Title of Rule: Revision to the Medical Assistance Case Management Rules Concerning CCM System, Sections 8.100; 8.393 8.400; 8.500; 8.600
Rule Number: MSB 21-01-13-A
Division / Contact / Phone: Entry Point & Case Management Section / Michelle Topkoff / 3659

STATEMENT OF BASIS AND PURPOSE

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

   Changes have been made throughout 8.300, 8.400, 8.500. The current rule identifies by name the ULTC 100.2 as the instrument used to determine eligibility for LTSS and incorporates the instrument in its entirety into the regulations. The changes remove this language and replaces it with updated terminology and more generic language to allow for an upcoming change in the assessment instrument and a phased implementation of it with the new Care and Case Management (CCM) system.

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:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303 and Section 25.5-6-104, C.R.S. (2021);

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REGULATORY ANALYSIS

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

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

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

   The new assessment has automation features that will streamline the assessment process for members and reduce duplication in administrative work for case managers.

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

   Initial cost associated with the change have been addressed through the fiscal note for SB 16-192. Enforcement costs are not anticipated to change.

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

   If the department fails to implement SB16-192, there is a risk of violating statute.

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

   Because the current rules identify a specific assessment instrument by name and incorporate it, the rule must be changed if a new instrument is to be used.

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.

Title of Rule: Revision to the Medical Assistance Case Management Rules Concerning CCM System, Sections 8.100; 8.393 8.400; 8.500; 8.600

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Not applicable.

8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM

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

8.390.1 DEFINITIONS

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

B. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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~~care, service needs, available resources, and potential funding resources using Department prescribed instruments.

C. Case Management means the A~~a~~ssessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic reassessment of such individual's needs.

D. Corrective Action Plan means a written plan by the CMA, 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.

E. Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it 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.

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

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

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

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

~~J. Functional Needs Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, friends and/or caregivers) chosen by the individual and a written evaluation by the case manager utilizing the ULTC 100.2LOC SCREEN, with supporting diagnostic information from the individual's medical provider, to~~

~~determine the individuals level of care and medical necessity for admission or continued stay in certain Long-Term Services and Supports (LTSS) Programs.~~

~~K~~I. Home and Community Based Services (HCBS) waivers means services and supports authorized through a waiver under Section 1915(c) of the Social Security Act and provided in home- and community-based settings to individuals who require an institutional level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

~~L~~J. Information Management System (IMS) means an automated data management system ~~approved~~ prescribed 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.

~~M~~K. Intake, Screening and Referral means the initial contact with individuals by the Single Entry Point 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 level of care assessment of~~ Assessment of the individual seeking services.

~~N~~L. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

M. Level of Care Eligibility Determination means the outcome of a comprehensive evaluation of an individual seeking Long-Term Services and Supports to determine their need for institutional level of care using the Department's prescribed assessment instrument.

~~O~~N. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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~~a~~ Department's prescribed assessment instrument.

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

~~O~~P. LTSS Program means any of the following: publicly funded programs, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), 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).

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

~~Q~~R. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to ~~certify~~ verify the client or member's need for institutional level of care.

~~R~~S. Reassessment means a periodic comprehensive reevaluation with the individual receiving services, appropriate collaterals, chosen by the individual, and case manager, to re-determine the individual's level of ~~functioning~~care, service needs, available resources and potential funding resources.

~~S~~T. Resource Development means the study, establishment and implementation of additional resources or services which will extend the capabilities of community LTSS systems to better serve individuals receiving long-term services and individuals likely to need long-term services in the future.

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

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

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

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

~~X~~Y. 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.

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.M. Functions of the Case Manager.

1. The SEP Agency's case manager(s) shall be responsible for: intake, screening and referral, ~~assessment~~Assessment/R~~r~~eassessment, development of Support Plans, ongoing case management, monitoring of individuals' health and welfare, documentation of contacts and case management activities in the Department-prescribed IMS, resource development, and case closure.

    a. The case manager shall contact the individual at least once within each quarterly period, or more frequently if warranted by the individual's condition or as determined by the rules of the LTSS Program in which the individual is enrolled.

b. The case manager shall have in-person monitoring at least one (1) time during the Support Plan year. The case manager shall ensure one required monitoring is conducted in-person with the Member, in the Member's place of residence.. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

c. The case manager shall complete a new ~~ULTC 100.2~~~~LOC SCREEN~~LOC Screen during a face-to-face reassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the LTSS Program in which the individual is enrolled. Upon Department approval, R~~r~~eassessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.2.B. Intake, Screening and Referral

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

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

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

   b. The provision of information and referral to other agencies, as needed;

   c. A screening to determine whether a ~~functional eligibility assessment~~LOC Screen is needed;

   d. The identification of potential payment source(s), including the availability of private funding resources; and

   e. The implementation of a SEP Agency procedure for prioritizing urgent inquiries.

2. When LTSS are to be reimbursed through one or more of the publicly funded LTSS programs served by the SEP system:

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

b. The SEP Agency shall coordinate the completion of the financial eligibility determination by:

i. Verifying the individual's current financial eligibility status; or

ii. Referring the individual to the county department of social services of the individual's county of residence for application; or

iii. 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

iv. Conducting and documenting follow-up activities to complete the ~~functional eligibility determination~~LOC Screen and coordinate the completion of the financial eligibility determination.

c. The determination of the individual's financial eligibility shall be completed by the county department of social services for the county in which the individual resides, pursuant to Section 8.100.7 A-U.

d. Individuals shall be notified by the SEP Agency at the time of their application for publicly funded long term services and supports that they have the right to appeal actions of the SEP Agency, the Department, and contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

e. The county department shall notify the SEP Agency of the Medicaid application date for the individual seeking services upon receipt of the Medicaid application.

f. The county shall not notify the SEP Agency for individuals being discharged from a hospital or nursing facility or Adult Long-Term Home Health.

8.393.2.C. Initial ~~Assessment~~Level of Care ~~Screen~~Eligibility Determination

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

~~a.~~ The SEP Agency shall complete the ~~ULTC 100.2~~LOC Screen~~CREEN~~ within the following time frames:

~~i.~~a. For an individual who is not being discharged from a hospital or a nursing facility, the ~~individual assessment~~ LOC Screen shall be completed 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.

~~ii.~~b. For a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the SEP Agency shall complete the ~~assessment~~LOC Screen within five (5) working days after notification by the nursing facility.

~~iii.~~c. For a resident who is being admitted to the nursing facility from the hospital, the SEP Agency shall complete the ~~assessment~~LOC Screen, including a PASRR Level 1 Screen within two (2) working days after notification.

~~1)~~i. For PASRR Level 1 Screen regulations, refer to 8.401.18, PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

~~b~~d. For an individual who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the SEP Agency shall complete the ~~assessment~~LOC Screen within five (5) working days after notification by the nursing facility.

~~c~~e. For an individual who is being transferred from a hospital to an HCBS program, the SEP Agency shall complete the ~~assessment~~ LOC Screen within two (2) working days after notification from the hospital.

2. Under no circumstances shall the start date for Level of Care Eligibility ~~functional eligibility~~ based on the LOC Screen be backdated by the SEP. See Section 8.486.30, ~~ASSESSMENT~~ LONG-TERM SERVICES AND SUPPORTS LEVEL OF CARE ELIGIBILITY DETERMINATION SCREEN (LOC SCREEN. Under no circumstances shall late PAR revisions be approved by the state or its agent. See Section 8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES.

3. The SEP Agency shall complete the ~~ULTC 100.2LOC SCREEN~~LOC Screen ~~CREEN~~ for LTSS Programs, in accordance with Section 8.401.1.

a. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may complete the ~~ULTC 100.2~~LOC S~~CREENLOC SCREEN~~creen for CHCBS.

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

5. The SEP Agency shall conduct the following activities for a ~~comprehensive assessment~~ Level of Care Eligibility Determination of an individual seeking services:

a. Obtain diagnostic information through the Professional Medical Information Page (PMIP) form from the individual's medical provider for individuals in nursing facilities, HCBS Programs for Community Mental Health Supports (HCBS-CMHS), Persons with a Brain Injury (HCBS-BI), Elderly, Blind and Disabled (HCBS-EBD), Persons with a Spinal Cord Injury (HCBS-SCI) and Children with a Life Limiting Illness (HCBS-CLLI).

i. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may obtain diagnosis(es) information from the individual's medical provider.

b. Determine the individual's ~~functional capacity~~ level of care during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting ~~and determine the functional capacity score in each of the areas identified in Section 8.401.1~~using the Department's prescribed ~~.~~instrument.

