Agencies will receive funding for the completion of the initial At-Risk outreach. The initial At-Risk outreach shall be completed within 10 business days after the Case Manager has received notification that the individual has been identified as At-Risk. Case

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Managers will complete ongoing At-Risk outreach every 90 days and assess additional support and services if the member continues to be identified as At-Risk. Ongoing At-Risk outreach will align with 8.7202.K.2.C where the Case Manager shall, at a minimum, perform quarterly monitoring contacts with the member, as defined by the Members certification period start and end dates.

Case Management Agencies will receive funding for the completion of the initial At-Risk outreach through CMA contracts. System generated reports will be required to issue payments. At-Risk Diversion will be added to the Case Management Agencies contracts on July 1, 2024. However, the Case Management Agencies will not receive the initial notification of At-Risk members until Fall 2024. The Department is actively working on developing a process and testing a variety of models to best identify individuals At-Risk of institutionalization.

2. An emergency rule-making is imperatively necessary

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

Explain:

3. Federal authority for the Rule, if any:

42 C.F.R § 440-169

4. State Authority for the Rule:

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

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REGULATORY ANALYSIS

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

   All members that receive Home and Community Based Services (HCBS) will be affected by these rules and all Case Management Agencies. The Department believes these regulations will positively impact Medicaid members. Any member that has been identified as At-Risk and that has unstable housing can be referred to Transition Coordination Services for the purpose of determining appropriate housing services. Members will be assessed and referred to appropriate and necessary Community-Based Services to meet the members' service needs as well as their basic health and safety needs in the community. The member will receive information necessary to make an educated choice of service setting if the member is seeking nursing facility care services..

   Case Management Agencies will have clearer expectations and a process to better support At-Risk members to live safely in the community. Through this implementation and the required documentation, the Case Managers will be able to thoroughly document their work and efforts in a clean and concise way. This will also align with best practices under the Case Management Agencies scope of work.

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

   HCBS members, unpaid support, and/or guardians should experience a positive qualitive impact from these regulations. Members will be assessed for Community-Based Services, including Housing services, and other services to remain in the community. Members will be educated and better informed of their options outside of a skilled nursing facility.

   Possible quantitative impacts could be a commencement or increase in services in the community.

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

The Department will provide funding to the Case Management Agencies through contracts and this funding will increase reimbursement to Case Management Agencies. The Department was approved $1,264,443 in funding for these initiatives through the Department's FY 2023-24 BA-7 Community Based Access to Services and the FY 2024-25 BA-8 Adjustments to Community Based Access to Services budget requests. There is a potential for an increase in home and community-based services and a potential for avoidance or delay in Nursing Facility admissions. Typically, home and community-based services are less costly than nursing facility costs.

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

   If the Department does not implement these regulations, it will not have the ability to provide additional support to members that are wanting to remain in the community setting of their choice. To the extent feasible and based on the members' needs and preferences and the availability of Community-Based Services, the Case Management Agency will assess current services and will make referrals to other agencies (as needed). The Case Management Agency will ensure that the members' basic health and safety needs can be met in the Community.

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

   There are no less costly methods to achieve the purpose of these rules. Regulatory requirements must be in place for Case Management Agencies to ensure that members are supported while they are in the community and receive complete information on support and services available outside of a skilled nursing facility. Although this can be partly accomplished through contracts for Case Management Agencies, At-Risk Diversion advances the Departments initiatives for increasing access to Community-Based Services to advance Home and Community Based Services. This initiative will keep individuals in the community and in a less restrictive environment throughout the State. The goal is to make improvements to our long-term care system that would benefit our members the most.

   The rule revision, as a matter of both state policy intention and federal compliance, must uphold policies of least restrictive environment and those requirements of the CMS Final Rule, including maximizing individual choice, autonomy, rights, community integration, among other principles. These policies and the services, person-centered commitment, will be balanced with members determined health and safety needs.

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

   No other methods for achieving the purpose outlined in these regulations were considered, as there are no other options that can accomplish these goals. Regulations must be in place that outline Case Management Agencies responsibilities and requirements.

8.7200 Case Management Agency Requirements

8.7200.B Definitions

1. Assessment means a comprehensive evaluation with the individual seeking services and appropriate supports (such as Family Members, advocates, friends and/or caregivers), chosen by the individual, conducted by the Case Manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources.

2. Case Management Agency is defined in Section 8.7100.A.8

3. Case Management Agency Defined Service Area means one or more counties that have been designated as a geographic region in which one Agency serves as the Case Management Agency for persons in need of Home and Community-Based Waiver Services or Long-Term Services and Supports.

4. Case Management Activities means the Assessment of an individual seeking or receiving Long-Term Services and Supports' needs, the development and implementation of a Person-Centered Support Plan for such individual, Referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic Reassessment of such individual's needs and collaboration with other entities impacting the Members' HCBS, health and welfare.

a. Case Management Activities means all activities performed by a Case Management Agency reimbursed through contracts and Targeted Case Management.

i. Administrative Case Management includes activities that are reimbursed through contracts with the Department of Health Care Policy and Financing.

ii. Targeted Case Management refers to coordination and planning services provided with, or on behalf of, an individual Member. Targeted Case Management is a state plan benefit and is reimbursed through direct billing, not contract payments.

5. Case Manager means an employee of a Case Management Agency, as defined at Section 8.7100.A.8, who performs the required Case Management Activities.

6. Colorado General Assembly means the legislature of the State of Colorado, comprising both the state senate and the state house of representatives.

7. Community Centered Board (CCB) means a private for-profit or not-for-profit organization that is an administrator of locally generated funding pursuant to C.R.S. § 25.5-10-206(6) and acts as a resource for persons with an Intellectual and Developmental Disability or a child with a Developmental Delay.

8. Complaint means any statement received by an individual or Member as it relates to unsatisfactory services provided through the Case Management Agency to include, but not limited to: general business functions, administration, State General Fund program functions, and

Case Management functions. Complaints regarding activities outside the scope of work for the Case Management Agency are excluded from this definition.

9. Conflict Free Case Management means Members enrolled in any Long-Term Services and Supports programs and/or Home and Community-Based Services waivers must receive direct Home and Community-Based Services and Case Management from separate entities.

10. Conflict-Free Case Management Waiver means the Case Management Agency may provide direct services to Members for whom it provides Case Management services.

11. Corrective Action Plan means a written plan by the Case Management Agency, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

12. Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a member; including events that may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include but are not limited to; injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

13. Defined Service Area means the geographical area the Department determines shall be served by a Case Management Agency.

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

15. Home and Community-Based Services (HCBS) Waivers is as defined in Waiver Eligibility Requirements Section 8.7100 et seq.

16. Intellectual and Developmental Disability has the same meaning set forth in Section 25.5-6-403 (3.3) (a), C.R.S and Section 8.7100.A.40.

17. Information Management System (IMS) means an automated data management system approved by the Department to enter Case Management information for each individual seeking or receiving long-term services as well as to compile and generate standardized or custom summary reports.

18. Intake, Screening and Referral means the initial contact with individuals by the Case Management Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for Long-Term Services and Supports; an individual's need for Referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive Functional Needs Assessment of the individual seeking services.

19. Long-Term Services and Supports (LTSS) means the services and support used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities. Long-term Services and Supports includes but is not limited to long -term care such as nursing facility care as part of the standard Medicaid benefit package and Home and Community-Based Services provided under waivers granted by the Federal government.

20. Long -Term Services and Supports Level of Care Eligibility Determination Screen (Level of Care Screen) means a comprehensive evaluation with the individual seeking services and appropriate support persons (such as Family Members, friends, and or caregivers) to determine an Applicant

or Member's eligibility for Long-Term Services and Supports based on their need for institutional Level of Care as determined using the Department's prescribed Assessment instrument as outlined in Section 8.7202.E.

21. Long -Term Services and Supports (LTSS) Program means any of the following: publicly funded programs, Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).

a. Children's Home and Community-Based Services (HCBS-CHCBS)

b. Developmental Disabilities (HCBS-DD)

c. Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD)

d. Home and Community-Based Services Complementary and Integrative Health (HCBS-CIH)

e. Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI)

f. Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS)

g. Home and Community-Based Services for Children with Life Limiting Illness (HCBS-CLLI), and

h. Home and Community-Based Services Supported Living Services (HCBS-SLS)

i. Children's Extensive Support Waiver (HCBS-CES)

j. Children's Habilitative Residential Program (HCBS-CHRP)

22. Member means any person enrolled in the state medical assistance program, the children's basic health plan, HCBS waiver program, or State General Funded program.

