DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules concerning the Children's Home and Community Based Services (CHCBS) and Children with Life Limiting Illnesses (CLLI) waivers.
Rule Number: MSB 17-06-22-B
Division / Contact / Phone: Office of Community Living, Long Term Services and Supports Division / Dennis Roy / 303-866-4828

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 17-06-22-B, Revision to the Medical Assistance Rules concerning the Children's Home and Community Based Services (CHCBS) and Children with Life Limiting Illnesses (CLLI) waivers.

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.504 and 8.506, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.504 with the proposed text beginning at 8.504 through the end of 8.504. Replace the current text at 8.506 with the proposed text beginning at 8.506 through the end of 8.506. This rule is effective October 30, 2017.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rules concerning the Children's Home and Community Based Services (CHCBS) and Children with Life Limiting Illnesses (CLLI) waivers.
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STATEMENT OF BASIS AND PURPOSE

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

   The proposed rule changes are to correct grammatical and technical errors identified as a part of the 2016 Rule Efficiency Review process. Additionally, the proposed changes align the definitions of the CHCBS and CLLI waivers with the definitions in the Single Entry Point rules at 8.393

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. §1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015); 25.5-6-313(1), C.R.S.(2016)

Initial Review **08/11/17** Final Adoption **09/08/17**
Proposed Effective Date **10/30/17** Emergency Adoption

DOCUMENT #07

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Title of Rule: Revision to the Medical Assistance Rules concerning the Children's Home and Community Based Services (CHCBS) and Children with Life Limiting Illnesses (CLLI) waivers.
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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.

   Children, and their family members, who are at risk of placement in a skilled nursing facility or acute care hospital will benefit from the proposed changes due to the consistent definitions across the waivers and the Single Entry Point regulations.

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 Department expects there to be quantitative and qualitative improvements to the operations of these waivers through the correction of grammatical and technical errors.

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.

   There will not be any probable costs to the Department as a result of the proposed rule changes.

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

   The proposed rule changes will have no impact on costs or benefits relative to inaction.

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

   There are no less costly or less intrusive methods for achieving the purpose of the proposed rule changes.

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

   There are no alternative methods for achieving the purpose of the proposed rule changes.

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

8.504.05 Legal Basis

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

8.504.1 DEFINITIONS

A. Assessment~~means a comprehensive and uniform process using the Uniform Long Term Care (ULTC) Instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, including Activities of Daily Living (ADL) and Instrumental Activities of Daily Living, health status and other factors relevant to determine the client's level of functioning.~~ 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 approved assessment tool to complete assessments.

~~Assessment process includes collecting information from the client and appropriate collaterals pertaining to service needs, available resources, potential funding sources and includes supporting diagnostic information from a licensed medical professional.~~

B. Bereavement Counseling means counseling 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 child with a life-threatening condition. Enabling the client and family members to manage this stress improves the likelihood that the child with a life-threatening condition will continue to be cared for at home, thereby preventing premature and otherwise unnecessary institutionalization. Bereavement activities offer the family a mechanism for expressing emotion and asking questions about death and grieving in a safe environment thereby potentially decreasing complications for the family after the child dies.

C. Case Management ~~means the assessment of the client's needs, the development and implementation of the Service Plan, coordination and monitoring of service delivery, the evaluation of service effectiveness and periodic reassessment of the client's needs.~~means the assessment of an individual 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. Continued Stay Review (CSR) means a reassessment by the Single Entry Point case manager to determine the client's continued eligibility and functional level of care.

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

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

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

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 assessment of the individual seeking services.

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

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 the administrative activities (specifically utilization management, that is; i.e. 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. Prior Authorization Request (PAR) means the Department's prescribed form to authorize ~~the reimbursement for~~ services.

M. Professional Medical Information Page (PMIP) means the medical information signed by a licensed medical professional used as a component of the Assessment to determine the client's need for institutional care.

N. 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 is provided in the client's residence and may be provided by different levels of providers depending upon the needs of the client.

O. ~~Service Plan means the document used to identify the client's needs and sets forth the services to be provided to the client including the funding source, amount, scope, duration, frequency, provider of each service, and the expected outcome or purpose of such services.~~

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. 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. ~~Uniform Long Term Care (ULTC) Instrument means the Department prescribed form used to determine Functional Eligibility and medical verification for long term care services~~

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.