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 8.402.10.15.

d. ~~Determine the need for long-term services and supports on the~~ ULTC 100.2~~LOC SCREEN during the evaluation.~~

e. For HCBS Programs and admissions to nursing facilities from the community, ~~the~~a copy of the ~~original~~ ULTC 100.2LOC S~~CREEN~~creen ~~copy~~ shall be sent to the provider agency~~ies~~to be ~~, and a copy shall be placed in the~~retained in the agency's ~~individual's~~ case record for the individual. If there are changes in the individual's condition which significantly change the payment or services amount, a copy of the ~~ULTC 100.2~~LOC S~~CREEN~~creen must be sent to the provider agency~~, and a copy is to be~~ to be maintained in the agency's case record for the individual.

f. When the SEP Agency assesses the individual's ~~functional capacity~~ ~~level of care needs~~level of care ~~on the~~ ULTC 100.2~~LOC SCREEN~~using the Department's prescribed instrument, the assessment is not an adverse action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into an LTSS Program by the SEP based on the ~~ULTC 100.2LOC SCREEN~~ thresholds for ~~functional eligibility~~Level of Care Eligibility Determination. The appeal process is governed by the provisions of Section 8.057.

6. The case manager and the nursing facility shall complete the following activities for discharges from nursing facilities:

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

b. The nursing facility and the SEP case manager shall coordinate the discharge date.

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

i. If the end date for the nursing facility is indefinite, the SEP Agency shall assign an end date not past one (1) year from the date of the most recent ~~assessment~~Level of Care Eligibility Determination.

ii. If the ~~ULTC 100.2~~Level of Care ~~-~~Eligibility Determination is less than six (6) months, the SEP Agency shall generate a ~~new certification~~ new Level

of Care Eligibility Determination~~page~~ that reflects the end date that was assigned to the nursing facility.

iii. The SEP Agency shall complete a new ~~ULTC 100.2~~LOC Screen if the current completion date is six (6) months old or older. The assessment results shall be used to determine level of care and the new length of stay.

iv. The SEP Agency shall ~~send a copy of~~ provide the ~~ULTC 100.2 certification~~ Level of Care Eligibility Determination~~page~~ to the eligibility enrollment specialist at the county department of social services.

v. The SEP Agency shall submit the HCBS prior authorization request to the Department or its fiscal agent.

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

a. Coordinate the admission date with the facility;

b. Complete the PASRR Level 1 Screen, and if there is an indication of a mental illness or developmental disability, submit to the Department or its agent to determine whether a PASRR Level 2 evaluation is required;

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

d. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ~~ULTC 100.2~~ Level of Care Eligibility Determination is not six (6) months old or older.

8.393.2.D. ~~Reassessment~~Ongoing Level of Care Eligibility Determination

1. The case manager shall commence a ~~regularly scheduled~~ R~~r~~eassessment using the LOC Screen at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete ~~a reassessment~~ the LOC Screen of an individual receiving services within twelve (12) months of the initial or most recent ~~individual assessment~~LOC Screen ~~or the most recent reassessment~~. A R~~r~~eassessment shall be completed sooner if the individual's condition changes or if required by program criteria.

2. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the ~~ULTC 100.2~~ LOC Screen.

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

a. Assess the individual's ~~functional status~~level of care needs face-to-face, in the location where the person currently resides. ~~.~~ Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

8.393.2.G. Ongoing Case Management

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

   a. Assessment/Reassessment: 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. Support Plan Development: The case manager shall work with individuals to design and update Support Plans that address individuals' goals and assessed needs and preferences;

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

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

      1. Be performed when necessary to address health and safety and services in the care plan;

      2. Include activities to ensure:

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

         B. Services in the Support Plan are adequate; and

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

      3. Include an in-person contact and observation with the individual in their place of residence, at least once per ~~certification~~eligibility period. Additional in-~~-~~person monitoring shall be performed when required by the individual's condition or circumstance. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)

   e. Remediation: 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.

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

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

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

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

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

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

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

   e. Informal assessment of changes in individual ~~functioning~~level of care, service effectiveness, service appropriateness and service cost-effectiveness;

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

   g. Referral to community resources as needed.

5. 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 Department of Human Services Income Maintenance Rules at 9 C.C.R. 2503-8, Section 3.810 and Section 8.076.

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

7. The case manager shall review the Department prescribed A~~a~~ssessment(s) and the Person-Centered Support Plan with the individual every six (6) months. The review shall be conducted by telephone or at the individual's place of residence, place of service or other appropriate setting as determined by the individual's needs or preferences.

8. The case manager shall complete a new ~~ULTC 100.2~~LOC Screen~~CREENLOC SCREEN~~ when there is a significant change in the individual's condition that would be expected to change their level of care and when the individual changes to an LTSS program~~s~~ for which they have not already been determined to meet the level of care and/or targeting criteria.

8.393.4. COMMUNICATION

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

1. The case manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of an individual receiving services in SEP 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~~Level of Care Determination. ~~page of the approved~~ ~~ULTC 100.2~~LOC ~~SCREEN~~ ~~form.~~

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

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

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

8.393.5 ~~FUNCTIONAL ELIGIBILITY~~ LEVEL OF CARE DETERMINATION

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

1. Ensuring that the ~~ULTC 100.2~~LOC SCREEN is completed in the IMS in accordance with Section 8.401.1 and justifies that the individual seeking or receiving services should be approved or disapproved for admission to or continued stay in an applicable LTSS program.

2. Once the LOC Screen~~assessment~~ is complete in the IMS, the case manager shall generate a ~~certification page~~ determination in the IMS within three (3) business days for hospital discharge to a Nursing Facility, within six (6) business days for Nursing Facility discharge and within eleven (11) business days of receipt of referral.

3. If the ~~assessment~~LOC Screen indicates approval, the SEP Agency shall notify the appropriate parties.

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

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

8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

8.393.6.A. Intercounty Transfers

1. SEP agencies shall complete the following procedures to transfer individuals receiving case management services to another county within the same SEP district:

   a. Notify the current county department of social services eligibility enrollment specialist of the individual's plans to relocate to another county and the date of transfer, with financial transfer details at Section 8.100.3.C.

   b. If the individual's current service providers do not provide services in the area where the individual is relocating, make arrangements, in consultation with the individual, for new service providers.

c. In order to assure quality of services and supports and health and welfare of the individual, the case manager must observe and evaluate the condition of the individual's residence. Upon Department approval, observation may be completed using virtual technology methods. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

d. If the individual is moving from one county to another to enter an Alternative Care Facility (ACF), forward copies of the following individual records to the ACF prior to the individual's admission to the facility:

i. ~~ULTC 100.2~~Completed LOC S~~CREEN, certified by the SEP;~~creen

ii. The individual's updated draft Prior Authorization Request (PAR) and/or Post Eligibility Treatment of Income (PETI) form; and

iii. Verification of Medicaid eligibility status.

8.393.6.B. Inter-district Transfers

1. SEP Agencies shall complete the following procedures in the event an individual receiving services transfers from one SEP district to another SEP district:

g. The receiving SEP Agency shall review the Support Plan and the ~~ULTC 100.2~~LOC Screen~~CREEN~~ and change or coordinate services and providers as necessary.

8.400 LONG-TERM CARE

.16 Target Population Definitions. For purposes of determining appropriate type of long-term services, including home and community-based services, as well as providing for a means of properly referring clients to the appropriate community agency, the following target group designations are established:

A. Developmentally Disabled - includes all clients whose need for long-term care services is based on a diagnosis of Developmental Disability and Related Conditions, as defined in Section 8.401.18.

B. Mentally Ill - includes all clients whose need for long-term care is based on a diagnosis of mental disease as defined in Section 8.401.18.

C. Functionally Impaired Elderly - includes all clients who meet the ~~level of care screening guidelines~~institutional level of care for SNF or ICF care, as determined by the LOC Screen and who are age 65 or over. Clients who are mentally ill, as defined in Section 8.401.18, shall not be included in the target group of Functionally Impaired Elderly, unless the person's need for long-term care services is primarily due to physical impairments that are not caused by any diagnosis included in the definition of mental illness at Section 8.401.18, and determined by (URC) from the medical evidence.

D. Physically Disabled or Blind Adult - includes all clients who meet the institutional level of care screening guidelines for SNF or ICF care, as determined by the LOC Screen and who are age 18 through 64. Clients who are developmentally disabled or mentally ill, as

defined in Section 8.401.18, shall not be included in the Physically Disabled or Blind target group, unless the person's need for long-term care services is primarily due to physical impairments not caused by any diagnosis included in the definition of intellectual or developmental disability or mental illness at Section 8.401.18, as determined by URC from the medical evidence.