23. Member Identified Team means the people, agencies or representatives a member selects to participate to support in their long-term care programs, processes, and procedures, including but not limited to, their service planning or other waiver program processes and procedures. Members may choose specific people or agencies and may select which portions of their program they want the team to be involved with. Members may revoke or change this team at any time. "Member Identified Team" applies to all waivers and replaces Interdisciplinary Team in former rules applicable to people with Intellectual and Developmental Disabilities.

24. Pre-Admission Screening and Resident Review (PASRR) is as defined in Section 8.401.18.

25. Person-Centered Case Management means Case Management services that offer people dignity, compassion and respect while facilitating Assessments and planning that support people to recognize and develop their own strengths and abilities to enable them to live an independent and fulfilling life.

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

27. Reassessment means a periodic reevaluation with the Member, their chosen supports, and Case Manager, to re-determine the individual's level of functioning, service needs, available resources and potential funding resources.

28. State General Fund (SGF) Programs means programs funded solely through the Colorado State General Fund. Those include but are not limited to: State Supported Living Services (State-SLS) at Section 8.7202.V.3, Specialized Nursing Care Services as set forth at 42 C.F.R. Chapter IV, Subchapter G, Part 483 (OBRA-SS), and Family Support Services Program (FSSP) at Section 8.7558.

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

30. Transition Coordination Agency (TCA) 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 coordination services for those transitioning from facility-based care to community-based care pursuant to a Provider Participation Agreement with the state department.

31. Waiver Benefit means covered benefits offered in addition to or as an alternative to state plan benefits as authorized by 42 U.S.C. 1396n(c) and include the Waiver Benefits described in Section 8.7101 for the following programs: Children's Home and Community-Based Services Waiver (CHCBS); Children's Extensive Support Waiver (HCBS-CES); Children's Habilitation Residential Program Waiver (HCBS-CHRP); Children With Life Limiting Illness Waiver (HCBS-CLLI); Persons With Brain Injury Waiver (HCBS-BI);Community Mental Health Supports Waiver (HCBS-CMHS); Elderly, Blind and Disabled Waiver (HCBS-EBD); Complementary and Integrative Health Waiver (HCBS-CIH; Supported Living Services Waiver (HCBS -SLS);and Developmental Disabilities Waiver (HCBS-DD).

32. At-Risk means a Medicaid member who lives outside of an institutional facility, has Long-Term Supports and Services, and is at risk for institutionalization as determined by the State.

33. At-Risk Diversion means a person-centered process through which services are arranged or provided to enable an at-risk member to avoid admission to an institution or an institution-like setting to live instead in a community-based setting.

8.7202 Functions of A Case Management Agency

8.7202.A Case Management Services Overview

1. Functions of the Case Manager

a. Ongoing Case Management and Targeted Case Management

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

8.7202.B Intake, Screening, and Referral

1. The Intake, Screening and Referral function of a Case Management Agency shall include, but not be limited to, the following activities:

a. The Case Management Agency shall verify the individual's demographic information collected during the intake;

b. The completion of the Intake, Screening and Referral functions using the Department's Information Management System to determine Applicant needs and eligibility for Long-Term Services and Supports and non- Long-Term Services and Supports services, information and Referral assistance to Long-Term Services and Supports and other services and supports, as needed;

c. Level of Care eligibility determination as applicable;

d. Referral to and facilitation of the Medicaid Financial Eligibility application process.

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

3. The Case Management Agency shall coordinate the completion of the Financial Eligibility determination by:

a. Verifying the individual's current Financial Eligibility status; or

b. Referring the individual to the county department of social services of the individual's county of residence for application and support with completing an application in accordance with Section 8.100.3.A.7; or

c. Providing the individual with Financial Eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides; and

d. Conducting and documenting follow-up activities to complete the Functional Eligibility determination and coordinate the completion of the Financial Eligibility determination.

4. In compliance with standards established by the Department, Case Management Agencies may ask referring agencies to complete and submit an intake and screening form to initiate the process.

a. Case Management Agencies shall not delay the completion of an intake screen based on the use of this form

b. Case Management Agencies shall accept Referrals for Long-Term Services and Supports including but not limited to the following modalities

i. Intake Screen form

ii. Phone calls

iii. County DHS Referrals and communication

iv. In person requests for Long-Term Services and Supports

v. Medical Assistance sites

5. The Case Manager shall perform a screening to determine whether a Functional Eligibility Assessment is needed; The individual shall be informed of the right to receive an Assessment if the individual disagrees with the Case Manager's decision.

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

7. The Case Manager shall implement the use of a Case Management Agency procedure for prioritizing urgent inquiries.

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

a. The status of friendships, the degree to which the person has access to the community, and the person's satisfaction with his or her current job or housing situation;

b. The status of the Family ties and involvement, the person's satisfaction with roommates or staff and other providers, and the person's level of freedom and opportunity to make and carry out decisions;

c. A review of the person's sense of belonging to any groups, organizations or programs for which they may have an interest, a review of the person's sense of personal security, and a review of the person's feeling of self-respect;

d. A review of other issues in the person's current life situation such as staff turnover, long travel times, relationship difficulties and immediate life Crises, which may be negatively affecting the person;

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

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

9. The Case Manager shall make Referrals to the Regional Centers and shall comply with the Regional Centers admission policy.

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

11. Issues identified in this comprehensive review that cannot be addressed by the Member Identified Team as led by the individual or their Guardian or other Legally Authorized Representative should be documented in the Person-Centered Support Plan, and the Case Management Agency, or regional center administration should be notified of these issues and the present or potential effect they will have on the person involved.

12. The Case Management Agency shall make a Referral to the regional center if, in this review, these issues cannot be maintained safely in a community setting.

8.7202.C Nursing Facility Admission and Discharge

1. For Members in HCBS Programs who are already determined to be at the nursing facility Level of Care and seeking admission into a nursing facility, the Case Management Agency shall:

a. Provide options counseling about community-based services to the individual to determine if they desire to live in the community with additional support:

b. Coordinate the admission date with the facility;

c. Complete the Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen, and if there is an indication of a mental illness or Developmental Disability, submit to the Department or its agent to determine whether a Pre-Admission Screening and Resident Review (PASRR) Level 2 evaluation is required;

d. Maintain the Level 1 Screen in the individual’s case file regardless of the outcome of the Level 1 Screen; and

e. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the most recent Level of Care screen is not six (6) months old or older.

2. The Case Manager and the nursing facility shall complete the following activities for discharges from nursing facilities:

a. The nursing facility shall contact the Case Management Agency in the district where the nursing facility is located to inform the Case Management Agency of the discharge if placement into home or community-based services is being considered.

b. The nursing facility and the Case Management Agency Case Manager shall coordinate the discharge date.

c. When placement into HCBS Programs is being considered, the Case Management Agency shall determine the remaining length of stay.

i. If the end date for the nursing facility is indefinite, the Case Management Agency shall assign an end date not beyond one (1) year from the date of the most recent Level of Care Screen.

ii. If the Level of Care Screen was conducted within the preceding twelve (12) months, the Case Management Agency shall generate a new certification page that reflects the end date that was assigned to the nursing facility.

iii. If no Level of Care Screen was completed within the preceding twelve (12) months, the Case Management Agency shall complete a new Level of Care Screen. The Assessment results shall be used to determine Level of Care and the new length of stay.

iv. The Case Management Agency shall send a copy of the Level of Care Screen certification page to the eligibility enrollment specialist at the county department of social services.

v. Within 2 business days of financial approval, the Case Management Agency shall outreach the Member to review available service options.

vi. The Case Management Agency shall submit the HCBS Prior Authorization Request to the Department or its fiscal agent.

3. If the individual is being discharged from a hospital or other institutional setting, the discharge planner shall contact the Case Management Agency for Assessment by emailing or faxing the initial intake and screening form.

4. The Case Manager shall view and document the current Personal Care Boarding Home license, if the individual lives, or plans to live, in a Congregate Facility as defined at Sections 8.7100.A.11 and 8.485.50.E.

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

6. If the individual has been evaluated with the Level of Care Screen and has been assigned a length of stay that has not lapsed, the Case Management Agency Case Manager is not required to conduct another review when the transition is requested unless a change in condition has occurred since the most recent Level of Care Screen.