8.504.2 BENEFITS

8.504.2.A. Home and Community Based Services under the Children with Life Limiting Illness Waiver (HCBS-CLLI) benefits shall be provided within Cost Containment.

8.504.2.B. Therapeutic Life Limiting Illness Support ~~shall~~ may be provided in individual or group setting.

1. Therapeutic Life Limiting Illness Support shall only be a benefit if it is not available under Medicaid Early and Periodic Screening, Diagnostic and Treatment (EPSDT) coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

2. Therapeutic Life Limiting Illness Support ~~shall be~~is limited to the client's assessed need up to a maximum of 98 hours per annual certification period.

8.504.2.C. Bereavement Counseling shall only be a benefit if it is not available under Medicaid EPSDT coverage, Medicaid State Plan benefits, third party liability coverage or by other means.

1. Bereavement Counseling ~~shall be~~is limited to the client's assessed need and is only billable one time.

2. Bereavement C~~c~~ounseling is initiated and billed while the child is on the waiver but may continue after the death of the child for a period of up to one year.

8.504.2.D. Expressive T~~t~~herapy ~~shall~~ may be provided in an individual or group setting.

1. Expressive T~~t~~herapy ~~shall be~~is limited to the client's assessed need up to a maximum of 39 hours per annual certification period.

8.504.2.E. Massage Therapy shall be provided in an individual setting.

1. Massage Therapy shall only be used for the treatment of conditions or symptoms related to the client's illness.

2. Massage Therapy shall be limited to the client's assessed need up to a maximum of 24 hours per annual certification period.

8.504.2.F. Respite Care shall be provided in the home of an eligible client on a short term basis, not to exceed 30 days per annual certification as determined by the Department approved ~~ULTC~~ Assessment. Respite Care shall not be provided at the same time as state plan Home Health or Palliative/Supportive Care services.

1. Respite Care services include any of the following in any combination necessary according to the ~~Service Plan~~Support Planning services:~~.~~

   a. Skilled nursing services~~.~~;

   b. Home health aide services; or

   c. Personal c~~C~~are services

8.504.2.G. Palliative/Supportive Care shall not require a nine month terminal prognosis for the client and includes:

1. Pain and Symptom Management; and

2. Care Coordination

8.504.2.H. HCBS-CLLI clients are eligible for all other Medicaid state plan benefits, including Hospice and Home Health.

8.504.3 NON-BENEFIT

8.504.3.A. Case Management ~~shall~~ is not ~~be~~ a benefit of the HCBS-CLLI waiver. ~~but shall be provided as an administrative activity through t~~The Single Entry Point (SEP) provides case management services as an administrative activity.

8.504.4 CLIENT ELIGIBILITY

8.504.4.A. An eligible client shall:

1. Be ~~determined~~ financially eligible.

2. Be at risk of institutionalization into a hospital as determined by the SEP case manager using the Department approved assessment tool ~~and physician's statementULTC Instrument and physician's statement~~.

3. Meet the target population criteria as follows:

   a. Have a life-limiting diagnosis, as certified ~~in writing~~ by a physician on the Department prescribed form, and

   ~~.~~

   b. Have not yet reached 19 years of age.

8.504.4.B.~~1~~4. A client shall receive at least one HCBS-CLLI waiver benefit per month to maintain enrollment in the waiver.

1~~2~~5. A client who has not received at least one HCBS-CLLI waiver benefit during a month shall be discontinued from the waiver.

2~~3~~6. Case Management does~~shall~~ not satisfy the requirement to receive at least one benefit per month on the HCBS-CLLI waiver.

8.504.5 WAIT LIST

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

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

8.504.5.C. The SEP case manager shall ensure the applicant meets all criteria as set forth in Section 8.504.4.A~~.1-3~~ prior to notifying the Department to place the applicant on the wait list.

8.504.5.D. The SEP case manager shall enter the client's Assessment and Professional Medical Information Page data in the Benefits Utilization System (BUS) and notify the Department by sending the client's enrollment information, utilizing the Department's approved form, to the program administrator.