E. Persons Living with AIDS - includes all clients of any age who meet either ~~the nursing home~~institutional level of care ~~or acute level of care screening guidelines~~ for nursing facilities or hospitals as determined by the LOC Screen and have the -diagnosis of Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS). Clients who are diagnosed with HIV or AIDS may alternatively request to be designated as any other target group for which they meet the definitions above.

.17 Services in Home and Community Based Services programs established in accordance with federal waivers shall be provided to clients in accordance with the URC determined target populations as defined herein above.

8.401 LEVEL OF CARE SCREENING GUIDELINES

.01 The client must have been found by the URC to meet the applicable institutional level of care ~~guidelines~~ for the type of services to be provided.

.02 The URC shall not make a level of care determination unless the recipient has been determined to be Medicaid eligible or an application for Medicaid services has been filed with the County Department of Social/Human services.

.03 Payment for skilled (SNF) and intermediate nursing home care (ICF) Payment for skilled (SNF) and intermediate nursing home care (ICF) will only be made for clients whose ~~functional assessment~~ LOC Screen and frequency of need for skilled and maintenance services meet the level of care guidelines for long-term care as determined by the LOC Screen.

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

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

8.401.1 GUIDELINES FOR LONG TERM CARE SERVICES (CLASS I SNF AND ICF FACILITIES, *HCBS-EBD, HCBS-CMHS, HCBS-BI, Children's HCBS, HCBS-CES, HCBS-DD, HCBS-SLS, HCBS-CHRP*, HCBS-SCI, HCBS-CLLI, PACE and Long-term Home Health)

.11 The guidelines for long-term care are based on a ~~functional needs assessment~~LOC Screen in which individuals are evaluated in ~~at least~~ the following areas of activities of daily living:

- Mobility
- Bathing
- Dressing
- Eating

- Toileting
- Transferring
- Need for supervision

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

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

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

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

- Skin care
- Medication
- Nutrition
- Activities of daily living
- Therapies
- Elimination
- Observation and monitoring

.15

A. The URC shall certify as to the ~~functional~~ need for ~~the~~ nursing facility level of care. A URC reviews the information submitted on the ~~ULTC 100.2~~LOC SCREEN ~~and assigns a score to each of the functional areas described in 10 CCR 2505-10 Section 8.401.11~~. The scores ~~in each of the functional areas are~~level of care determination is based on a set of criteria ~~and weights~~ approved by the State which measures the degree of impairment in areas activities of daily living described in 10 CCR 2505-10 Section 8.401.11.~~each of the functional areas. When the score in a minimum of two ADLs or the score for one category of supervision is at least a (2), the URC may certify that the person being reviewed is eligible for nursing facility level of care.~~

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

C. A person's need for basic Medicaid benefits should not be a ~~is not a proper~~ consideration in determining whether a person needs long-term care services (including Home and Community Based Services).

~~D. The ULTC 100.2 shall be the comprehensive and uniform client assessment process for all individuals in need of long-term care, the purpose of which is to determine the~~

appropriate services and levels of care necessary to meet clients' needs, to analyze alternative forms of care and the payment sources for such care, and to assist in the selection of long-term care programs and services that meet clients' needs most cost-efficiently.

LONG-TERM CARE ELIGIBILITY ASSESSMENT

General Instructions: To qualify for Medicaid long-term care services, the recipient/applicant must have deficits in 2 of 6 Activities of Daily Living, ADLs, (2+ score) or require at least moderate (2+ score) in Behaviors or Memory/Cognition under Supervision.

ACTIVITIES OF DAILY LIVING

I. BATHING

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

ADL SCORING CRITERIA

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

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

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

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

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

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

~~Comments:~~

II. DRESSING

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

ADL SCORING CRITERIA

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

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

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

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

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

Physical Impairments: ☐Pain ☐Sensory Impairment ☐Limited Range of Motion ☐Weakness ☐Balance Problems ☐Shortness of Breath ☐Decreased Endurance ☐Fine Motor Impairment ☐Paralysis ☐Neurological Impairment ☐Bladder Incontinence ☐Bowel Incontinence ☐Amputation ☐Oxygen Use ☐Muscle Tone	☐Open Wound Supervision: ☐Cognitive Impairment ☐Memory Impairment ☐Behavior Issues ☐Lack of Awareness ☐Difficulty Learning ☐Seizures Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia

Comments:

III. TOILETING

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

ADL SCORING CRITERIA

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

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

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

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

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

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

Comments:

IV. MOBILITY

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

ADL SCORING CRITERIA

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

☐1=The client is mobile in their own home but may need assistance outside the home.

☐2=The client is not safe to ambulate or move between locations alone; needs regular cueing, stand-by assistance, or hands on assistance for safety both in the home and outside the home.

☐3=The client is dependent on others for all mobility.

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

Physical Impairments:	Supervision Need:
☐Pain	☐Cognitive Impairment
☐Sensory Impairment	☐Memory Impairment
☐Limited Range of Motion	☐Behavior Issues
☐Weakness	☐Lack of Awareness
☐Shortness of Breath	☐Difficulty Learning
☐Decreased Endurance	☐Seizures
☐Fine or Gross Motor Impairment	☐History of Falls
☐Paralysis	Mental Health:
☐Neurological Impairment	☐Lack of Motivation/Apathy
☐Amputation	☐Delusional
☐Oxygen Use	☐Hallucinations
☐Balance	☐Paranoia
☐Muscle Tone	

Comments:

V. TRANSFERRING

Definition: The physical ability to move between surfaces: from bed/chair to wheelchair, walker or standing position; the ability to get in and out of bed or usual sleeping place; the ability to use assisted devices, including properly functioning prosthetics, for transfers. Note: Score Client's ability to transfer without regard to use of equipment.

ADL SCORING CRITERIA

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

☐1=The client transfers safely without assistance most of the time, but may need standby assistance for cueing or balance; occasional hands on assistance needed.

☐2=The client transfer requires standby or hands on assistance for safety; client may bear some weight.

☐3=The client requires total assistance for transfers and/or positioning with or without equipment.

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

Physical Impairments: ☐Pain ☐Sensory Impairment ☐Limited Range of Motion ☐Weakness ☐Balance Problems ☐Shortness of Breath ☐Falls ☐Decreased Endurance ☐Paralysis ☐Neurological Impairment ☐Amputation ☐Oxygen Use	Supervision Need: ☐Cognitive Impairment ☐Memory Impairment ☐Behavior Issues ☐Lack of Awareness ☐Difficulty Learning ☐Seizures Mental Health: ☐Lack of Motivation/Apathy ☐Delusional ☐Hallucinations ☐Paranoia

Comments:

VI. EATING

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

ADL SCORING CRITERIA

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

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

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

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

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

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

Comments:

VII. SUPERVISION

A. Behaviors

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

SCORING CRITERIA

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

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

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

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

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

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

Comments:

B. Memory/Cognition Deficit

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

SCORING CRITERIA

☐0= Independent no concern

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

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

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

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

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

Comments:

8.402.10 ADMISSION PROCEDURES FOR CLASS I NURSING FACILITIES

.11 The URC/Single Entry Pointy (SEP) shall certify a client for nursing facility admission after a client is determined to meet the functional level of care and passes the PASRR Level 1 screen

requirements for long-term care. However, the URC/SEP shall not certify a client for nursing facility admission unless the client has been advised of long-term care options including Home and Community Based Services as an alternative to nursing facility care.

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

.13 The ~~ULTC 100.2~~LOC Screen and other transfer documents concerning medical information as applicable, must accompany the client to the facility.

8.402.30 ADMISSION PROCEDURES FOR HOME AND COMMUNITY BASED SERVICES

.37 If the community agency develops an approved plan for long-term care services, the URC will approve one (1) certification for long-term care services and the client shall be placed in alternative services. Following receipt of the fully completed ~~ULTC~~ LOC Screen the URC will review the information submitted and make a certification decision. If certification is approved, the URC shall assign an initial length of stay for alternative services. If certification is denied, the decision of the URC may be appealed in accordance with Section 8.057 through 8.057.8.

8.402.50 DENIALS (ALL TARGET GROUPS)

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

.52 If the URC denied long-term care certification based upon the information on the ~~ULTC 100.2~~LOC Screen, written notification of the denial shall be sent to the client, the attending physician, and the referral source (hospital, nursing facility, etc.).

