COLORADO
Department of Health Care Policy & Financing

OPERATIONAL MEMO

Title: Intake Referral and Enrollment Processes for Case Management Agencies	**Topic:** Intake Referral and Enrollment
Audience: Case Management Agencies (CMAs)	**Sub-Topic:** Case Management
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Purpose and Audience:

The purpose of this Operational Memo is to provide temporary administrative relief, policy and operational guidance to Case Management Agencies (CMAs) regarding timely and quality case management services related to intake referral and enrollment processes.

Definitions

Attestation Form: The medical attestation forms signed by a treating Licensed Medical Professional used to verify the level of care required for enrollment in Home and Community-Based Services (HCBS) Children's Habilitation Residential Program (CHRP)(Serious Emotional Disturbance only) and HCBS-Children with Life Limiting Illness (CLLI) (HCBS-Children with Complex Health Needs (CwCHN) beginning July 1, 2025).

Colorado Intake Screen Tool (CIST): Intake screening tool used to verify the individual's demographic information and determine the appropriateness of a Long-Term Services and Supports (LTSS) Level of Care (LOC) Eligibility Determination Assessment.

HCBS Start Date: Date authorizing the start of HCBS once the individual has met functional, Targeting Criteria, and financial eligibility requirements.

Intake Referral: Any communication modality used by an individual, or their representative, including but not limited to community members, advocates, and interested parties, to initiate a request to a CMA to conduct a LOC Screen required to determine functional level of care eligibility for LTSS including the HCBS program.

LOC Certification Dates: Dates used to identify the length of time an individual is eligible for LTSS, including HCBS.

LOC Eligibility Determination: Electronic transaction between the Care and Case Management (CCM) system and Colorado Benefits Management System (CBMS), via the PEAK*Pro* interface, indicating the LOC Eligibility Determination.

LOC Screen[1]: A comprehensive evaluation with the individual seeking services and appropriate support persons (such as family members, friends, and or caregivers) to determine an individual's eligibility for LTSS based on their need for institutional level of care.

Licensed Medical Professional: The primary care provider of the individual, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA), and Advanced Practicing Nurse (APN). License Medical Professional practices shall adhere to the Colorado Medical Practice Act or the Colorado Nurse Practice Act, as applicable to the professional licensure category.

LTSS LOC Referral Form: The Department of Health Care, Policy, and Financing (HCPF)-issued form used by hospitals and nursing facilities (NFs) to make a referral for an LOC Screen.

Nursing Facility Length of Stay (NFLOS) Form: Form used during initial and reassessment LOC Screens to determine the length of stay for individuals residing in NFs.

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[1] The current tool used to conduct the LOC Screen is the ULTC 100.2 Assessment.

Participant Directed Services Start Date: Date authorizing the start of participant directed services.

Payer Source Change: Referral received from a NF indicating a resident requires a change to their pay source from Medicare or private insurance to Medicaid.

Professional Medical Information Page (PMIP): The medical information form signed by a treating Licensed Medical Professional[2] used to verify level of care.

Information:

Over the past year, the LTSS system has been impacted by several challenges at the same time, including:

- Increased workload due to the end of the Public Health Emergency (PHE),
- The implementation of IT system changes that have resulted in additional workload for Case Managers, and
- Unanticipated complications with the transition of Members to CMAs to achieve conflict-free case management.

The impact of all three occurring at once, which was not intended, caused short-term challenges to Member eligibility, Provider reimbursement, CMA processing, and Member service response time.

HCPF's top priority is ensuring ongoing coverage for LTSS Members while mitigating payment delays for LTSS Providers so Members can access needed services. To support CMAs in performing case management activities, HCPF is providing the following written guidance to Case Managers establishing temporary timeline requirements that balance the need for the Colorado Case Management ecosystem to stabilize while ensuring Members receive timely access to services. Temporary changes will be in effect until December 31, 2025.