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

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

1. Reassess the applicant for functional level of care using the Department approved aAssessment tool ~~ULTC Instrument Form~~ if the date of the last Assessment is more than six months old.

2. Update the existing Department approved a~~A~~ssessment tool ~~ULTC Instrument Form~~ data if the date is less than six months old.

3. Reassess for the target population criteria.

4. Notify the Department of the applicant's eligibility status.

8.504.6 PROVIDER ELIGIBILITY

8.504.6.A. Providers shall conform to all federal and state established standards for the specific service they provide under the HCBS-CLLI waiver, ~~and~~ enter into an agreement with the Department. ~~and~~ Providers must comply with the requirements of 10 CCR 2505-10, Section 8.130.

8.504.6.B. Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure ~~status and~~ regulations.

8.504.6.C. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall enroll ~~individually~~ with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

8.504.6.D. Individuals providing Therapeutic Life Limiting Illness Support and Bereavement Counseling shall be one of the following:

1. Licensed Clinical Social Worker (LCSW)

2. Licensed Professional Counselor (LPC)

3. Licensed Social Worker (LSW)

4. Licensed Independent Social Worker (LISW)

5. Licensed Psychologist; or

6. Non-denominational s~~S~~piritual c~~C~~ounselor, if employed by a qualified Medicaid home health or hospice agency.

8.504.6.E. Individuals providing Expressive T~~t~~herapy ~~providers~~ shall enroll ~~individually~~ with the fiscal agent or be employed by a qualified Medicaid home health or hospice agency.

1. Individuals providing Expressive Therapy ~~providers~~ delivering ~~services~~ ~~utilizing~~ art or play therapy services shall ~~be provided by individuals who~~ meet the requirements for individuals providing Therapeutic Life Limiting Illness Support ~~providers~~services and shall have at least one year of experience in the provision of art or play therapy to pediatric/adolescent clients.

2. Individuals providing Expressive Therapy ~~providers~~ delivering~~services utilizing~~ music therapy services shall ~~be provided by individuals who~~ hold a Bachelor's, Master's or

Doctorate in Music Therapy, maintain certification from the Certification Board for Music Therapists, and have at least one year of experience in the provision of music therapy to pediatric/adolescent clients.

8.504.6.F. Massage Therapy providers shall have an approved registration and be in good standing with the Colorado Office of Massage Therapy Registration.

8.504.6.G. Individuals providing Palliative/Supportive Care services ~~services providers~~ shall be ~~provided by individuals whom are~~ employed by or working under a formal contract with a qualified Medicaid hospice or home health agency.

8.504.6.H. Individuals providing Respite services ~~services~~~~providers~~ shall be ~~provided by individuals whom are~~ employed by a qualified Medicaid home health, hospice or personal care agency.

8.504.7 PROVIDER RESPONSIBILITIES

8.504.7.A. HCBS-CLLI p~~P~~roviders shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining and terminating employees.

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section 19-3-3074 C.R.S. (201605).

8.504.7.B. HCBS-CLLI p~~P~~roviders shall:

1. Ensure a client is not discontinued or refused services unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure client records and documentation of services are made available at the request of the case manager.

3. Ensure that adequate records are maintained.

a. Client records shall contain:

i. Name, address, phone number and other identifying information for the client and the client's parent(s) and/or legal guardian(s).

ii. Name, address and phone number of the SEP and the Case Manager.

iii. Name, address and phone number of the client's primary physician.

iv. Special health needs or conditions of the client.

v. Documentation of the specific services provided which includes:

1. Name of individual provider.

2. The location for the delivery of services.

3. Units of service.

4. The date, month and year of services and, if applicable, the beginning and ending time of day.

5. Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.

6. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.02.

7. Documentation of communication with the client's SEP case manager.

8. Documentation of communication/coordination with other providers.

b. Personnel records for each employee shall contain:

i. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

ii. Documentation of training.

iii. Documentation of supervision and performance evaluation.

iv. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.504.7.~~B~~A.

v. A copy of the employee's job description.

4. Ensure all care provided is coordinated with any other services the client is receiving.

a. ~~Documentation of communication with the client's SEP case manager.~~

~~b. Documentation of communication/coordination with additional providers.~~

8.504.8 PRIOR AUTHORIZATION REQUESTS

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

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

8.504.8.C. The first date for which services may~~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 Department approved a~~A~~ssessment tool ~~ULTC Instrument~~.