If the information provided on the ~~ULTC 100.2~~LOC Screen indicates the client does meet the level of care requirements, the URC shall proceed with the admission and/or referral procedures described above.

~~T~~8.405.2 ADMISSION PROCEDURES FOR ICF/IID FACILITIES

24. The ~~ULTC 100.2~~LOC Screen and other transfer documents concerning medical information as applicable must accompany the client to the facility.

.25 Following receipt of the fully completed ~~ULTC 100.2~~LOC Screen, the URC/CCB shall review the information and make a final certification decision. If certification is approved, the URC/CCB shall assign an initial length of stay according to Section 8.404.1. If certification is denied, the decision of the URC/CCB may be appealed in accordance with the appeals process at 10 CCR 2505-10 Section 8.057.

8.405.30 ADMISSION PROCEDURES FOR HCBS-DD

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

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

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

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

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

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

8.485.50 GENERAL DEFINITIONS

M. Intake/Screening/Referral shall be as defined Section 8.390.1.M.

N. Level of Care Eligibility shall be defined as ~~means~~ an individual meetings the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

O. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) ~~means~~ shall be defined as a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.~~N. Level of care screen shall be as defined as an assessment conducted in accordance with Section 8.401~~.

~~O~~P. Provider agency shall be defined as an agency certified by the Department and which has a contract with the Department to provide one or more of the services listed at Section 8.485.40. A Single Entry Point Agency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria in Sections 8.390-8.393 are met.

~~P~~Q. Reassessment shall be as defined at Section 8.390.1.R.

~~Q~~R. Service Plan means the written document that identifies approved services, including Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a client to remain safely in the community and developed in accordance with the Department rules, including the funding source, frequency, amount and provider of each service, and written on a State-prescribed Long-term Care Plan form.

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

~~S~~T. The Department shall be defined described in 8.390.1.F.

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

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

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

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

8.485.60 ELIGIBLE PERSONS

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

B. Level of Care (LOC) Screen and Target Group

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

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

2. Determined by a ~~formal level of care assessment~~LOC Screen to require the level of care available in a nursing facility, according to Section 8.401.11 through 8.401.15; or

3. Determined by a ~~formal level of care assessment~~LOC Screen to require the level of care available in a hospital;

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

D. Institutional Status

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

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

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

F. Waiting List

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

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

d. Clients with high ~~ULTC-100.2~~LOC Screen scores who are at risk of imminent nursing facility placement.

8.485.70 START DATE

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

B. Level of Care: This date is determined by the ~~official URC's stamp and the URC~~ assigned start date on the ~~ULTC 100.2~~LOC Screen ~~form~~.

8.485.90 STATE PRIOR AUTHORIZATION OF SERVICES

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

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

8.486 HCBS-EBD CASE MANAGEMENT FUNCTIONS

8.486.20 INTAKE

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

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

8.486.30 LONG-TERM SERVICES AND SUPPORTS LEVEL OF CARE ELIGIBILITY DETERMINATION SCREEN (LOC SCREEN)~~ASSESSMENTLEVEL OF CARE (LOC) SCREEN~~

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

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

.33 A SEP may determine that a client is eligible for HCBS-EBD while the client resides in a nursing facility when the client meets the ~~eligibility criteria~~ level of care ~~as established at Section 8.400, et seq~~~~in accordance with~~using the State prescribed assessment ~~tool~~.instrument~~.~~, the client requests

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

8.486.40 HCBS-EBD DENIALS

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

8.486.400 COMMUNICATION

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

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

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

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

8.500.1 DEFINITIONS

Q. ~~FUNCTIONAL~~ LEVEL OF CARE ELIGIBLITY means ~~that~~ the applicant meets the Level of Care criteria for long term services and supports as determined by the Department's prescribed instrument.

R. LONG-TERM SERVICES AND SUPPORTS LEVEL OF CARE ELIGIBILITY DETERMINATION SCREEN (LOC SCREEN) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 state prescribed assessment instrument. ~~FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long-term Care instrument and medical verification on the Professional Medical Information Page to determine if the Client meets the institutional Level of Care (LOC).~~

II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the client of member's need for

institutional level of care. ~~means the medical information form signed by a licensed medical professional used to certify the client's medical necessity for long-term care services.~~

8.500.2 HCBS-DD WAIVER ADMINISTRATION

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

zation of the HCBS-DD Waiver program is projected to exceed the spending authority.

8.500.4 CLIENT ELIGIBILITY

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

1. Be determined to have an intellectual or developmental disability,

2. Be eighteen (18) years of age or older,

3. Require access to services and supports twenty-four (24) hours a day,

4. Meet ICF-IID level of care as determined by the ~~functional needs assessment~~LOC Screen, and

5. Meet the Medicaid financial determination for LTC eligibility as specified in Section 8.100, *et seq*.

8.500.90 SUPPORTED LIVING SERVICES WAIVER (SLS)

8.500.90 DEFINITIONS

P. FAMILY means a relationship as it pertains to the Client and includes the following:

A mother, father, brother, sister; or,

Extended blood relatives such as grandparent, aunt, uncle, cousin; or

An adoptive parent; or,

One or more individuals to whom legal custody of a Client with an intellectual or developmental disability has been given by a court; or,

A spouse; or

The Client's children.

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

~~R. FUNCTIONAL NEEDS ASSESSMENT means a comprehensive face-to-face evaluation using the Uniform Long-term Care instrument and medical verification on the professional medical information page to determine if the applicant or Client meets the institutional Level of Care (LOC).~~

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

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

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

~~V~~T. INSTITUTION means a hospital, nursing facility, or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF-IID) for which the Department makes Medicaid payment under the Medicaid State Plan.

~~W~~U. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a public or private facility that provides health and habilitation services to a Client with intellectual or developmental disabilities or related conditions.

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

~~Y~~W. LEVEL OF CARE (LOC) means the specified minimum amount of assistance that a Client must require in order to receive services in an institutional setting under the state plan.

~~L.~~X LEVEL OF CARE ELIGIBILITY means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

~~M~~Y. LONG-TERM SERVICES AND SUPPORTS LEVEL OF CARE ELIGIBILITY DETERMINATION SCREEN (LOC SCREEN) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

GG. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to ~~certify~~ verify the Applicant's or Client's need for institutional level of care.~~long-term care services.~~

8.500.91 HCBS-SLS WAIVER ADMINISTRATION

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

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

8.500.93 CLIENT ELIGIBILITY

8.500.93.A To be eligible for the HCBS-SLS waiver an individual shall meet the target population criteria as follows:

5. Meet ICF-IID level of care as determined by the ~~Functional Needs Assessment~~LOC Screen

8.500.103 RETROSPECTIVE REVIEW PROCESS

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

1. Identified in the service plan are based on the Client's identified needs as stated in the ~~functional needs~~LOC Screen,

8.501 State Funded Supported Living Services Program

8.501.A Definitions

14. HOME AND COMMUNITY-BASED SERVICES (HCBS) WAIVER means services and supports authorized through a 1915(c) waiver of the Social Security Act and provided in community settings to a Client who requires a level of institutional care that would otherwise be provided in a hospital, nursing facility or intermediate care facility for individuals with intellectual disabilities (ICF-IID).

15. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

16. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

~~15~~17. LONG-TERM CARE SERVICES AND SUPPORTS (LTSS) means the services and supports utilized by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

~~16~~18. MEDICAID ELIGIBLE means an Applicant or Client meets the criteria for Medicaid benefits based on a financial determination and disability determination.

~~17~~19. MEDICAID STATE PLAN means the federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses federal Medicaid statutory requirements concerning the operation of its Medicaid program.

~~18~~20. NATURAL SUPPORTS means an informal relationship that provides assistance and occurs in the Client's everyday life including, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

~~19~~21. PERFORMANCE AND QUALITY REVIEW means a review conducted by the Department or its contractor at any time to include a review of required case management services performed by the CCB to ensure quality and compliance with all statutory and regulatory requirements.

~~20~~22. PLAN YEAR mean a twelve (12) month period starting from the date when State-SLS Supports and Services where authorized.

~~21~~23. PRIOR AUTHORIZATION means approval for an item or service that is obtained in advance either from the Department, a State fiscal agent.

~~22~~24. PROGRAM APPROVED SERVICE AGENCY (PASA) means a developmental disabilities service agency or a service agency as defined in 8.602, that has received program approval, by the Department, to provide Medicaid Wavier services.

~~23~~25. RELATIVE means a person related to the Client by virtue of blood, marriage, or adoption.