Action To Be Taken:

<u>Intake Referral Activities and LOC Screen Timelines</u>

Effective April 1, 2025, CMAs shall begin implementing the following Intake Referral Activities, LOC Screen Timelines, and additional operational guidance until this memo

[2] During this stabilization period, Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) may sign the PMIP.

has been superseded. Case Managers shall schedule, conduct, and complete documentation for LOC Screens, including Pre-Admission Screening and Resident Reviews (PASRRs), if applicable, based on the timelines below. In addition, CMAs shall have a written policy and procedure for expediting referrals in the event an individual is in an emergency situation as required by contract and §8.7202.B.7. Please note, the one (1) business day to conduct and document the CIST allows for additional time outside of conducting and documenting the LOC Screen, which is a temporary change from previous direction. All timelines below are subject to the individual or family's availability and the referral having accurate and complete information.

LOC Type	Temporary Referral Timeline	Temporary Assessment Timeline	Temporary Documentation Timeline
Community to HCBS or PACE	One (1) business day to conduct and document the Intake Referral, to include the CIST, once the individual has been contacted.	Conducts the LOC Screen within 10 business days of receiving the completed and signed PMIP.	Documents the LOC Screen and generates the electronic LOC Eligibility Determination within five (5) business days of the LOC Screen held date.
Hospital to HCBS or PACE	One (1) business day to conduct and document the Intake Referral, to include the CIST, once the individual has been contacted. If referred using the LTSS LOC Referral Form, no PMIP or CIST is required. The CMA shall manually generate a Referral Card in the CCM system.	Conducts the LOC Screen within two (2) business days of receiving the completed and signed LTSS LOC Referral Form or PMIP.	Documents the LOC Screen and generates the electronic LOC Eligibility Determination within two (2) business days of the LOC Screen held date.
NF to HCBS or PACE	One (1) business day to conduct and document the Intake Referral, to include the CIST, once the	Conducts the LOC Screen within five (5) business days of receiving the completed and	Documents the LOC Screen and generates the LOC Eligibility Determination within five (5) business days

	individual has been contacted. If referred using the LTSS LOC Referral Form, no PMIP or CIST is required. The CMA shall manually generate a Referral Card in the CCM system.	signed LTSS LOC Referral Form or PMIP.	of the LOC Screen held date.
Adult or Child Waiver to Different Waiver	NA	Conducts the LOC Screen within 10 business days of receiving the completed and signed PMIP.	Documents the LOC Screen and generates the electronic LOC Eligibility Determination within five (5) business days of the LOC Screen held date.
Youth Transition	NA	Conducts the LOC Screen within 10 business days of receiving the completed and signed PMIP. May be conducted up to six (6) months in advance.	Documents the LOC Screen and generates the electronic LOC Eligibility Determination within five (5) business days of the LOC Screen held date.
Hospital to NF	One (1) business day to conduct and document the Intake Referral, to include the CIST, once the individual has been contacted. If referred using the LTSS LOC Referral Form, no PMIP or CIST is required. The CMA shall manually generate a Referral Card in the CCM system.	Conducts the LOC Screen and PASRR Level I within two (2) business days of receiving the completed and signed LTSS LOC Referral Form or PMIP.	Documents the LOC Screen, PASRR Level I, NFLOS Form, and generates the electronic LOC Eligibility Determination within two (2) business days of the LOC Screen held date.

Community/ HCBS to NF	One (1) business day to conduct and document the Intake Referral, to include the CIST, once the individual has been contacted. If referred using the LTSS LOC Referral Form, no PMIP or CIST is required. The CMA shall manually generate a Referral Card in the CCM system.	Conducts the LOC Screen and PASRR Level I within 10 business days of receiving the completed and signed LTSS LOC Referral Form or PMIP.	Documents the LOC Screen, PASRR Level I, NFLOS Form, and generates the electronic LOC Eligibility Determination within five (5) business days of the LOC Screen held date.
NF to NF	The CMA shall manually generate a Referral Card in the CCM system.	Updates the LOC Screen Additional Program Information with the new NF and Date of Admission within five (5) business days of the notification date.	Updates the old NF's Care Provider Card with the End/Discharge Date and adds a new Care Provider Card with the new NF's information, including the Start/Admit Date, within five (5) business days of the notification date.
NF Payer Source Change	One (1) business day to conduct and document the Intake Referral, to include the CIST, once the individual has been contacted. If referred using the LTSS LOC Referral Form, no PMIP or CIST is required. The CMA shall manually generate a Referral	Conducts the LOC Screen within five (5) business days of receiving the completed and signed LTSS LOC Referral Form or PMIP.	Documents the LOC Screen, PASRR Level I, NFLOS Form, and generates the electronic LOC Eligibility Determination within five (5) business days of the LOC Screen held date.