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

8.504.8.D. The PAR shall not cover a period of time longer than the certification period assigned on the certification page of ~~the Department~~the Department approved a~~A~~ssessment tool~~UTLC Instrument~~.

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

8.504.8.F. The revised ~~Service Plan~~Support Planning document shall list the service being changed and state the reason for the change. Services on the r~~R~~evised ~~Service Plan~~Support Planning document, plus all services on the original ~~Service Pla~~document~~n~~, shall be entered on the revised PAR.

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

8.504.8.H. A revised PAR shall not be submitted if services on the Support Planning document~~ervice Plan~~ are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.

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

8.504.9 REIMBURSEMENT

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

1. Submitted charges; or

2. A fee schedule as determined by the Department.

8.506 CHILDREN'S HOME AND COMMUNITY BASED SERVICES WAIVER PROGRAM

8.506.1 Legal Basis:

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

8.506.2 Definitions of Services Provided

8.506.2.A Case Management means services as defined at Section 8.506.3~~4~~.B and the additional operations specifically defined for this waiver in Section 8.506.4.B.

8.506.2.B In Home Support Services (IHSS) means services as defined at Section 8.506.4.C and Section 8~~.506~~.552

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 approved instrument to complete assessments.~~the Department prescribed instrument to obtain information about a client including his/her condition, personal goals and preferences, functional abilities, health status, and other factors relevant to determine the client's level of functioning.~~

B. ~~Assessment Process means collecting information from the client and appropriate collaterals pertaining to service needs, available resources, and potential funding sources and includes supporting diagnostic information from a licensed medical professional.~~

Case Management means ~~assistance provided by a Case Management Agency on behalf of an eligible child, which includes referral of needed Medicaid services and supports to enable the child to remain in his/her community based setting, the~~the assessment of an individual 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. Additional operations specifically defined for this waiver are described~~ of which are defined i~~ in Section 8.506.4.B.

C. Case Management Agency (CMA) means a public, private, or non-governmental non-profit agency~~ which is certified by the State in accordance with procedures found in Provider Eligibility, Section 8.506.8, and Provider Responsibilities, Section 8.506.9, of the Children's HCBS Waiver Program rules, to provide services throughout the State~~.

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

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

F. County Department means the Department of Human or Social Services in the county where the resident resides.

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.

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

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 assessment of the individual seeking services.

L. ~~Intake/Screening/Referral means the Case Management Agency's initial contact with the applicant and shall include, but not be limited to, a determination of the need for a comprehensive client Assessment, referral to other waivers or services and long term care services.~~

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

M. Professional Medical Information Page (PMIP) means the medical information signed by a licensed medical professional used as a component of the Department approved a~~A~~ssessment tool to determine the client's need for institutional care.

~~N. Professional Medical Information Page (PMIP) means the medical information signed by a licensed medical professional used as a component of the Assessment to determine the client's need for institutional care.~~

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. Service Plan means the document used to identify the client's needs and sets forth the services to be provided to the client including the funding source, amount, scope, duration, and frequency, provider of each service, and the expected outcome or purpose of such services.~~

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

P. Utilization Review Contractor means the Department or the agency contracted with the Department to review the CHCBS waiver application for confirmation that functional eligibility 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:

1. Case Management Agencies must follow requirements and regulations in accordance with state statutes on Confidentiality of Information at 26-1-114, C.R.S., as amended.

2. Case Management Agencies will complete all administrative functions of a client's benefits as described in HCBS-EBD Case Management Functions, Section 8.486.

3. Initial Referral:

   a. The Case Management Agency shall begin assessment activities within ten (10) calendar days of receipt of client's information. Assessment activities shall consist of at least one (1) face-to-face contact with the child, or document reason(s) why such contact was not possible.

   b. At the time of making the initial face-to-face contact with the child and their parent/guardian, assess child's health and social needs to determine whether or not program services are both appropriate and cost effective.

   c. Inform the parent(s) or guardian of the purpose of the Children's HCBS Waiver Program, the eligibility process, documentation required, and the necessary

agencies to contact. Assist the parent(s) or guardian in completing the identification information on the assessment form.