~~24~~26. RETROSPECTIVE REVIEW means the Department's review after services and supports are provided and the PASA is reimbursed for the service, to ensure the Client received services according to the service plan and standards of economy, efficiency and quality of service.

~~25~~27. STATE-SLS INDIVIDUAL SUPPORT PLAN means the written document that identifies an individual's need and specifies the State-SLS services being authorized, to assist a Client to remain safely in the community.

~~26~~28. STATE FISCAL YEAR means a 12-month period beginning on July 1 of each year and ending June 30 of the following calendar year. If a single calendar year follows the term, then it means the State Fiscal Year ending in the calendar year.

~~27~~29. Services and Supports or Supports and Services means one or more of the following: Education, training, independent or supported living assistance, therapies, identification of natural supports, and other activities provided to

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

~~28~~30. SUPPORT SERVICE means the service(s) established in the State SLS program that a CCB Case Manager may authorize to support an eligible Client to complete the identified tasks identified in the Client's Individualized Support Plan.

~~29~~31. WAIVER SERVICE means optional services and supports defined in the current federally approved HCBS waiver documents and do not include Medicaid State Plan benefits.

8.503 DEFINITIONS

Q. FISCAL MANAGEMENT SERVICE (FMS) means the entity contracted with the Department to complete employment related functions for CDASS attendants and track and report on individual Client allocations for CDASS.

~~R. FUNCTIONAL ELIGIBILITY means that the applicant meets the criteria for long-term services and supports as determined by the Department~~

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

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

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

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

~~W~~U. INSTITUTION means a hospital, nursing facility, or ICF-IID for which the Department makes Medicaid payments under the state plan.

~~X~~V. INTERMEDIATE CARE FACILITY FOR INDIVIDUALS WITH INTELLECTUAL DISABILITIES (ICF-IID) means a publicly or privately operated facility that provides health and habilitation services to a Client with developmental disabilities or related conditions.

~~Y~~W. LEGALLY RESPONSIBLE PERSON means the parent of a minor child, or the Client's spouse

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

~~AA~~Y. LICENSED MEDICAL PROFESSIONAL means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses: physician, physician assistant and nurse governed by the Colorado Medical License Act and the Colorado Nurse Practice Act.

~~BB~~Z. LEVEL OF CARE ELIGIBILITY means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

~~CC~~AA. LONG-TERM SERVICES AND SUPPORTS LEVEL OF CARE ELIGIBILITY DETERMINATION SCREEN (LOC SCREEN) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

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

II. PROFESSIONAL MEDICAL INFORMATION PAGE (PMIP) means the medical information form signed by a licensed medical professional used to verify the Applicant's or Client's need for institutional level of care ~~certify the Applicant's or Client's need for long-term care.~~

8.503.30 CLIENT ELIGIBILITY

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

4. Meet ICF-IID Level Of Care as determined by the ~~Functional Needs Assessment~~LOC Screen,

8.503.60 WAITING LIST PROTOCOL

A. When the HCBS-CES waiver reaches capacity for enrollment, a Client determined eligible for HCBS-CES waiver benefits shall be placed on a statewide waiting list in accordance with these rules and the Department's procedures.

3. The Case Management Agency shall complete the ~~Functional Needs Assessment~~LOC Screen, as defined in Department rules, to determine if the ~~Client's~~ Client meets Level of Care criteria.

4. The Case Management Agency shall complete the HCBS-CES waiver application with the participation of the Family. The completed application and a copy of the ~~Functional Needs Assessment~~LOC Screen that determines the Client meets the ICF-IID Level Of

Care shall be submitted to the Department or its agent within fourteen (14) calendar days of parent signature.

8.503.70 ENROLLMENT

A. When an opening becomes available for an initial enrollment to the HCBS-CES waiver it shall be authorized in the order of placement on the waiting list. Authorization shall include an initial enrollment date and the end date for the initial enrollment period.

1. The Case Management Agency shall complete the HCBS-CES waiver application and the ~~Functional Needs Assessment~~LOC Screen in the Family home with the participation of the Family. The completed application and a copy of the ~~Functional Needs Assessmen~~LOC Screen ~~t~~ shall be submitted to the Department or its agent within thirty (30) days of the authorized initial enrollment date.

   a. If it has been less than six (6) months since the review to determine waiting list eligibility by the URC and there has been no change in the Client's condition, the Case Management Agency shall complete the ~~Functional Needs~~LOC Screen and Assessment and the parent may submit a letter to the Case Management Agency in lieu of the HCBS-CES waiver application stating there has been no change.

   b. If there has been any change in the Client's condition the Case Management Agency shall complete a ~~Functional Needs~~LOC Screen and Assessment and the HCBS-CES waiver application which shall be submitted to the Department or its agent.

8.503.80 CLIENT RESPONSIBILITIES

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

1. Provide accurate information regarding the Client's ability to complete activities of daily living, daily and nightly routines and medical and behavioral conditions;

2. Cooperate with providers and Case Management Agency requirements for the HCBS-CES waiver enrollment process, ~~continued stay review~~Reassessment process and provision of services;

3. Cooperate with the local Department of Human Services in the determination of financial eligibility;

4. Complete the HCBS-CES waiver application with fifteen (15) calendar days of the authorized initial enrollment date as determined by the HCBS-CES waiver coordinator or in the event of a ~~continued stay review~~Reassessment, at least thirty (30) days prior to the end of the current certification period;

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

8.504.1 DEFINITIONS

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

H. Intake/Screening/Referral means the initial contact with individuals by the Single Entry Point 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~~n Aassessment of the individual seeking services.

I. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

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

K~~M~~. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

L~~J~~. Massage Therapy means the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.

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

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

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

~~L~~N. Prior Authorization Request (PAR) means the Department's prescribed form to authorize services.

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

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

QO. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' A~~a~~ssessment 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.

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

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

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

8.506.3 General Definitions

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

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

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

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

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

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

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

K~~I~~. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

L~~M~~ Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

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

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

O~~M~~. Professional Medical Information Page (PMIP)Client means the medical information form signed by a licensed medical professional used to verify the client of member's need for institutional level of care.~~certify Level of Care~~.

P~~N~~. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services'

Aassessment 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.

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

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

8.506.4 Benefits

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

8.506.4.B Case Management:

3. Initial Referral:

.

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

4. Continued Stay Review

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

8.506.6 Client Eligibility

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

2. ~~Functional Eligibility~~Level of Care Eligibility:

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

8.506.7 Waiting List

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

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

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

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

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

8.506.10 Prior Authorization Requests

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

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

2. The assigned start date on the ~~certification page of the Assessment~~Level of Care Eligibility Determination.

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

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

8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

8.508.20 DEFINITIONS

MM.. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

~~NN. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.~~MM. ~~Level of Care Determination: An eligibility determination by a CCB of an Individual for a Long-Term Services and Supports (LTSS) program.~~

~~NN. Level of Care Evaluation: A comprehensive evaluation with the Individual seeking services and others chosen by the Individual to participate, conducted by the case manager utilizing the Department's prescribed tool, with supporting diagnostic information from the Individual's medical providers, for the purpose of determining the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports (LTSS) programs.~~

~~OO~~NN. Licensed Child Care Center (less than 24 hours): As defined in Section 26-6-102 (5), C.R.S. and as described in 12 CCR 2509-8; Section 7.701.

~~PP~~OO. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Clients of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

PP. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen): a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

AAA. Professional Medical Information Page (PMIP): The medical information form signed by a Licensed Medical Professional used to verify the client or member's need for institutional level of care.~~certify Level of Care~~.

8.508.70 CASE MANAGEMENT FUNCTIONS

A. Case management services will be provided by a CMA as a Targeted Case Management service pursuant to sections 8.761.14 and 8.519 and will include:

1. Completion of a ~~Comprehensive~~n Assessment;

2. Completion of a Service Plan (SP);

3. Referral for services and related activities;

4. Monitoring and follow-up by the CMA including ensuring that the SP is implemented and adequately addresses the Client's needs.

5. Monitoring and follow-up actions, which shall

   a. Be performed when necessary to address health and safety and services in the SP;

   b. Services in the SP are adequate; and

   c. Necessary adjustments in the SP and service arrangements with providers are made if the needs of the Client have changed.