	Card in the CCM system.		
Hospital or NF to Hospital Back-Up (HBU)	One (1) business day to conduct and document the Intake Referral, to include the CIST, once the individual has been contacted. If referred using the LTSS LOC Referral Form (from a hospital or NF), no PMIP or CIST is required. The CMA shall manually generate a Referral Card in the CCM.	Conducts the LOC Screen within the required two (2) or five (5) business day timeline based on the individual's location at the time of referral, upon receipt of the completed and signed LTSS LOC Referral Form or PMIP.	Documents the LOC Screen and generates the electronic LOC Eligibility Determination within two (2) or five (5) business days, based on the individual's location at the time of referral, of the LOC Screen held date.
Case Managers shall have made and documented in the CCM system at least three (3) attempts on different days, at different times, and different communication modalities, if available, to contact the individual. If no contact is made within 15 business days, the Case Manager shall close the referral[3].			

Case Managers shall document all activities and upload supporting documentation within the CCM system. If the CMA does not have access to the individual in the CCM system, or lacks sufficient information to create a record, they can document this in the record once access has been granted, including documentation of the cause for any delay.

If a referral is received for an individual not seeking LTSS services, the CMA shall:

- Manually generate a Referral Card in the CCM system,
- Ensure the Referral Date is the date the referral was received by the CMA,
- Label the referral as *Information and Referral Only-No Assessment*,
- Note the individual is not interested in LTSS in the *Additional Comments* section,
- Generate any outbound referrals, if applicable,
- Enter the Referral Closed Date, then

[3] Case Managers can refer to the Referrals Section Job Aid for system guidance.

- Close the referral.

Regardless of the potential program or services the individual chooses, LOC Screen timelines are based on where the individual is at the time of referral; two (2) business days for those in a hospital, five (5) business days for those in a NF, and 10 business days for those in the community, including PACE. The start of the assessment timeline is no longer based on receipt of the referral, but on the following:

- Upon receipt of the completed and signed LTSS LOC Referral Form,
- Upon completion (conducted and documented) of the CIST, or
- Upon receipt of the completed and signed PMIP[4].

A LOC Screen shall be conducted at an individual's request regardless of whether or not one is indicated by the CIST.

A PMIP is required for all initial enrollments and are used to verify the individual meets level of care and targeting criteria. In order for a PMIP to be valid it must contain the names of the individual's diagnoses and medications; both the PMIP and the applicable attestation form must be signed by a treating Licensed Medical Professional[5].

The new LTSS LOC Referral Form for hospitals and NFs has been developed. When this form is used by hospitals and NFs for referrals and all items are completed and the form is signed by the treating Licensed Medical Professional, it replaces the need for the PMIP and CIST.

Case Managers shall determine if individuals meet the definition of Intellectual and/or Developmental Delay or Disability (IDD) within 30 calendar days of the receipt of all necessary information.

- Case Managers shall facilitate the IDD Determination process, to include but not limited to providing information, resources, and support to individuals to obtain additional needed testing and/or assessments.
- Case Managers shall utilize information from the LTSS LOC Referral Form or CIST to reasonably determine if an LOC Screen for non-IDD services and

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[4] During this stabilization period, Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) may sign the PMIP.

[5] During this stabilization period, Registered Nurses (RNs) and Licensed Practical Nurses (LPNs) may sign the PMIP.

supports should be pursued concurrently with the IDD Determination and discuss the below options with the individual informing them if the LOC Screen is delayed that this will also delay the submission for LTC Medicaid (financial eligibility).