8.7202.D Determination of Developmental Delay and/or Disability

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

8.7202.E Level of Care Determination

1. The Level of Care Screen shall be used to establish a Member's Level of Care.

2. At the time of completing the Level of Care Screen, unless the individual opposes community living, the Case Manager shall provide options counseling on community based services to the individual to determine if they desire to live in the community with additional support.

3. The Case Management Agency shall complete the Level of Care Screen within the following time frames:

a. For an individual who is not being discharged from a hospital or a nursing facility, the individual Assessment shall be completed and documented in the Department prescribed technology system within ten (10) working days after receiving confirmation that the Medicaid application has been received by the county department of social services, unless a different time frame specified below applies.

b. The Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility for a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility.

c. For a resident who is being admitted to the nursing facility from the hospital, the Case Management Agency shall complete and document the Assessment, including a Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen within two (2) working days after notification.

i. For Pre-Admission Screening and Resident Review (PASRR) Level 1 Screen regulations, Section 8.401.18

d. For an individual who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the Case Management Agency shall complete and document the Assessment within five (5) working days after notification by the nursing facility.

e. For an individual who is being transferred from a hospital to an HCBS program, the Case Management Agency shall complete and document the Assessment within two (2) working days after notification from the hospital.

4. Under no circumstances shall the start date for Functional Eligibility based on the Level of Care Screen be backdated by the Case Manager.

5. The Case Management Agency shall complete and document the Level of Care Screen for Long-Term Services and Supports Programs, in accordance with Section 8.401.1. Under no circumstances shall late PAR revisions be approved by the State or its agent.

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

7. The Case Management Agency shall conduct the following activities when completing a Level of Care Screen of an individual seeking services:

a. Obtain diagnostic information in the manner prescribed by the Department from the individual's medical provider for individuals in nursing facilities, ICF-IID, or HCBS waivers.

b. Determine the individual's functional capacity during an assessment, with observation of the individual and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section 8.401.1.

c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.15.

d. Determine the need for Long-Term Services and Supports on the Level of Care Screen during the assessment.

e. For HCBS Programs and admissions to nursing facilities from the community, the original Level of Care Screen and Person-Centered Support Plan copy shall be sent to entities or persons of the Member's choosing. If changes to the individual's condition occur which significantly change the payment or services amount, a copy of the Person-Centered Support Plan must be sent to the Provider Agency, and a copy is to be maintained in the Member's record.

f. When the Case Management Agency assesses the individual's functional capacity on the Level of Care Screen, it is not an Adverse Action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into a Long-Term Services and Supports Program by the Case Management Agency based on the Level of Care Screen for Functional Eligibility. The appeal process is governed by the provisions of Section 8.057.

8.7202.F Needs Assessment

1. Needs Assessment

a. The Case Manager shall continually identify individuals' strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of Critical Incidents.

b. The Case Manager shall complete a new Level of Care Screen during an in-person Reassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the Long-Term Services and Supports Program in which the individual is enrolled. Upon Department approval, Reassessment may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g., natural disaster, pandemic, etc.).

2. Reassessment

a. The Case Manager shall commence a regularly scheduled Reassessment at least one (1) but no more than three (3) months before the required completion date. The Case Manager shall complete a Reassessment of a Member within twelve (12) months of the initial individual assessment or the most recent Reassessment. A Reassessment shall be completed within ten (10) days if the individual's condition changes or if required by program criteria.

b. The Case Manager shall update the information provided at the previous Level of Care Screen in the Department prescribed system within five (5) business days of completion of the Assessment.

c. Reassessment shall include, but not be limited to, the following activities:

i. Assess the individual's functional status face-to-face, in the location where the person currently resides. Upon Department approval, Assessment may be completed by the Case

Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g., natural disaster, pandemic, etc.).

ii. Review Person-Centered Support Plan, service agreements and provider contracts or agreements;

iii. Evaluate effectiveness, appropriateness and quality of services and supports;

iv. Verify continuing Medicaid eligibility, other financial and program eligibility;

v. Annually, or more often if indicated, complete a new Person-Centered Support Plan and service agreements;

vi. Inform the individual's medical provider of any changes in the individual's needs;

vii. Maintain appropriate documentation, including type and frequency of Long-Term Services and Supports the individual is receiving for certification of continued program eligibility, if required by the program;

viii. Refer the individual to community resources as needed and develop resources for the individual if the resource is not available within the individual's community; and

ix. Submit appropriate documentation for authorization of services, in accordance with program requirements.

x. In order to assure quality of services and supports and the health and welfare of the individual, the Case Manager shall ask for permission from the individual to observe the individual's residence as part of the Reassessment process, but this shall not be compulsory of the individual.

d. The Case Management Agency shall be responsible for completing Reassessments of Members receiving care in a nursing facility. A Reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a Reassessment, or if the Case Manager assigns a definite end date. The nursing facility shall be responsible to send the Case Management Agency a Referral for a new Assessment as needed. At the time of completing the Reassessment, unless the individual opposes community living, the Case Manager shall provide options counseling on community-based services to the individual to determine if they desire to live in the community with additional support.

8.7202.G Waitlist Management

1. When the total capacity for enrollment or the total appropriation authorizations by the Colorado General Assembly has been met, the Department shall maintain one statewide waiting list for individuals eligible for the HCBS-DD waiver.

a. The Department of Health Care Policy and Financing shall maintain at least two categories of the one waitlist to include statuses of: As Soon As Available or Safety Net.

i. As Soon As Available (ASAA) means the individual has requested enrollment as soon as available.

ii. Safety Net (SN) means the individual does not currently need or want adult services, but requests to be on the waiting list in case a need arises. This category includes individuals who are not yet eligible for adult programs due to not having reached their 18th birthday.

b. Date Specific in a waitlist means the individual does not need services at this time but has requested enrollment at a specific future date. This category includes individuals who are not yet eligible for adult programs due to not having reached their 18th birthday.

2. The name of an individual eligible for the HCBS-DD waiver program shall be placed on the waiting list by the Case Management Agency making the eligibility determination if the Member meets DD waiver target criteria.

3. When an individual is placed on the waiting list for HCBS-DD Waiver Services, a written Notice of Action shall be sent to the individual or the individual's legal Guardian that includes information regarding individual rights and the Member's right to appeal pursuant to Section 8.057 et seq.

4. The placement date used to establish an individual's position on a waiting list shall be:

a. The date on which the individual was initially determined to have a Developmental Disability by the Case Management Agency; or

b. The fourteenth (14) birth date if a child is determined to have a Developmental Disability by the Case Management Agency prior to the age of fourteen.

5. As openings become available in the HCBS-DD Waiver program in a Defined Service Area, that Case Management Agency shall report that opening to Health Care Policy and Financing.

6. Individuals whose names are on the waiting list shall be considered for enrollment to the HCBS-DD waiver in order of placement date on the waiting list. Exceptions to this requirement shall be limited to:

a. An emergency situation where the health and safety of an individual or others is endangered, and the emergency cannot be resolved in another way and if the individual meets DD waiver Target Criteria. Individuals at risk of experiencing an emergency are defined by the following criteria:

i. Homeless: the individual will imminently lose their housing as evidenced by an eviction notice; or their primary residence during the night is a public or private facility that provides temporary living accommodations; or they are experiencing any other unstable or non-permanent housing situation; or they are discharging from prison or jail; or they are in the hospital and do not have a stable housing situation to go to upon discharge.

ii. Abusive or neglectful situation: the individual is experiencing ongoing physical, sexual or emotional abuse or neglect in the individual's present living situation and the individual's health, safety or well-being is in serious jeopardy.

iii. Danger to others: the individual's behavior or psychiatric condition is such that others in the home are at risk of being hurt by the individual and sufficient supervision to ensure safety of the individual in the community cannot be provided by the current caretaker.

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

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

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

a. An individual who is eligible for the HCBS-DD Waiver and is no longer eligible for services in the foster care system due to an age that exceeds the foster care system limits,

b. Individuals who reside in long-term care institutional settings who are eligible for the HCBS DD Waiver and have requested to be placed in a community setting,

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

d. Individuals who are in an emergency situation.

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

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

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

c. If an individual does not respond to the offer of enrollment within the time set forth in subsection 2 and/or 3 above, the offer is considered declined and the individual shall maintain their position on the waiting list as determined by their placement date.

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

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

8.7202.H Telehealth and Delivery

1. Members eligible to use HCBS Telehealth are those enrolled in the waivers and services as defined in this rule at Section 8.7100.