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

e. Submit the assessment and documentation of the enrollment application to the Utilization Review Contractor to ensure the targeting criteria and functional eligibility criteria are met. Minimum documents required:

i. Initial Enrollment Form

ii. Department prescribed Professional Medical Information Page

f. Submit a copy of the approved initial enrollment form to the County Department for activation of a Medicaid State Identification Number.

g. Develop the ~~Service Plan~~Support Planning ~~Dd;~~ocument in accordance with Section 8.506.4.B.7.

h. Develop a Cost Containment Record in accordance with Section 8.506.12 at the time that the Support Planning ~~service plan~~ is completed.

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

4. Continued Stay Review

a. Complete a new Assessment of each child, at a minimum, every twelve (12) months and before the end of the eligibility period approved by the Utilization Review Contractor.

b. Review and revise the Support Planning document ~~Service Plan~~ in accordance with Section 8.506.4.B.7.

c. Calculate expected costs to the Medicaid Program, as set forth in Section 8.506.12, for the redetermination period.

d. Notify the county technician of the renewed Long Term Care certification.

5. Discharge/Withdrawal

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

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

ii. Submit a Department designated Discharge form to the Utilization Review Contractor.

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

iv. Notify County Department of termination.

v. Notify agencies providing services to the client that the child has been discharged from the waiver.

6. Transfers

a. Sending a~~A~~gency responsibilities:

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

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

2) Negotiate an appropriate transfer date.

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

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

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

This rule incorporates by reference the Colorado Department of Human Services, Income Maintenance Staff Manual, Case Transfer Section at 9 CCR 2503-5, § 3.560 is available at http://www.sos.state.co.us/CCR/GenerateRulePdf.do?ruleVersionId=6389. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.

b. Receiving agency responsibilities

i. Conduct a fact-to-face visit with the child within ten (10) working days of the child's transfer, and~~;~~

ii. Review and revise the Support Planning document ~~Service Plan~~ and the Prior Approval Cost Containment Record and change or coordinate services and providers as necessary.

7. ~~Service~~ Support Planning

a. Inform the parent(s) or guardian of the freedom of choice between institutional and home and community based services. A signature from the parent(s) or guardian is required on this state designated form.

b. On a monthly basis, evaluate the effectiveness of the Support Planning document ~~service plan~~ by monitoring services provided to the child. This monitoring may include:

i. Conducting child, parent(s) or guardian, and provider interviews.

ii. Reviewing cost data.

iii. Reviewing any written reports received.

8.506.4.C In Home Support Services:

1. IHSS for CHCBS clients shall be limited to tasks defined as Health Maintenance Activities as set forth in Section 8.552.

2. Family members of a client can only be reimbursed for extraordinary care.

8.506.4.D CHCBS clients are eligible for all other Medicaid state plan benefits.

8.506.5 Non-Benefit

8.506.5.A Tasks defined as Personal Care or Homemaker in Section 8.552 are not benefits of this waiver.

8.506.6 Client Eligibility

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

1. Targeting Criteria:

a. Not have reached his/her eighteenth (18th) birthday.

b. Living at home with parent(s) or guardian and, due to medical concerns, is at risk of institutional placement and can be safely cared for in the home.

c. The child's parent(s) or guardian chooses to receive services in the home or community instead of an institution.

d. The child, due to parental income and/or resources, is not otherwise eligible for Medicaid benefits or enrolled in other Medicaid waiver programs.

2. Functional Eligibility:

a. The Utilization Review Contractor 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.

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

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

8.506.6.B Financial Eligibility

1. Parental income and/or resources will result in the child being ineligible for Medicaid benefits.

2. The income and resources of the child do not exceed 300% of the current maximum Social Security Insurance (SSI) standard maintenance allowance

3. Trusts shall meet criteria in accordance with procedures found in the Medical Assistance Eligibility, Long-Term Care Medical Assistance Eligibility, Consideration of Trusts in Determining Medicaid Eligibility, Section 8.100.7.E.

8.506.6.C Roles of the County Department

1. Processing the Disability Determination Application through the contracted entity determined by the Department.

2. Certify that the child's income and/or resources does not exceed 300% of SSI.

3. Ensure that the parent(s) or guardian is in contact with a case management agency.

4. Determine and notify the parent(s) or guardian and case management agency of changes in the child's income and/or relevant family income, which might affect continued program eligibility within five (5) workings days of determination.