6. Face to face monitoring to be completed at least once per quarter and to include direct contact with the Client in a place where services are delivered. Upon Department approval, monitoring may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

8.508.121 REASSESSMENT AND REDETERMINATION OF ELIGIBILITY

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

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

8.509.12 SERVICES PROVIDED [Eff. 7/1/2012]

8.509.14 GENERAL DEFINITIONS

N. Intake/Screening/Referral shall be as defined at Section 8.390.1(M) and as the initial contact with Clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term care services; 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 Long-Term Services and Supports Level of Care Eligibility Determination Screen~~comprehensive long-term care Client assessment.~~

~~M~~L. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

~~M~~N. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.~~O. Level Of Care Screen shall be defined as an assessment conducted in accordance with Section 8.401.~~

~~P~~O. Non-Diversion shall be defined as a Client who was certified by the URC as meeting the level of care screen and target group for the HCBS-CMHS program, but who did not receive HCBS-CMHS services for some other reason.

~~Q~~P. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8.390-8.393 and 8.487 are met.

~~R~~Q. Reassessment shall be defined as a periodic revaluation according to the requirements at Section 8.509.32.C.

~~S~~R. Three Hundred Percent (300%) Eligible persons shall be defined as persons:

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

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

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for thirty (30) consecutive days.

8.509.15 ELIGIBLE PERSONS

c. A Client who is already an HCBS-CMHS recipient and who enters a nursing facility may not receive HCBS-CMHS services while in the nursing facility;

1) The case manager must terminate the Client from the HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ~~ULTC-100.2~~LOC Screen~~CREEN~~ for the nursing facility placement, as verified by telephoning the URC.

2) A Client receiving HCBS-CMHS services who enters a nursing facility for Respite Care as a service under the HCBS-CMHS program shall not be required to obtain a nursing facility ~~ULTC-100.2~~LOC Screen~~CREEN~~, and shall be continued as an HCBS-CMHS Client in order to receive the HCBS-CMHS service of Respite Care in a nursing facility.

8.509.16 START DATE

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

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B. Level of Care This date is determined by the official URC-assigned start date on the ~~ULTC-100.2~~LOC Screen~~SCREEN form~~.

8.509.30 CASE MANAGEMENT FUNCTIONS

8.509.31 NEW HCBS-CMHS CLIENTS

A. INTAKE/SCREENING/REFERRAL

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a Long-Term Services and Supports Level of Care Eligibility Determination Screen~~comprehensive uniform long-term care Client assessment~~ (~~ULTC-100.2~~LOC Screen~~CREEN~~), and shall explain the reasons for the decision on the Intake form. The Client shall be informed of the right to request an assessment if the Client disagrees with the case manager's decision.

4. If the case management agency staff has determined that a ~~comprehensive uniform long-term care client assessment (~~ULTC-100.2~~LOC Screen~~SCREEN)~~ is needed, or if the Client requests a LOC Screen~~n assessment~~, a case manager shall be assigned to schedule the assessment.

B. ASSESSMENT

1. The URC/SEP case manager shall complete the ~~Uniform Long-term Care Client Assessment Instrument (ULTC-100.2~~LOC Screen~~CREEN)~~ in accordance with Section 8.393.2, ASSESSMENT.

3. The URC/SEP case manager shall complete the following activities for a comprehensive client assessment:

j. Complete documentation on the ~~ULTC-100.2~~LOC SCREEN form.

k. To de-institutionalize a Client who is in a nursing facility under payment by Medicaid, and with a current ~~ULTC-100.2~~LOC SCREEN already certified by the

URC/SEP agency for the nursing facility level of ~~ULTC 100.2~~LOC SCREEN completion date is older than six (6) months, the URC/SEP case manager shall complete a new ~~ULTC 100.2~~LOC SCREEN and determine if the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-CMHS, the case manager must obtain a new ~~ULTC 100.2~~LOC SCREEN and the Client shall be treated as an applicant from the community rather than as a de-institutionalized Client.

8.509.32 ONGOING HCBS-CMHS CLIENTS

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS Clients shall be in accordance with Section 8.393.2. In addition, the case manager shall:

b. Review the ~~ULTC.100.2~~LOC Srceen, Assessment and the S~~ervice~~upport Plan with the client every six (6) months on a face-to-face basis. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

C. REASSESSMENT

2. The case manager shall complete the reassessment, utilizing the ~~Uniform Long-term Care Client Assessment Instrument (ULTC 100.2LOC~~ LOC Screen.

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

d. Ensure that all information needed from the medical provider for the URC level of care review is included on the ~~ULTC 100.2~~LOC Screen ~~form~~;

h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31(G). For Clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ~~ULTC 100.2~~LOC Screen. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the Client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Office of Administrative Courts to the Client; or (c) a copy of the notice of a scheduled court date.

Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be accepted as a substitute for the approved ~~ULTC 100.2~~LOC Screen. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

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

1. The case manager shall inform the income maintenance technician of any and all changes in the Client's participation in HCBS-CMHS and shall provide the technician with copies of the first page of all URC-approved ~~ULTC-100.2~~LOC SCREEN forms.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

H. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual Client's ~~functional eligibility~~Level of Care for one or more Home and Community-based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the Client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and periodic reassessment of Client needs.

R. Fiscal/Employer Agent (F/EA) provides FMS by performing payroll and administrative functions for Clients receiving CDASS benefits. The F/EA pays Attendants for CDASS services and maintains workers' compensation policies on the Client-employer's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both Client-employer and Attendant-employee Social Security and Medicare taxes.

~~S. Functional Eligibility means the physical and cognitive functioning criteria a Client must meet to qualify for a Medicaid waiver program, as determined by the Department's functional eligibility assessment tool.~~

~~T~~S. Home and Community-based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to Clients in community settings. These services are designed to help older persons and persons with disabilities to live in the community.

~~U~~T. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and Operations Vendor or the FMS, and which includes documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language.

~~V~~U. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

~~W~~V.. ~~Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.~~

~~V~~W.. Licensed Medical Professional means the primary care provider of the Client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN), as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

X. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

~~W~~Y. Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the Client.

~~X~~Z. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web site, Client account statements, Case Manager contact, or FMS vendor contact.

~~Y~~AA. Stable Health means a medically predictable progression or variation of disability or illness.

~~Z.~~BB. Training and Operations Vendor means the organization contracted by the Department to provide training and customer service for self-directed service delivery options to Clients, Authorized Representatives, and Case Managers.

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

8.504.1 DEFINITIONS

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

~~J~~L. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

~~KM~~. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument

L~~J~~. Massage Therapy means the physical manipulation of muscles to ease muscle contractures, spasms, extension, muscle relaxation and muscle tension.

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

1. Care Coordination includes development and implementation of a care plan, home visits for regular monitoring of the health and safety of the Client and central coordination of medical and psychological services. The Care Coordinator will organize the multifaceted array of services. This approach will enable the Client to receive all medically necessary care in the community with the goal of avoiding institutionalization in an acute care hospital. Additionally, a key function of the Care Coordinator will be to assume the majority of responsibility, otherwise placed on the parents, for condensing, organizing, and making accessible to providers, critical information that is related to care and necessary for effective medical management. The activities of the Care Coordinator will

allow for a seamless system of care. Care Coordination does not include utilization management, that is review and authorization of service requests, level of care determinations, and waiver enrollment, provided by the case manager at the Single Entry Point.

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

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

PM. Professional Medical Information Page (PMIP) Client means the medical information form signed by a licensed medical professional used to verify the client or member's need for institutional level of care. ~~verify the Client needs institutional Level of Care~~

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

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

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

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

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

8.506.3 General Definitions

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

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

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

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

~~L~~K. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

~~M~~L. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

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

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

~~M~~O. Professional Medical Information Page (PMIP)Client means the medical information form signed by a licensed medical professional used to verify the client or member's need for institutional level of care.~~certify Level of Care.~~

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

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

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

8.506.4.B Case Management:

3. Initial Referral:

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

8.506.6 Client Eligibility

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

2. ~~Functional Eligibility~~Level of Care Eligibility:

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

8.506.7 Waiting List

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

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

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

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8.508 CHILDREN'S HABILITATION RESIDENTIAL PROGRAM

8.508.20 DEFINITIONS

MM. Level of Care Determination: An eligibility determination by a CCB of an Individual for a Long-Term Services and Supports (LTSS) program.

~~NN. Level of Care Evaluation: A comprehensive evaluation with the Individual seeking services and others chosen by the Individual to participate, conducted by the case manager utilizing the Department's prescribed tool, with supporting diagnostic information from the Individual's medical providers, for the purpose of determining the Individual's level of functioning for admission or continued stay in Long-Term Services and Supports (LTSS) programs.~~

~~OO~~NN. Licensed Child Care Center (less than 24 hours): As defined in Section 26-6-102 (5), C.R.S. and as described in 12 CCR 2509-8; Section 7.701.