2. The Case Management Agency shall ensure the use of HCBS Telehealth is the choice of the Member through the Person-Centered Support Planning process by indicating the Member's choice to receive HCBS Telehealth in the Department prescribed IT system.

3. Through the Person-Centered Support Planning process, the Case Management Agency shall identify and address the benefits and possible detriments to Members choosing to use HCBS Telehealth for service delivery.

4. HCBS Telehealth delivery must be prior authorized and documented in the Member's Person-Centered Support Plan.

5. Telehealth as a service delivery method for authorized HCBS Waiver Services, shall not interfere with any individual rights or be used as any part of a Rights Modification plan.

8.7202.I Utilization Review

1. The Case Manager shall complete a Utilization Review at quarterly monitoring and as needed.

2. The Case Manager shall immediately report, to the appropriate Agency, any information which indicates an overpayment, incorrect payment or mis-utilization of any public assistance benefit and shall cooperate with the appropriate Agency in any subsequent recovery process, in accordance with Section 8.076.

8.7202.J Person-Centered Support Coordination

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

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

2. Service and support coordination shall assist the Member Determine the individual's functional capacity to ensure:

a. A Person-Centered Support Plan is developed, utilizing necessary information for the preparation of the Person-Centered Support Plan and using the Member Identified Team process;

b. Facilitating access to and provision of services and supports identified in the Person-Centered Support Plan;

c. The coordination and continuity of services and supports identified in the Person-Centered Support Plan for continuity of service provision; and

d. The Person-Centered Support Plan is reviewed periodically, as needed, to determine the results achieved, if the needs of the Member are accurately reflected in the Person-Centered Support Plan, whether the services and supports identified in the Person- Centered-Support Plan are appropriate to meet the person's needs, and what actions are necessary for the plan to be successfully implemented.

3. Person-Centered Support Plan Development

a. The Case Manager shall work with individuals to design and update Person-Centered Support Plans that address individuals' goals and assessed needs and preferences;

b. The Case Manager shall share a copy of the completed Person-Centered Support Plan with all providers that are providing services under the plan within fifteen (15) working days after the plan is completed or updated.

4. Remediation

a. The Case Manager shall identify, resolve, and to the extent possible, establish strategies to prevent Critical Incidents and problems with the delivery of services and supports.

5. The Case Manager shall develop the Person-Centered Support Plan for individuals not residing in nursing facilities within fifteen (15) working days after determination of program eligibility.

6. The Case Manager shall:

a. Address the functional needs identified through the individual Assessment in the Person-Centered Support Plan;

b. Offer informed choices to the individual regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed, but that may not be available;

c. Support Members in provider selection to the degree and extent that the Member or Family requests or requires for successful placement with a direct service provider;

d. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

e. Reflect cultural considerations of the individual and be conducted by providing information in Plain Language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency;

b. Formalize the Person-Centered Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;

c. Contain prior authorization for services, in accordance with program directives;

d. Contain prior authorization of Adult Long-Term Home Health Services, pursuant to Sections 8.520.8;

e. Include a method for the individual to request updates to the plan as needed;

f. Include an explanation to the individual of procedures for lodging Complaints against Case Management Agencies and providers;

g. Include an explanation to the individual of Critical Incident procedures; and

h. Explain the appeals process to the individual.

7. The Case Manager shall provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and shall ensure that the development of the Person-Centered Support Plan:

a. Occurs at a time and location convenient to the Member;

b. Is led by the individual, the individual's Parent's (if the individual is a minor), and/or the individual's Legally Authorized Representative;

c. Includes people chosen by the individual;

d. Addresses the goals, needs and preferences identified by the individual throughout the planning process;

e. Includes the arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the individual regarding service provision and formalizing provider agreements in accordance with program rules; and

f. Includes Referral to community resources as needed and development of resources for the individual if a resource is not available within the individual's community.

8. Prudent purchase of services:

a. The Case Manager shall arrange services and supports using the most cost-effective methods available in light of the individual's needs and preferences.

b. When family, friends, volunteers or others are available, willing and able to support the individual at no cost, these supports shall be utilized before the purchase of services, providing these services adequately meet the individual's needs.

c. When public dollars must be used to purchase services, the Case Manager shall encourage the individual to select the lowest-cost provider of service when quality of service is comparable.

d. The Case Manager shall assure there is no duplication in services provided by Long-Term Services and Supports programs and any other publicly or privately funded services.

9. Individuals and/or their Guardians and other Legally Authorized Representatives, as appropriate, who enroll in HCBS Waiver Services shall have the freedom to choose from qualified Provider Agencies in accordance with Section 8.7400, as applicable.

10. Case Managers shall follow all documented rules, regulations, policies and operational guidance in these rules and set forth by the Department for Case Management and Home and Community-Based Services.

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

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

a. Home modification

b. Vehicle modification

c. Organized Health Care Delivery System

d. Consumer Directed Attendant Supports and Services

e. In Home Supports and Services

f. Nursing Facilities

g. Transition Services

h. Long-Term Home Health

i. Private Duty Nursing

8.7202.K Monitoring

1. Case Management Agencies shall be responsible to monitor the overall provision of services and supports authorized by Case Managers to ensure the rights, health, safety and welfare of Members, quality services, and that service provision practices promote Member's ability to engage in self-determination, self-representation, and self-advocacy. Monitoring is required for all waivers in accordance with federal waiver requirements and §§ 25.5-6-1701 through 25.5-6-1709, C.R.S.

2. Monitoring activities shall include but not be limited to the following:

a. Case Managers shall monitor service providers and the delivery of services and supports identified within the Person-Centered Support Plan and the Prior Authorization Request (PAR) for potential rights violations, risks to health, safety and welfare; changed needs, issues with utilization or provision of services, quality of service deliver, or issues with statutory or legal compliance. This may include, but is not limited to:

i. Reviewing and following up on Incident reports, individualized service plans, Rights Modifications, and other provider documentation

ii. Observing the environment(s) where services are being provided

iii. Contacting Provider Agency staff about service provision and Member satisfaction

iv. Contacting Members and/or their Legally Authorized Representative about service provision and Member satisfaction

b. The Case Manager shall contact service provider(s) to perform monitoring no less frequently than every six (6) months.

c. The Case Manager shall, at a minimum, perform quarterly monitoring contacts with the Member, as defined by the Member's certification period start and end dates.

i. At a minimum, Member monitoring contacts shall include the following:

1) A review of the Member's Level of Care Screen, Needs Assessment and Person-Centered Support Plan, with the Member, to determine whether their Level of Care or needs have changed, or needs are not being met.

2) A review of the Member's service utilization to determine whether services are being delivered/utilized as outlined in the Person-Centered Support Plan /Prior Authorization Request (PAR).

3) An evaluation of the Member's satisfaction with services, to include whether service provision practices promote self-determination, self-representation, and self-advocacy, and are person-centered.

4) An evaluation of the Member's health, safety and welfare, including respect for individual rights.

5) A review of the Member's goals, choices, and preferences

a) An in-person monitoring contact is required at least one (1) time during the Person-Centered Support Plan certification period not to include the annual Long-Term Services and Supports Level of Care Reassessment. The Case Manager shall ensure the one (1) required in-person monitoring contact occurs, with the Member physically present, in the Member's place of residence or location of services. Case Managers shall contact service providers and Members to coordinate the monitoring.

ii. The Case Manager shall contact service provider(s) to perform monitoring no less frequently than every six (6) months.

iii. Upon Department approval in advance, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods.

iv. Such approval may be granted for situations in which in- person face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g. natural disaster, pandemic, etc.).

1) The Case Manager shall perform three (3) monitoring contacts each certification period in addition to the one (1) required in-person monitoring. The three (3) additional monitoring contact shall be either in-person, on the phone, or through other technological modalities based on the Member preference of engagement. Additional monitoring contacts may also be performed based on any Critical Incident Reports or other needs that arise throughout the service plan year.

v. Contacts shall be directly with the Member and/or their Legally Authorized Representative.

vi. Contacts shall be bi-directional, i.e., questions and responses, conversation between the Case Manager and the Member and/or their Legally Authorized Representative; letters, emails or voicemails to the Member and/or their Legally Authorized Representative shall not constitute a monitoring contact for purposes of this requirement.

3. The Case Manager shall take appropriate action to remediate any risks or issues identified during monitoring activities regarding the rights, health, safety and welfare of the Member or service provision or utilization.

a. The identified issue(s) shall be documented in the Information Management System.

b. The action(s) taken to remediate identified issue(s) shall be documented in the Information Management System.