- If an individual chooses to pursue non-IDD services and supports while seeking an IDD Determination, the Case Manager shall conduct and document the LOC Screen within the timelines outlined in this memo regardless of the IDD Determination status and concurrently with the IDD Determination.
  - If the individual is eligible and enrolls in a non-IDD program, is later determined to have an IDD, and wished to enroll in an IDD program at that time, the Case Manager shall follow the Adult or Child Waiver to Different Waiver Temporary Timelines outlined above.
- If an individual chooses not to pursue non-IDD services and supports for which they may be eligible, while seeking an IDD Determination, the Case Manager shall:
  - Document this in the individual's record in the CCM system,
  - Conduct the LOC Screen within the required two (2), five (5), or 10 business day timeline based on the individual's location at the time of referral, upon receipt of the individual being determined to have an IDD, and
  - Document the LOC Screen and generate the electronic LOC Eligibility Determination within two (2) or five (5) business days based on the individual's location at the time of referral.

The CMA shall only distribute the LOC Screen Certification to the individual's Medicaid eligibility site as part of the eligibility determination process, NFs, and PACE Organizations. The LOC Screen in its entirety may be shared with the individual and/or their Guardian or Legally Authorized Representative, if applicable, upon their request; CMAs are not required to distribute the LOC Screen on behalf of the Member and/or their Guardian or Legally Authorized Representative, if applicable[6].

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[6] The LOC Screen (UTLC 100.2) is not considered part of the Person-Centered Support Plan (PCSP), it is the assessment that determines functional level of care and is not required to be distributed. The PCSP is regulatorily required to be distributed to the Member, their Guardian, if applicable, and Provider(s). Since the LOC Screen is not part of the PCSP it is not required to be distributed and HCPF has historically and continues to provide guidance that it should not be distributed to the MIT as it is not a person-centered document as it is deficit-based rather than skill-based. However, the LOC Screen is part of the Member Record, and any part of the Member Record may be distributed to whomever the Member authorizes through a signed release of information.

LOC Certification Periods

The LOC Certification Start Date shall be the latter of the:

- LTSS LOC Referral Form signature date,
- PMIP signature date, or
- LOC Screen held date.

LOC Certification Periods shall not exceed 12 months and Certification End Dates shall be the last calendar day of the month prior to the twelfth month from the LOC Screen Assessment Date[7], unless otherwise indicated below. Case Managers shall authorize LOC Certification Periods based on the program in which the Member is enrolled and the LOC Screen held date as outlined below:

- HCBS -12 Months
  - May be less that 12 months for Youth Transitions.
- NF - Less than 12 Months, 12 Months, or Indefinite (§8.402.10.15)
  - Indefinite lengths of stay shall be approved by the Case Manager Supervisor.
- PACE - 12 Months or Indefinite
  - Indefinite LOC Certification Periods for PACE shall only occur for LOC Screen Reassessments (§8.497.11.F(2)).
- Intermediate Care Facility for Individuals with Developmental Disabilities (ICF/IDD) - Indefinite
  - ICF/IDD LOC Certification Periods do not require a LOC Screen Reassessment.
- HBU – 90 Days

Case Managers shall conduct and document a new LOC Screen to determine specific waiver target criteria eligibility when Members request to change from one HCBS waiver to another during an established Certification Period[8]. The LOC Certification Period for the new waiver shall be 12 months with the exception of Youth Transitions.

NF Start Dates

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[7] Example: LOC Screen Held Date 1/23/25 = Certification End Date 12/31/25.

[8] Case Managers shall refer to the Waiver to Waiver Job Aid.

Case Managers shall authorize NF Start Dates as outlined in §8.402.10.18. The first date in which a NF shall be authorized is the latter of the following:

- Functional level of care eligibility,
- Financial eligibility, or
- Hospital discharge date, if applicable.

Case Managers shall use the LTSS LOC Referral Form Referral Date or PMIP signature date as the NF Start Date when the above requirements were met as of the same date or an earlier date.

HCBS Support Planning Timelines, Start Dates, and Prior Authorization

Case Managers shall develop the PCSP[9] after the LOC Screen Certification has been submitted to PEAKPro, after financial eligibility approval has subsequently been confirmed, and as outlined in §8.7202.J. Case Managers shall schedule and facilitate, the PCSP with the Member and their Member Identified Team (MIT) at the date, time, and location[10] preferred by the Member within fifteen (15) business days of program financial eligibility approval[11].