~~PP~~OO. Level of Care Eligibility ~~means~~ :an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

PP. Licensed Medical Professional: A physician, physician assistant, registered nurse, and advanced practice nurse. Long-Term Services and Supports (LTSS): The services and supports used by Clients of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

~~RR~~QQ. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen): ~~means~~ a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument

~~QQ~~RR. Medicaid Eligible: The Applicant or Client meets the criteria for Medicaid benefits based on the financial determination and disability determination.

~~RR~~SS. Medicaid State Plan: The federally approved document that specifies the eligibility groups that a state serves through its Medicaid program, the benefits that the state covers, and how the state addresses additional federal Medicaid statutory requirements concerning the operation of its Medicaid program.

~~SS~~TT. Medication Mis-Management: Issues with medication dosage, scheduling, timing, set-up, compliance and administration or monitoring which results in harm or an adverse effect which necessitates medical care.

~~TT~~UU. Missing Person: A waiver participant is not immediately found, their safety is at serious risk, or there is a risk to public safety.

~~UU~~VV. "Mistreated" or "Mistreatment": As defined at Section 25.5-10-202(29.5)(a)-(d) and 26.3.1-101.

~~VV~~WW. Natural Supports: Unpaid informal relationships that provide assistance and occur in the Client's everyday life such as, but not limited to, community supports and relationships with family members, friends, co-workers, neighbors and acquaintances.

~~WW~~XX. Other Serious Issues: Incidents that do not fall into one of the Critical Incident categories.

~~XX~~YY. Predictive Risk Factors: Known situations, events, and characteristics that indicate a greater or lesser likelihood of success of Crisis interventions.

~~YY~~ZZ. Prior Authorization: Approval for an item or service that is obtained in advance either from the Department, a state fiscal agent or the CMA.

~~ZZ~~AAA. Professional: Any person, not including family, performing an occupation that is regulated by the State of Colorado and requires state licensure and/or certification.

~~AAA.~~BBB Professional Medical Information Page (PMIP): The medical information form signed by a Licensed Medical Professional used to verify the client or member's need for institutional level of care. ~~certify Level of Care.~~

8.508.40 ELIGIBILITY

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

3. Meet ICF-IID Level of Care as determined by a Level of Care ~~Evaluation~~Screen.

8.508.60 RESPONSIBILITIES OF THE CCB

A. The CCB shall make eligibility determinations for developmental disabilities services to include the Level of Care ~~Evaluation~~Eligibility Determination for any Applicant or Client being considered for enrollment in the HCBS-CHRP waiver.

8.508.70 CASE MANAGEMENT FUNCTIONS

A. Case management services will be provided by a CMA as a Targeted Case Management service pursuant to sections 8.761.14 and 8.519 and will include:

1. Completion of a ~~Comprehensive Assessment;~~LOC Screen.

8.508.72 PRIOR AUTHORIZATION REQUESTS (PAR)

A. The case manager shall submit a PAR in compliance with applicable regulations and ensure requested services are:

1. Consistent with the Client's documented medical condition and ~~Comprehensive~~ Assessment.

8.508.121 REASSESSMENT AND REDETERMINATION OF ELIGIBILITY

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

B. The CMA shall conduct an ~~Comprehensive~~ Assessment to redetermine or confirm a Client's individual needs, at a minimum, every twelve (12) months.

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

8.508.190 APPEALS

I. The Client shall be notified, pursuant to section 8.057.2. when the following results in an Adverse Action that does not relate to waiver Client eligibility requirements:

1. A waiver service is reduced, terminated or denied because it is not a demonstrated need in the Level of Care ~~Evaluation and Determination~~Screen.

2. A Service Plan or waiver service exceeds the limits set forth in the federally approved waiver.

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

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

8.509.14 GENERAL DEFINITIONS

N. Intake/Screening/Referral shall be as defined at Section 8.390.1(M) and as the initial contact with Clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term care services; 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 long-term care Client assessment.~~an Assessment.

~~L.~~O Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

~~M~~P. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.~~O. Level Of Care Screen shall be defined as an assessment conducted in accordance with Section 8.401.~~

~~P~~Q. Non-Diversion shall be defined as a Client who was certified by the URC as meeting the level of care screen and target group for the HCBS-CMHS program, but who did not receive HCBS-CMHS services for some other reason.

~~Q~~R. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8.390-8.393 and 8.487 are met.

~~R~~S. Reassessment shall be defined as a periodic revaluation according to the requirements at Section 8.509.32.C.

~~S~~U~~T~~. Three Hundred Percent (300%) Eligible persons shall be defined as persons:

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

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

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program or are in a nursing facility or hospitalized for thirty (30) consecutive days.

8.509.15 ELIGIBLE PERSONS

A. HCBS-CMHS services shall be offered to persons who meet all of the eligibility requirements below:

2. Level of Care AND Target Group.

Clients who have been determined to meet the level of care AND target group criteria shall be certified by the Utilization Review Contractor (URC) as functionally eligible for HCBS-CMHS. The URC shall only certify HCBS-CMHS eligibility for those Clients:

a. Determined to meet the target group definition, defined as a person experiencing a severe and persistent mental health need that ~~requires assistance with one or more Activities of Daily Living (ADL);~~meets Level of Care Eligibility criteria.

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

4. Institutional Status

a. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-CMHS services while residing in such institutions.

b. A Client who is already an HCBS-CMHS recipient and who enters a hospital may not receive HCBS-CMHS services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the Client from the HCBS-CMHS program.

c. A Client who is already an HCBS-CMHS recipient and who enters a nursing facility may not receive HCBS-CMHS services while in the nursing facility;

1) The case manager must terminate the Client from the HCBS-CMHS program if Medicaid pays for all or part of the nursing facility care, or if there is a URC-certified ~~ULTC 100.2~~LOC Screen~~-~~ for the nursing facility placement, as verified by telephoning the URC.

2) A Client receiving HCBS-CMHS services who enters a nursing facility for Respite Care as a service under the HCBS-CMHS program shall not be required to obtain a nursing facility LOC Screen,~~-~~and shall be continued as an HCBS-CMHS Client in order to receive the HCBS-CMHS service of Respite Care in a nursing facility.

8.509.16 START DATE

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

B. Level of Care This date is determined by the official URC-assigned start date on the ~~ULTC 100.2~~LOC SCREEN form.

8.509.30 CASE MANAGEMENT FUNCTIONS

8.509.31 NEW HCBS-CMHS CLIENTS

A. INTAKE/SCREENING/REFERRAL

3. Based upon information gathered on the Intake form, the case manager shall determine the appropriateness of a referral for a ~~comprehensive uniform long-term care Client assessment (ULTC 100.2~~LOC Screen~~SCREEN)~~, and shall explain the reasons for the decision on the Intake form. The Client shall be informed of the right to request an assessment if the Client disagrees with the case manager's decision.

4. If the case management agency staff has determined that a ~~comprehensive uniform long-term care client assessment (ULTC-100.2~~LOC S~~creen~~CREEN~~)~~ is needed, or if the Client requests an ~~assessment~~LOC Screen, a case manager shall be assigned to schedule ~~the assessment~~it.

B. ASSESSMENT

1. The URC/SEP case manager shall complete the ~~Uniform Long-term Care Client Assessment Instrument (ULTC-100.2~~LOC S~~CREEN~~creen~~)~~ in accordance with Section 8.393.2~~, ASSESSMENT~~.

2. The URC/SEP case manager shall begin and complete the ~~assessment~~ LOC Screen within ten (10) days of notification of Client's need for A~~a~~ssessment.

3. The URC/SEP case manager shall complete the following activities: ~~for a comprehensive client assessment:~~

   a. Obtain all required information from the Client's medical provider including information required for target group determination;

   j. Complete documentation on the ~~ULTC-100.2~~LOC Screen in the Department prescribed IMS. ~~form~~.

   k. To de-institutionalize a Client who is in a nursing facility under payment by Medicaid, and with a current ~~ULTC-100.2~~LOC Screen already certified by the URC/SEP agency for the nursing facility level of ~~ULTC-100.2~~LOC ~~completion~~Screen completion date is older than six (6) months, the URC/SEP case manager shall complete a new ~~ULTC-100.2~~LOC Screen and determine if the client continues to meet the nursing facility level of care. The nursing facility staff shall notify the URC/SEP agency of the planned date of discharge and shall assign a new length of stay for HCBS if eligibility criteria are met. If a client leaves a nursing facility, and no one has notified the URC/SEP agency of the client's intent to apply for HCBS-CMHS, the case manager must obtain a new ~~ULTC-100.2~~LOC Screen and the Client shall be treated as an applicant from the community rather than as a de-institutionalized Client.

   l. It is the URC/SEP case manager's responsibility to assess the behaviors of the Client and assure that community placement is appropriate.