4. The following criteria may be used by the Case Manager to determine the individual's level of Case Management involvement needed:

a. Member preference;

b. Availability and level of involvement of family, volunteers, or other supports;

c. Overall level of physical capabilities;

d. Mental status or cognitive capabilities;

e. Duration of disabilities or conditions;

f. Length of time supports have been in place;

g. Stability of providers/unpaid supports;

h. Whether the Member is in a Crisis or acute situation;

i. The Member's perception of need for services;

j. The Member's familiarity with navigating the system/services;

k. The Member's move to a new housing alternative; and

l. Whether the individual was discharged from a hospital or Nursing Facility.

5. At-Risk Diversion

1. The Case Management Agency shall contact Members that have been identified by the Department as At-Risk for institutionalization.

    a. Initial At-Risk outreach shall be completed within ten (10) working days after receiving notification that the Member has been identified as At-Risk for Institutionalization.

    b. Ongoing At-Risk outreach shall be completed within ninety (90) days from the initial outreach. The Ongoing At-Risk outreach can be aligned with the member's quarterly monitoring contact as indicated in Section 8.7202.K.

        i. The Case Manager shall assess and refer the member to appropriate and necessary services to meet the member's service needs as well as their basic health and safety needs in the community. The Case Manager shall provide necessary information and support to members seeking nursing facility care services.

ii. The Case Manager shall be responsible for documenting efforts in the Department's prescribed system within ten (10) working days from the time of the outreach.

iii. The Case Manager shall submit referrals to Transition Coordination within two (2) working days if the member is in need of housing support.

iv. The Case Manager shall complete referrals to other agencies, programs, and services as needed within ten (10) working days.

8.7202.L Critical Incident Reporting

1. Case Managers shall report Critical Incidents within twenty-four (24) hours of notification within the Information Management System.

2. Critical Incident reporting is required when the following occurs:

a. Injury/Illness;

b. Missing Person;

c. Criminal Activity;

d. Unsafe Housing/Displacement;

e. Death;

f. Medication Management Issues;

g. Other High-Risk Issues;

h. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;

i. Damage to the Consumer's Property/Theft.

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

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

5. Each Critical Incident Report must include:

a. Incident type

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

ii. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, or other high-risk issues.

b. Date and time of Incident;

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

d. Individuals involved;

e. Description of Incident, and

f. Resolution of Incident, if applicable.

6. The Case Manager shall complete required follow up activities and reporting in the Information Management System within assigned timelines.

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

8.7202.M Case Management Agency Transfers

1. Case Management Agencies shall complete the following procedures in the event a Member transfers from one Case Management Agency Defined Service Area to another Case Management Agency Defined Service Area.

2. Transfer activities shall include, at minimum,

a. Initial contact by the originating Case Management Agency with the receiving Case Management Agency in the Case Management Agency Defined Service Area of the Member.

b. Determination of transfer date.

i. Determination of transfer date shall not be delayed based on receipt of mailed, electronic, or paper records.

c. Necessary access and permissions in all appropriate Department prescribed systems.

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

e. All transfer activities shall be documented and recorded in the Department’s prescribed system.

f. The originating Case Management Agency shall notify the originating county department of social services eligibility enrollment specialist of the individual’s plan to transfer and the transfer date, and the eligibility enrollment specialist shall comply with the transfer requirements set forth in Section 8.100.3.C. The receiving Case Management Agency shall coordinate the transfer with the eligibility enrollment specialist of the receiving county.

3. The transferring Case Management Agency shall contact the receiving Case Management Agency by telephone or email and give notification that the individual is planning to transfer, negotiate a transfer date and provide all information necessary to ensure that the receiving Case Management Agency is able to meet the individual's needs.

4. Both agencies, sending and receiving, shall verify and document the transfer request sent and transfer request received.

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

6. Prior to transfer, the transferring Case Management Agency shall make available to the receiving Case Management Agency the individual's case records in the Information Management System.

7. If the individual is moving from one Case Management Agency Defined Service Area to another Case Management Agency Defined Service Area to enter an Alternative Care Facility or Nursing Facility, the transferring Case Management Agency shall forward copies of the individual's records to the facility prior to the individual's admission to the facility, in accordance with Section 8.7202.M.

8. To ensure continuity of services and supports, the originating Case Management Agency and the receiving Case Management Agency shall coordinate the arrangement of services prior to the individual's relocation to the receiving Case Management Agency's defined service area and within ten (10) working days after notification of the individual's relocation.

9. If a failure of Case Management Agency transfer results in a break in payment authorization, the Case Management Agencies shall be subject to Payment Liability as outlined in Section 8.7202.Z.

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

11. The receiving Case Management Agency shall review the Person-Centered Support Plan and the Level of Care Screen and change or coordinate services and providers as necessary. The originating Case Management Agency shall not close out the case until face-to-face contact is verified.

12. If indicated by changes in the Person-Centered Support Plan, the receiving Case Management Agency shall revise the Person-Centered Support Plan and prior authorization forms as identified during the review.

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

8.7202.N Case Management Agency Member Exceptions Process

1. Members, and their Legally Authorized Representative, may request to be served by a Case Management Agency outside of their defined service area with the approval of the Case Management Agency outside their defined service area and Department oversight.

2. The Case Management Agency must be willing and able to incur all costs to meet all regulatory and contractual requirements for the Members served outside their defined service areas. The Department does not provide additional funding for any travel costs incurred by a Case Management Agency that is serving a Member enrolled in any HCBS Waiver or State General Fund programs outside of the Agency's approved Defined Service Area.

3. The Case Management Agency must be willing and able to perform monitoring and follow up in the same manner and frequency as required for a Member within the defined service area. The Department shall not allow an exception to in-person Assessments or monitoring visit requirements based solely on travel time.

4. Case Management Agency policies and procedures must outline how the Case Management Agency plans to ensure all regulatory and contractual requirements can be met for Members receiving Case Management services from a Case Management Agency outside their defined service area.

5. The Case Management Agency shall follow the process approval and reporting requirements set forth by the Department for Members being served outside their defined service area.

6. If a person requires a transfer to a new Case Management Agency for any reason, both Case Management Agencies must follow the transfer process in Section 8.7202.M to maintain Member eligibility and services.

7. Case Management Agencies shall have a policy and procedure to grant Members a choice of Case Manager at their Agency.

8.7202.O State General Fund Transfers

1. When an individual enrolled in, or on the waiting list for, State General Fund program and moves to another Case Management Agency’s defined service area and wishes to transfer their State General Fund program, the following procedure shall be followed:

2. All transfer activities outlined in Section 8.7202.M shall apply to State General Fund Programs.

a. The originating Case Management Agency shall send the State General Fund Individual Person-Centered Support Plan to the receiving Case Management Agency, where the receiving Case Management Agency shall determine if appropriate State General Fund funding is available or if the individual will need to be placed on a waiting list by reviewing the State General Fund Individual Person-Centered Support Plan in the Department’s prescribed system. The receiving Case Management Agency decision of service availability will be communicated in the following way:

b. The receiving Case Management Agency shall notify the individual seeking transfer of its decision by the individual’s preferred method, no later than ten (10) business days from the date of the request; and

c. The receiving Case Management Agency shall notify the originating Case Management Agency of its decision by U.S. Mail, phone call or email of its decision no later than ten (10) business days from the date of the request.

i. The decision shall clearly state:

1) The receiving Case Management Agency's decision;

2) The basis of the decision; and

3) The contact information of the assigned Case Manager or waiting list manager.

ii. The originating Case Management Agency shall contact the individual requesting the transfer no more than five (5) days from the date the decision was received to:

1) Ensure the individual understands the decision; and

2) Support the individual in making a final decision about the transfer.

d. After the transfer, there shall be a transfer meeting in-person when possible, or by phone if geographic location or time does not permit, within fifteen (15) business days of when the notification of service determination is sent out by the receiving Case Management Agency. The transfer meeting must include but is not limited to the transferring individual and the receiving Case Manager. Any additional attendees must be approved by the transferring individual.

e. The receiving Case Management Agency must ensure that:

i. The transferring individual meets his or her primary contact of the receiving Case Management Agency.

ii. The individual is informed of the date when Services and Supports will be transferred, when Services and Supports will be available, and the length of time the Supports and Services will be available.

iii. The receiving Case Management Agency Case Manager shall have an in-person meeting with the individual to review and update the Person-Centered Support Plan, prior to the Supports and Services being authorized. Upon Department approval, contact may be completed by the Case Manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the Case Manager or individual (e.g. natural disaster, pandemic, etc.).