Case Managers shall discuss participant directed service delivery options In-Home Support Services (IHSS) or Consumer Directed Attendant Support Services (CDASS)) with Members during the PCSP meeting, as applicable. If a Member opts to enroll into a participant directed service delivery option, Case Managers shall authorize appropriate non-CDASS/IHSS HCBS services during the enrollment process whenever possible.

The first date in which Case Managers shall authorize HCBS Service Start Dates and Prior Authorization Requests (PARs) shall be latter of the following:

- LOC Screen Certification Start Date,
- Financial eligibility approval date,

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[9] The PCSP is utilized for HCBS only and it not intended for use by the PACE, HBU, SNF, or ICF/IDD programs.

[10] The PCSP is not required to be conducted in person.

[11] Program eligibility approval includes functional and financial approval. Functional approval includes meeting target criteria for the program selected (including Developmental Disability or Delay Determination approval, if applicable).

- The PCSP Member or Guardian or Legally Authorized Representative, if applicable, signature date agreeing to services[12], or
- Hospital discharge date, if applicable.

Case Managers shall use the LTSS LOC Referral Form Referral Date as the Alternative Care Facility (ACF) Start Date so long as the above requirements were met as of the same date or an earlier date.

Case Managers shall document the PCSP and submit HCBS PARs within 10 business-days of the PCSP held date and ensure all Providers are Medicaid-enrolled and certified by the Colorado Department of Public Health and Environment (CDPHE). HCBS PARs shall:

- Be consistent with the Member's documented medical condition and assessed needs,
- Provide adequate detail regarding frequency, scope, and duration to meet the Member's needs within the guidelines set forth in the current federally approved waiver, and
- Not be duplicative of any other service the Member receives including, but not limited to services provided through:
    - Medicaid state plan benefits,
    - Third-party resources,
    - Natural supports,
    - Charitable organizations, and/or
    - Other public assistance programs.

Case Managers shall authorize CDASS Start Dates as outlined in §8.7515.L and stated below:

- Physician Attestation of Consumer Capacity is completed,
- Client/Authorized Representative (AR) Responsibilities form is completed,
- Task Worksheet is completed,
- Member and AR training is completed,
- Attendant Support Management Plan (ASMP) is completed and approved,
- "Good to Go" date is established by the Financial Management System (FMS) vendor

[12] Case Managers shall not use the Intake Form signature date as currently indicated in 10 CCR 2505-10 §8.7202.CC.3(c).

- Appropriate Utilization Review/Utilization Management approval is received, and
- Any duplicative Homemaker, Personal Care, and/or Home Health services are discontinued.

Case Managers shall authorize IHSS Start Dates §8.7528.I.9 and stated below:

- Physician Attestation of Consumer Capacity Form is completed,
- IHSS Care Plan Calculator from the Case Manager and IHSS Care Plan from the IHSS Agency has been completed,
- Attendant and/or AR training is complete,
- Appropriate Utilization Review/Utilization Management approval is received,
- Any duplicative Homemaker, Personal Care, or Home Health services are discontinued,
- Intake Assessment by the IHSS Agency is complete, and
- IHSS Shared Responsibilities Plan is received and complete (for Members requiring an AR, the Shared Responsibilities Form must include the designation and attestation of an AR).

Case Managers shall distribute[13] the following within 15 business days of the PCSP held date for Members receiving HCBS Wavier services(§8.7202.J.3(b)):

- CCM Service Plan[14],
- Pages 3-8 of the Service Plan PDF[15],
- PAR,
- Completed Service Plan Signature Page,
- CDASS Monthly Allocation and Task Worksheet, if applicable,
- IHSS Care Plan Calculator, if applicable, and
- Rights Modification, if applicable.

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[13] Case Managers shall document the distribution of the PCSP and PAR in the Member's record in the CCM system.

[14] The CCM Service Plan Printout can be found in *Page Resources* using the *Merge and Send* function.