A. COORDINATION, MONITORING AND EVALUATION OF SERVICES

1. The coordination, monitoring, and evaluation of services for HCBS-CMHS Clients shall be in accordance with Section 8.393.2. In addition, the case manager shall:

b. Review the ~~ULTC.100.2~~LOC Screen and the Service Plan with the client every six (6) months on a face-to-face basis. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or Client (e.g. natural disaster, pandemic, etc.).

C. REASSESSMENT

2. The case manager shall complete the reassessment, utilizing the ~~Uniform Long-term Care Client Assessment Instrument (ULTC 100.~~2LOC S~~CREEN~~creen~~)~~.

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

d. Ensure that all information needed from the medical provider for the URC level of care review is included on the ~~ULTC 100.2~~LOC SCREEN ~~form~~;

h. Submit a continued stay review PAR, in accordance with requirements at Section 8.509.31(G). For Clients who have been denied by the URC at continued stay review, and are eligible for services during the appeal, written documentation that an appeal is in progress may be used as a substitute for the approved ~~ULTC 100.2~~LOC SCREEN. Acceptable documentation of an appeal include: (a) a copy of the request for reconsideration, or the request for appeal, signed by the Client and sent to the URC or to the Office of Administrative Courts; (b) a copy of the notice of a scheduled hearing, sent by the URC or the Office of Administrative Courts to the Client; or (c) a copy of the notice of a scheduled court date.

Copies of denial letters, and written statements from case managers, are not acceptable documentation that an appeal was actually filed, and shall not be accepted as a substitute for the approved ~~ULTC 100.2~~LOC SCREEN. The length of the PAR on appeal cases may be up to one year, with the PAR being revised to the correct dates of eligibility at the time the appeal is resolved.

8.509.33 OTHER CASE MANAGEMENT REQUIREMENTS

A. COMMUNICATION

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

1. The case manager shall inform the income maintenance technician of any and all changes in the Client's participation in HCBS-CMHS and shall provide the technician with copies of the first page of all URC-approved ~~ULTC 100.2~~LOC Screen~~SCREEN forms~~.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

H. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual Client's ~~functional eligibility~~Level of Care for one or more Home and Community-based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the Client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and periodic reassessment of Client needs.

~~S. Functional Eligibility means the physical and cognitive functioning criteria a Client must meet to qualify for a Medicaid waiver program, as determined by the Department's functional eligibility assessment tool.~~

S~~T~~. Home and Community-based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to Clients in community settings. These services are designed to help older persons and persons with disabilities to live in the community.

~~U~~T. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and Operations Vendor or the FMS, and which includes documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language.

~~V~~U. Licensed Medical Professional means the primary care provider of the Client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN), as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

~~W.~~V.Prior Authorization Request (PAR) means the Department-prescribed process used to authorize HCBS waiver services before they are provided to the Client.

~~X~~W. Notification means a communication from the Department or its designee with information about CDASS. Notification methods include but are not limited to announcements via the Department's CDASS web site, Client account statements, Case Manager contact, or FMS vendor contact.

~~Y~~X. Stable Health means a medically predictable progression or variation of disability or illness.

~~Z~~Y. Training and Operations Vendor means the organization contracted by the Department to provide training and customer service for self-directed service delivery options to Clients, Authorized Representatives, and Case Managers.

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8.516.70 RESPITE CARE

D. CERTIFICATION STANDARDS AND PROCEDURES

1. Respite care standards and procedures for nursing facilities are as follows:

D. An admission to a nursing facility under HCBS-BI respite does not require a new ~~ULTC-100.2~~LOC SCREEN, a PASARR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

F. The nursing facility should obtain a copy of the ~~ULTC-100.2~~LOC SCREEN and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite Client's entry into the facility.

8.517.5 CLIENT ELIGIBILITY

8.517.5.A. ELIGIBLE PERSONS

Home and Community-based Services for ~~Persons with Spinal Cord Injury (HCBS-SCI)~~ Complementary and Integrative Health (HCBS-CIH) waiver services shall be offered only to individuals who meet all of the following eligibility requirements:

1. Individuals shall be aged 18 years or older.

2. Individuals shall have a ~~diagnosis~~ qualifying condition of a s~~S~~pinal c~~C~~ord i~~I~~njury (traumatic or nontraumatic), multiple sclerosis, a brain injury, spina bifida, muscular dystrophy, or cerebral palsy with the inability for independent ambulation directly resulting from one of these conditions as defined by broad diagnoses related to each condition within the most current version of the International Classification of Diseases (ICD) at the time of assessment). This diagnosis must ~~be outlined in 8.517.2.1 and~~ be documented on the individual's Professional Medical Information Page (PMIP) and in the ~~Uniform Long-term Care 100.2 (ULTC 100.2~~LOC Screen~~CREEN) assessment tool~~.

3. Individuals ~~shall have been determined to have a significant functional impairment as evidenced by a comprehensive functional assessment using~~ must have been determined to have an inability for independent ambulation resulting from the qualifying condition as identified by the case manager through the the ~~ULTC 100.2~~LOC Screen. ~~assessment tool that results in at least the minimum scores required per Section 8.401.1.15.~~ The inability for independent ambulation in the HCBS-CIH waiver means:

a. The individual does not walk, and requires use of a wheelchair or scooter in all settings, whether or not they can operate the wheelchair or scooter safely, on their own, OR;

b. The individual does walk, but requires use of a walker or cane in all settings, whether or not they can use the walker or cane safely, on their own, OR;

c. The individual does walk, but requires "touch" or "stand-by" assistance to ambulate safely in all settings.

8.517.6 WAITING LIST

9. Within ten business days of notification from the Department that an opening for the HCBS-SCI waiver is available the Case Management Agency shall:

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

b. Update the existing ~~functional level of care~~LOC ~~assessment~~ Screen in the official Client record if less than six months has elapsed since the date of the previous LOC Screen~~assessment~~.

8.517.9 PRIOR AUTHORIZATION OF SERVICES

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

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

8.517.9.G. Services requested on the PAR shall be supported by information on the Long-Tterm Care Service Plan, the ~~ULTC-100.2~~LOC Screen~~CREEN~~, and written documentation from the income maintenance technician of the Client's current monthly income.

8.519 Case Management

8.519.1 Definitions

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

B. Agency Applicant means an entity seeking approval to be a provider of case management services for Home and Community-Based Services.

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

D. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 care, service needs, available resources, and potential funding resources using Department prescribed instruments.

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

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

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

~~G~~H. Case Management means the assessment of an individual's needs receiving long-term services and supports, the development and implementation of a support plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of services effectiveness, and the periodic reassessment of such individual's needs.

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

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

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

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

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

~~M. Comprehensive Assessment means an initial assessment or periodic reassessment of individual needs to determine the need for any medical, educational, social or other services and completed annually or when the Client experiences significant change in need or in level of support.~~

Z. Information Management System (IMS) means an automated data management system ~~approved~~ prescribed 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.

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

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

~~CC. Level of Care Determination means determining eligibility of an individual for a Long-Term Services and Supports (LTSS) program and determined by a Community Centered Board or Single Entry Point Agency.~~

~~DD. Level of Care Evaluation means a comprehensive evaluation with the individual seeking services and others chosen by the individual to participate and an evaluation by the Case Manager utilizing the Department prescribed tool, with supporting diagnostic information from the Client's medical provider, and to determine the Client's level of functioning for admission or continued stay in certain Long-Term Services and Supports (LTSS) programs.~~

CC. Level of Care Eligibility means an individual meets the level of care criteria for Long-Term Service and Supports (LTSS) programs, as determined by the Department.

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

EE. Long-Term Services and Supports Level of Care Eligibility Determination Screen (LOC Screen) means a comprehensive evaluation with the individual seeking services and appropriate collaterals (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 a Department prescribed assessment instrument.

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

KK. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to verify the client or member's need for institutional level of care.~~certify Level of Care~~.

8.519.22 Notice and Appeal Rights

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

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

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

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

8.550.6.B. Special Requirements

2. Nursing facility placement for a Client who has Medicaid and has Elected Hospice Services in a nursing facility does not require a ~~ULTC 100.2~~LOC Screen.