8.7202.P Informed Consent for Rights Modifications

1. The Case Manager is responsible for following the HCBS Settings Final Rule, as codified at Section 8.7001.B, and shall ensure compliance with all requirements of Section 8.7001.B, and shall obtain, maintain, and distribute a signed Informed Consent for any Rights Modification pursuant to Section 8.7001.B.4 per Department requirements as set forth in rule, other issuances, and trainings.

2. The Case Manager shall arrange for meetings to discuss proposed Rights Modifications consistent with the timelines in Sections 8.7001.B.4.g-h.

3. Before requesting or obtaining Informed Consent, the Case Manager shall make the offers required under Section 8.7001.B.4.d.i to the Member and record the Member's responses in the Department prescribed Information Management System.

4. The Case Management Agency's Case Manager is responsible for obtaining Informed Consent and other documentation supporting any Rights Modifications, maintaining these materials in the prescribed Department system as a part of the Person-Centered Support Plan, and distributing them to any providers implementing the Rights Modifications.

8.7202.Q Human Rights Committees

1. Each Case Management Agency shall establish at least one Human Rights Committee (HRC) as a third party mechanism to safeguard the rights of members in waivers targeted to individuals with Intellectual and Developmental Disabilities. The Human Rights Committee is an advisory and review body to the administration of each Case Management Agency.

2. The Human Rights committee shall be constituted as required by Section 25.5-10-209(2)h, C.R.S.

3. If a consultant to the Case Management Agency, regional center, or Provider Agency serves on the Human Rights Committee, procedures shall be developed related to potential conflicts of interest.

4. The Case Management Agency shall orient members regarding the duties and responsibilities of the Human Rights Committee.

5. The Case Management Agency shall provide the Human Rights Committee with the necessary staff support to facilitate its functions.

6. Each Provider Agency shall make referrals as required in rules and regulations for review by the Human Rights Committee(s) in the manner required by Department.

7. The recommendations of the Human Rights Committee shall become a part of the Case Management Agency's record as well as a part of the individual's master record.

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

9. The Human Rights Committee shall establish and implement operating and review procedures to determine that the practices of the Case Management Agency is in compliance with Title 25.5, Article 10, C.R.S., are consistent with the mission, goals and policies of the Department, and Case Management Agency and ensure that:

a. Informed Consent is obtained when required from the person receiving services, the Parent of a minor, or the Guardian or other Legally Authorized Representative as appropriate;

b. Modifications of the rights of members occurs only within procedural safeguards as stipulated in Section 8.7001 and that continued modification of such rights is reviewed by the individual, their Guardian or other Legally Authorized Representative, and the rest of the Member Identified Team at a frequency decided by the team, but not less than every six months;

c. Psychotropic medications and other prescribed medications used for the purpose of modifying the behavior of Members receiving services through the Intellectual and Developmental Disability waivers are used in accordance with the requirements of Section 8.7416, and are monitored by the Human Rights Committee on a regular basis; and,

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

8.7202.R Denials/Discontinuations/Adverse Actions

1. Individuals seeking or receiving services shall be denied or discontinued from services provided pursuant to publicly funded programs for which the Case Management Agency provides case management services if they are determined ineligible for any of the reasons below. Individuals shall be notified of any of the adverse actions and appeal rights as follows:

a. Financial Eligibility

i. The eligibility enrollment specialist from the county department of social services shall issue to the Member a Long Term Care Waiver Program Notice of Action (LTC-803) regarding denial or discontinuation of services for reasons of Financial Eligibility which shall inform the individual of appeal rights in accordance with Section 8.057.

ii. If the individual or Member is found to be financially ineligible for HCBS or Long-Term Services and Supports benefits, the Case Management Agency shall issue to the Member a Long Term Care Waiver Program Notice of Action (LTC-803) that informs the individual of their appeal rights in accordance with Section 8.057. The Case Manager shall not attend the appeal hearing for a denial or discontinuation based on Financial Eligibility, unless subpoenaed, or unless requested by the Department.

b. Functional Eligibility and Target Group

i. The Case Management Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Long-Term Care Waiver Program Notice of Action and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual does not meet the Functional Eligibility requirement for HCBS waiver and Long-Term Services and Supports Programs or nursing facility admissions; or

2) The individual does not meet the Target Group Criteria as specified by the HCBS waivers; or

3) The individual failed to submit the required paperwork, documents or any other part of the eligibility criteria and/or application within 90 days from Level of Care Screen.

c. Receipt of Services

i. The Case Management Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Long-Term Care Waiver Program Notice of Action and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual has not received long-term services or supports for one calendar month;

2) The individual does not keep or schedule an appointment for Assessment or monitoring two (2) times in a one month consecutive period as required by these regulations.

d. Institutional Status

i. The Case Management Agency shall notify the individual of denial or discontinuation by sending the Long-Term Care Waiver Program Notice of Action when the Case Manager determines that the individual does not meet the following program eligibility requirements.

1) The individual is not eligible to receive HCBS services while a resident of a nursing facility, hospital, or other Institution; or

2) The individual who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.

2. The Long-Term Care Waiver Program Notice of Action shall be completed in the Information Management System for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, and at the time of discontinuation.

3. In the event the individual appeals a denial or discontinuation action, except for reasons related to Financial Eligibility, the Case Manager shall attend the appeal hearing to defend the denial or discontinuation action.

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

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

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

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

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

e. The individual or Applicant voluntarily withdraws.

5. The Case Management Agency shall appear and defend its decision at the Office of Administrative Courts as described in Section 8.057 et seq. when the Case Management Agency has made a denial or adverse action against an individual.

6. The Case Management Agency shall notify the providers in the individual's service plan within one (1) business day of the discontinuation or adverse action.

7. The Case Manager shall notify all providers on the Person-Centered Support Plan no later than within one (1) business day of discontinuation or adverse action.

8. The Case Manager shall follow procedures to close the individual's case in the Information Management System within one (1) business day of discontinuation for all HCBS Programs.

9. The Case Management Agency shall notify the County Department of Human/Social Services income maintenance technician within ten (10) business days of an adverse action that affects Medicaid Financial Eligibility.

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

a. At the same time it notifies the individual seeking or receiving services of the adverse action;

b. When the individual has filed a written appeal with the Case Management Agency; and

c. When the individual has withdrawn the appeal or a final Agency decision has been entered.

11. The Applicant or individual shall be informed of an adverse action if the individual or Applicant is determined ineligible and the following:

a. The individual or Applicant is detained or resides in a correctional facility, or

b. The individual or Applicant enters an institute for mental health with a duration that continues for more than thirty (30) days.

12. The Case Management Agency shall refer individuals to the Medicaid Buy-In program who do not qualify for waivers due to Financial Eligibility.

13. Case Management Agencies shall document in the Information Management System all voluntary withdrawals from all programs.

8.7202.S Case Management Support to Members and Families Receiving Services Related to Dispute Resolution with Provider Agencies

1. Every Case Management Agency shall have procedures which comply with requirements as set forth in these rules and Section 25.5-10- 212, C.R.S., for resolution of disputes between Members or individuals and Provider Agencies involving individuals or Members. This dispute resolution does not supersede or negate the requirement for a Long Term Care Waiver Program Notice of Action (LTC-803). Case Management Agency dispute resolution procedures shall include but not limited to the following circumstances:

a. The individual or Member is no longer eligible for services or supports;

b. Services or supports are to be terminated; or,

c. Services set forth in the Person-Centered Support Plan are to be changed or reduced, or denied.

2. The procedure shall contain an explanation of the process to be used by Members or Applicants for services or Parents of a minor, Guardians and/or other Legally Authorized Representatives in

the event that they are dissatisfied with the decision or action of the regional center or Provider Agency.

3. The dispute resolution procedure shall be stated in writing, in English. Interpretation in native languages other than English and through such modes of communication as may be necessary for the Member's accommodation needs shall be made available upon request.

a. The procedure shall be provided, orally and in writing, to all Members or Applicants for services and Parents of a minor, Guardian, and/or other Legally Authorized Representative at the time of application, at the time the individualized plan is developed, any time changes in the plan are contemplated, and upon request by the above named persons.

b. The procedure shall state that use of the dispute resolution procedure shall not prejudice the future provision of appropriate services or supports to the individual in need of and/or receiving services.

c. The procedure shall state that an individual shall not be coerced, intimidated, threatened or retaliated against because that individual has exercised his or her right to file a Complaint or has participated in the dispute resolution process.