[15] Case Managers shall include the Member's personal goal(s) in the Service Plan PDF if they are not in the approved PAR.

Services delivered without prior authorization shall not be reimbursed except for provision of services during an emergency as outlined in §8.058.4.

CMAs are responsible for payment liability as outlined in §8.7202.Z.3; failure to prepare the PCSP and PAR or failure to submit these forms in accordance with HCPF policies and procedures shall result in the reversal and recovery of reimbursement for services authorized retroactive to the first date of service. The CMA and/or Providers may not seek reimbursement for these services from the Member. If the CMA causes an HCBS Member to have a break in payment authorization, the CMA shall ensure that all services continue and shall be solely financially responsible for any losses incurred by Providers until payment authorization is reinstated.

Revisions

Case Managers shall submit a revised PAR if a change in the PCSP results in a change to services[16] or at the Member and/or their Guardian's, if applicable, request. Case Managers shall complete a revision to the PAR within 10 business days of receiving all necessary information to include:

- Provider,
- Service,
- Requested Start Date,
- Frequency, and
- Duration.

Revised PARs shall not be authorized past the end date of the LOC Certification as outlined in §8.7202.CC.7.

If a revision includes discontinuation with a Provider, the Case Manager shall provide a Formal Discontinuation Notice for Providers to the Provider as soon as possible prior to the service discontinuation date. Case Managers shall upload a copy of the notice in the Member record in the CCM system.

Case Managers shall provide a copy of the PAR to affected Providers within five (5) business days of approval.

LOC Screen Reassessments (Continued Stay Reviews)

[16] This includes the Supported Living Program within HCBS-BI regardless of the dollar amount.

LOC Screen Reassessments are required for the HCBS, NF, PACE, HBU, and ICF/IDD programs.

Case Managers shall conduct and document HCBS LOC Screen Reassessments at least one (1) but no more than three (3) months before the LOC Certification End Date (§8.7202.F). Case Managers shall document the LOC Screen and generate the LOC Eligibility Determination within 10 business days of the held date. If a CMA fails to conduct the LOC Screen Reassessment for a Member enrolled in HCBS prior to the current LOC Certification End Date causing a break in payment authorization, the CMA shall ensure services continue and shall be solely responsible for any losses incurred by Provider Agencies until payment authorization is reinstated (§8.7202.Z.3(b)).

NFs, PACE Organizations, HBU and ICF/IDD Providers shall notify the CMA at least one (1) but no more than three (3) months before the current LOC Certification Period End Date (§8.7202.F). The completed PMIP must be received at least 90 calendar days prior to the Certification End Date for NF, PACE, HBU, and ICF/IDD. CMAs shall not be accountable for a lapse in eligibility for Members enrolled in the NF, PACE, HBU, or ICF/IDD program due to a Provider not notifying the CMA or submitting PMIP to the CMA within the required timeline.

Member Records

CMAs shall have a record retention and document management policy and procedure that outlines how records and documentation can be requested and how their agency ensures Federal and State HIPAA and privacy laws as outlined in §8.7201.H-I.

Case Managers shall provide individuals information regarding their right to request and receive their records.

The CMA shall provide a Member and/or their Guardian any information contained in their record upon request. The CMA shall provide a Member's Legally Authorized Representative with information contained in the Member's record that are within the scope of their authority.

Case Managers shall enter all case management activities in the CCM system regardless of any alternative documentation system or note templates used by the CMA and are required to upload supplemental documents into Members' CCM record, when applicable.

HCBS Provider Agencies are required to conduct interviews and assessments to create service plans and plans of care that identifies a Member's preference, goals, and support needs.

CMAs are not required to regularly obtain records from an HCBS Provider Agency such as assessments, protocols, or other provider documentation used by CDPHE to conduct licensing and compliance surveys. At HCPF's discretion, CMAs may be required to obtain additional documentation to complete a review of a Member's health, safety, and welfare.

Attachment(s):

None

Links

Formal Discontinuation Notice for Providers[17]

LTSS LOC Referral Form

HCPF Contact:

HCPF_HCBS_CaseManagement@state.co.us

[17] Hover over text field for tool tips.