4. The procedure of the Case Management Agency shall stipulate that notice of action proposed as defined in Section 8.7202.R shall be provided to the Member/Applicant, and to the person's Parents if a minor, Guardian and/or other Legally Authorized Representative at least fifteen (15) days prior to the date actions enumerated in Section 8.7202.S.1 become effective. The above named persons may dispute such action(s) by filing a Complaint with the Agency initiating the action. Upon such Complaint, the procedures set forth by the Case Management Agency shall be initiated.

5. The procedure of the Case Management Agency shall provide the opportunity for resolution of any dispute through an informal negotiation process which may be waived only by mutual consent. Mediation by the Case Manager could be considered as one means to informal negotiation if both parties voluntarily agree to this process.

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

7. After opportunities for informal negotiation of the dispute have been attempted or mutually waived, either party may request that the dispute resolution process set forth by the Case Management Agency and the following provisions shall be initiated. Parent(s) or Guardian of a minor, age birth to three years, may utilize the dispute resolution process specified under the requirements of the Procedural Safe Guards for early intervention services pursuant to the Individuals with Disabilities Education Act.

8. The dispute resolution procedures of the Case Management Agency shall, at a minimum, afford due process by providing for:

a. The opportunity of the parties to present information and evidence in support of their positions to an impartial decision maker. The impartial decision maker may be the director of the Agency taking the action or their designee. The impartial decision maker shall not have been directly involved in the specific decision at issue;

b. Timely notification of the meeting (at least ten days prior) to all parties unless waived by the objecting parties;

c. Representation by counsel, Legally Authorized Representative, or another individual if the objecting party desires;

d. The opportunity to respond to or question the opposing position;

e. Recording of the proceeding by electronic device or reporter;

f. Issuance of a written decision setting forth the reasons therefore within fifteen (15) days of the meeting;

g. Notification that if the dispute is not resolved, the objecting party may request that the Executive Director of the Department or their designee review the decision; and,

h. Notification to the Department by the Case Management Agency of all disputes proceeding and the decision issued.

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

a. A request to the Executive Director of the Department to review the outcome of the dispute resolution process shall be submitted to the Department within fifteen (15) working days from which the written decision was postmarked;

b. The request for review shall also contain a statement of the matters in dispute and all information or evidence which is deemed relevant to a thorough review of the matter. The Case Management Agency shall be afforded the opportunity to respond within fifteen (15) working days;

c. The Executive Director of the Department or designee shall have the right to additional information and may request oral argument or a hearing if deemed necessary by the Executive Director or designee to render a decision;

d. The Executive Director of the Department or designee shall be de novo and a decision shall be rendered within ten (10) working days of the submission of all relevant information; and,

e. The decision of the Executive Director of the Department shall constitute Final Agency Action regarding dispute.

10. No Member may be terminated from services or supports during the dispute resolution process unless the Department determines an emergency situation, as meeting the criteria set forth in Section 8.7000.A.4 exists.

8.7202.T Disputes between Department and Case Management Agency

1. The following shall apply in the event that the terms of the Case Management Agency requirements and responsibilities in these rules for Targeted Case Management Activities are disputed by either party:

a. The Case Management Agency shall notify the Director of the Office of Community Living of the circumstances of the dispute.

b. The parties shall informally meet at a mutually agreeable time to attempt resolution.

c. If the dispute cannot be resolved through this informal process, then the formal process at Section 8.7202 shall be used.

d. The Case Management Agency shall submit a written request for formal dispute resolution to the Department.

i. The request shall state the specific grounds for the dispute.

ii. It shall include all available exhibits, evidence, arguments, and documents believed to substantiate the protest, and the relief requested.

e. The Department may request additional information deemed necessary to resolve the dispute.

f. Within fifteen (15) working days following the receipt of written materials and additional requested information, the Department shall respond to the request by issuing a written decision, which shall be inclusive of the reasons for the decision.

g. A copy of the documentation presented or considered, the decision made and the contract shall be maintained in the Department's files.

h. The Department's decision shall represent final Agency action on the disputed issue.

i. Notwithstanding the dispute, the Case Management Agency shall honor all contractual obligations entered into in its contract with the Department. No Agency shall have its contract terminated pending resolution of a contractual dispute, unless an emergency order is necessary for the preservation of public health, safety or welfare, as determined pursuant to Section 8.7000.A.4.

j. Nothing in this procedure shall prohibit the Department from initiating corrective action based on evidence presented in the request for Departmental intervention or during its review.

k. Disputes related to administrative Case Management Activities must follow the process outlined in the Case Management Agency contract.

8.7202.U Continuous Quality Improvement of the Case Management Agency

1. To ensure the Case Management Agency is completing Case Management Activities according to requirements, the Department shall conduct performance reviews and evaluations of the Case Management Agency.

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

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

4. The Case Management Agency shall perform internal oversight of their Agency work product to ensure Case Management Activities described in rule and contract are performed as required.

5. The Department shall make the results of any performance reviews and evaluations available to the public and publicly post the results of any performance reviews and evaluations.

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

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

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

9. Case Management Agency Satisfaction Survey

a. At least annually, the Case Management Agency shall survey a random sample of Members to determine their level of satisfaction with services provided by the Agency. The Case Management Agency shall have a written policy and procedure for completing the Member satisfaction survey.

b. The random sample of individuals shall constitute forty (40) individuals or ten percent (10%) of the Case Management Agency's average monthly caseload, whichever is higher.

c. The individual satisfaction survey shall conform to guidelines provided by the Department, including multiple survey formats and shall be ADA compliant.

d. The results of the individual satisfaction survey shall be made available to the Department upon request and shall be utilized for the Case Management Agency's quality assurance and resource development efforts.

e. The Case Management Agency shall assure that consumer information regarding HCBS waiver programs is available for all individuals at the local level.

f. The Survey results shall be provided to the Community Advisory Committee for review regarding actions necessary to respond to quality concerns or issues and community engagement.

8.7202.V Provision of State Program Services

1. The Case Management Agency is responsible for the administration of state plan Long-Term Services and Supports programs including: State Supported Living Services (State-SLS), OBRA-SS, and Family Support Services Program (FSSP), in accordance with Medical Services Board regulations, and the Case Management Agency contract, and all the requirements associated with these programs including, but not limited to: Family Support Council development and maintenance, rates for State SLS and monitoring of services, and the PASSR program.

2. Family Support Program

a. Case Management for State General Fund program support is the coordination of services provided for individuals with an Intellectual and Developmental Disability or Developmental Delay that consists of facilitating enrollment, assessing needs, locating, coordinating, and monitoring needed FSSP funded services, such as medical, social, education, and other services to ensure nonduplication of services, and monitoring to ensure the effective and efficient provision of services across multiple funding sources.

b. At minimum, the Case Manager is responsible for:

i. Determining initial and ongoing eligibility for the FSSP;

ii. Assisting Applicants with the Assessment;

iii. The development and annual Reassessment of the Family Support Plan (FSP); and

iv. Ensuring service delivery in accordance with the FSP, and

v. Coordinating with the Family Support Council as needed

3. OBRA-SS State General Fund Program

a. Case Management Agencies shall follow all contractual obligations, rules and regulations pertaining to OBRA-SS at 42 C.F.R. § 483.

4. State Supported Living Services State General Fund Program

a. The Case Manager shall coordinate, authorize, and monitor services based on the approved State-SLS Person-Centered Support Plan.

b. The Case Manager shall complete monitoring activities in compliance with Section 8.7557.D.4.

c. The Case Management Agency Case Manager shall assist individuals to gain access to other resources for which they are eligible and to ensure individuals secure long-term support as efficiently as possible.

d. The Case Management Agency Case Manager shall provide all State-SLS documentation upon the request from the Department.

e. Referrals to the State-SLS program shall be made through the Case Management Agency in the defined service area the individual resides in.

5. Home Care Allowance program

a. Case Management Agencies shall contract with the Colorado Department of Human Services to administer the Home Care Allowance program.

b. The Case Managers shall complete all requirements for Home Care Allowance in accordance with 9 C.C.R. 2503-5; and with any applicable contract(s).

8.7202.W Organized Health Care Delivery System (OHCDS)

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

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

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

4. The Organized Health Care Delivery System may contract and/or employ for delivery of approved Waiver Services for the Organized Health Care Delivery System.

5. The Organized Health Care Delivery System shall:

a. Ensure that the Contractor and/or employee meets minimum provider qualifications as set forth in the applicable HCBS waiver;

b. Ensure that services are delivered according to the applicable HCBS waiver definitions and as identified in the Member's Service Plan;

c. Ensure that any subcontractor maintains sufficient documentation to support the claims submitted; and

d. Monitor the health and safety of HCBS waiver Members receiving services from a subcontractor and report concerns for health and welfare to the proper authorities.

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

a. Establish reimbursement rates that are consistent with efficiency, economy and quality of care;

b. Establish written policies and procedures regarding the process that will be used to set rates for each service type and for all providers;

c. Ensure that the negotiated rates are sufficient to promote quality of care and to enlist enough providers to provide choice to individuals or Members;

d. Negotiate rates that are in accordance with the Department's established fee for service rate schedule and the Department's procedures:

i. Manually priced items that have no maximum allowable reimbursement rate assigned, nor a Manufacturer's Suggested Retail Price (MSRP), shall be reimbursed at the lesser of the submitted charges or the sum of the manufacturer's invoice cost, plus 13.56 percent.

d. Collect and maintain the data used to develop provider rates and ensure data includes the costs for allowable services provided to Members to address the individual and stakeholders' needs, that are allowable activities within the HCBS waiver service definition and that supports the established rate;

e. Maintain documentation of provider reimbursement rates and provide the documentation to the Department, and Centers for Medicare and Medicaid Services (CMS); and

f. Report by August 31 of each year, the names, rates and total payment made to the subcontractors

8.7202.X Member and Individual Documentation and Recordkeeping

1. Documentation includes:

a. Documentation of the Member's choice of services, providers, nursing home placement, or other services, including a signed statement of choice from the Member;

b. Documentation that the individual or Member was informed of the right to free choice of providers from among all the available and qualified providers for each needed service, and that the individual understands his/her right to change providers;

c. Except when a individual or Member is residing in an alternative care facility, documentation to include a process, developed in coordination with the Member, the Member's Family or

Guardian and the Member's physician, by which the Member may receive necessary care if the Member's Family or service provider is unavailable due to an emergency situation or to unforeseen circumstances. The individual and the individual's Family or Guardian shall be duly informed of these alternative care provisions at the time the service plan is initiated.

2. Case Managers shall support Members in determining their per diem payment obligation pursuant to Section 8.509.31.E. Case Managers shall inform Members residing in an Alternative Care Facility of their individual payment obligation on a form prescribed by the state at the time of the first Assessment visit; by the end of each plan period; or within ten (10) working days whenever there is a significant change in the diem payment amount.

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

b. Copies of individual payment forms shall be kept in the individual files at the Case Management Agency and shall not be mailed to the State of its agent except as required for a Prior Authorization Request, pursuant to Section 8.509.31(G)], or if requested by the state for monitoring purposes.

3. All Case Management documentation shall meet all of the following standards:

a. Records shall be objective and understandable;

b. Records shall be prepared at the time of the activity or no later than five (5) business days from the time of the activity;

c. Records shall be dated according to the date of the activity, including the year;

d. Records shall be entered into the Department's Information Management System;

e. Records shall identify the person creating the documentation;

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

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

h. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact or is a someone's judgment or conclusion;

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

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

k. If the Case Manager is unable to comply with any of the regulations specifying the time frames within which Case Management Activities are to be completed, due to circumstances outside the Case Management Agency's control, the circumstances shall be documented in the case record.

4. Documentation of Contacts and Case Management Activities in the Department Prescribed Information Management System.

5. All case documentation must be entered into the Department's Information Management System within five (5) business days from the date of activity.

6. The Case Manager shall use the Department-prescribed Information Management System for purposes of documentation of all Case Management Activities, monitoring of service delivery, and service effectiveness. If applicable, the individual's Legally Authorized Representative or Long-Term Services and Supports Representative or both shall be identified in the case record, with a copy of appropriate documentation.

7. The Case Management Agency may accept physical or digital signatures on Department forms. If the individual is unable to sign a form requiring his/her signature because of a medical condition, any mark the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a Guardian or other Legally Authorized Representative shall be accepted.

8.7202.Y Communication

1. The Case Management Agency's Case Manager shall be responsible for ensuring materials, documents, and information used to conduct Case Management Activities are adapted to the cultural background, language, ethnic origin and preferred means of communication of the individual.

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

a. The Case Manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of a Member in Case Management Agency-served programs, including changes in income, within one (1) working day after the Case Manager learns of the change. The Case Manager shall provide the eligibility enrollment specialist with copies of the certification page of the approved Level of Care Screen form.

b. If the individual has an open adult protective services (APS) or child protective services (CPS) case at the county department of social services, the Case Manager shall keep the individual's APS or CPS worker informed of the individual's status and shall participate in mutual staffing of the individual's case.

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

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

e. The Case Manager shall inform all Alternative Care Facility individuals of their obligation to pay the full and current State-prescribed room and board amount, from their own income, to the Alternative Care Facility provider.

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

g. The Case Manager shall coordinate with the Regional Accountable Entity and Behavioral Health Administration along with other community partners involved with the Members' services and supports.

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

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

8.7202.Z Targeted Case Management Activity Billing and Payment Liability

1. Billing:

a. Claims are reimbursable only when supported by the following documentation:

i. The name of the individual;

ii. The date of the activity;

iii. The nature of the activity including whether it is direct or indirect contact with the individual;

iv. The content of the activity including the relevant observations, Assessments, findings;

v. Outcomes achieved, and as appropriate, follow up action;

vi. For HCBS waiver programs, documentation required pursuant to Sections 8.519 and 8.760.

b. Claims are subject to a post-payment review by the Department. If the Department identifies an overpayment or a claim reimbursement not in compliance with requirements, the amount reimbursed shall be subject to reversal of claims, recovery of the amount reimbursed, or the Case Management Agency may be subject to suspension of payments.

c. Targeted Case Management services consist of facilitating enrollment; locating, coordinating, and monitoring Long-Term Services and Supports services; and coordinating with other non waiver funded services, such as medical, social, educational, and other services to ensure non-duplication of services and monitor the effective and efficient provision of services across multiple funding sources. The individual does not need to be physically present for this service to be performed if it is done on the individual's/Member's behalf.

d. TCM services provided to Members enrolled in HCBS waiver programs are to be reimbursed based on the Department's TCM Fee Schedule.

e. TCM providers shall record what documentation exists in the log notes and enter necessary documentation into the Department prescribed system as required by the Department.

i. Case Management Agencies shall document all targeted Case Management services and meet the following criteria:

1) All targeted Case Management services must be documented in the Department's system within 10 business days of the activity and prior to submitting a claim for reimbursement.

2) Documentation must be specific to the Member and clearly and concisely detail the activity completed.

3) Documentation must specify the Member's preference for in-person or virtual for monitoring contacts in adherence with Department direction and requirements.

4) The use of mass email communication, robotic and/or automatic voice messages cannot be used to replace the Case Management Agencies required Case Management services or any billable targeted Case Management service.

e. Reimbursement rates shall be published prior to their effective date in accordance with Federal requirements at 42 C.F.R. § 447.205(d) and shall be based upon a market-based research and standards.

f. TCM services may not be claimed prior to the first day of enrollment into an eligible program nor prior to the actual date of eligibility for Medicaid benefits.

2. Exclusions

a. Case Management services provided to any individuals enrolled in the following programs are not billable as Targeted Case Management services as specified in Section 8.7202.Z:

i. Persons enrolled in a Home and Community-Based Services waiver not included as an eligible HCBS service as described in Sections 8.7000-8.7100 and 8.7500.

ii. Persons residing in a Class I nursing facility.

iii. Persons residing in an Intermediate Care Facility for the Intellectually Disabled (ICF-ID).

3. Payment Liability

a. Failure to prepare the service plan and prior authorization or failure to submit the service plan forms in accordance with Department policies and procedures shall result in the reversal and recovery of reimbursement for services authorized retroactive to the first date of service. The Case Management Agency and/or providers may not seek reimbursement for these services from the Member.

b. If the Case Management Agency causes an individual enrolled in HCBS Waiver Services to have a break in payment authorization, the Case Management Agency shall ensure that all services continue and shall be solely financially responsible for any losses incurred by Provider Agencies until payment authorization is reinstated.

8.7202.AA Person-Centered Budget Algorithm and Resource Allocation