8.506.7 Waiting List

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

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

8.506.7.C The waiting list shall be maintained by the Utilization Review Contractor.

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

8.506.7.E When an eligible individual is placed on the waiting list for the CHCBS waiver, the Case Manager shall provide a written notice of the action in accordance with section 8.057 et seq.

8.506.7.F As openings become available within the capacity limits of the federally approved waiver, individuals shall be considered for CHCBS services in the order of the individual's placement on the waiting list.

8.506.7.G When an opening for the CHCBS waiver becomes available the Utilization Review Contractor will provide written notice to the Case Management Agency.

8.506.7.H Within ten business days of notification from the Utilization Review Contractor 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 in the official client record.

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

4. Notify the Utilization Review Contractor of the individual's eligibility status.

8.506.7.I A child on the waitlist shall be prioritized for enrollment onto the waiver if they meet any of the following criteria:

1. Have been in a hospital for 30 or more days and require waiver services in order to be discharged from the hospital.

2. Are on the waiting list for an organ transplant.

3. Are dependent upon mechanical ventilation or prolonged intravenous administration of nutritional substances.

4. Have received a terminally ill prognosis from their physician.

8.506.7.J Documentation that a child meets one or more of these criterion shall be received by the child's case manager prior to prioritization on the waiting list.

8.506.8 Provider Eligibility

8.506.8.A Providers shall enter into an agreement with the Department to conform to all federal and state established standards for the specific service they provide under the HCBS-CHCBS waiver.

8.506.8.B Providers must comply with the requirements of 10 CCR 2505-10, Section 8.130.

8.506.8.C Licensure and required certification for providers shall be in good standing with their specific specialty practice act and with current state licensure statute and regulations.

8.506.8.D IHSS providers shall ~~conform~~ comply with IHSS Rules in Section 8.552.

8.506.9 Provider Responsibilities

8.506.9.A CHCBS p~~P~~roviders shall have written policies and procedures regarding:

1. Recruiting, selecting, retaining, and terminating employees;

2. Responding to critical incidents, including accidents, suspicion of abuse, neglect or exploitation and criminal activity appropriately, including reporting such incidents pursuant to section C.R.S. 19-3-307 (2016~~05~~).

~~This rule incorporates by reference C.R.S. § 19-3-307 (2015). The incorporation of this statute excludes later amendments, or editions of, the referenced material. It is available at: http://www.lexisnexis.com/hottopics/colorado/. Pursuant to § 24-4-103 (12.5), C.R.S., the Department maintains copies of the incorporated text in its entirety, available for~~

~~public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Certified copies of incorporated materials are provided at cost upon request.~~

8.506.9.B CHCBS Providers shall:

1. Ensure a client is not discontinued or refused services unless documented reasonable efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.

2. Ensure client records and documentation of services are made available at the request of the case manager, Department, or Utilization Review Contractor.

3. Ensure that adequate records are maintained.

   a. Client records shall contain:

      i. Name, address, phone number and other identifying information for the client and the client's parent(s) and/or legal guardian(s).

      ii. Name, address and phone number of child's Case Manager.

      iii. Name, address and phone number of the client's primary physician.

      iv. Special health needs or conditions of the client.

      v. Documentation of the specific services provided, including ~~which includes~~:

         ~~vi~~a. Name of individual provider.

         ~~vii~~b. The location for the delivery of services.

         ~~viii~~c. Units of service.

         ~~ix~~d. The date, month and year of services and, if applicable, the beginning and ending time of day.

      x. Documentation of any changes in the client's condition or needs, as well as documentation of action taken as a result of the changes.

      xi. Financial records for all claims, including documentation of services as set forth at 10 C.C.R. 2505-10, Section 8.040.2.

      xii. Documentation of communication with the client's case manager.

      xiii. Documentation of communication/coordination with any additional providers.

   ~~Xii~~b. Personnel records for each employee shall contain:

      i~~1~~. Documentation of qualifications to provide rendered service including screening of employees in accordance with Section 8.130.35.

      ii~~2~~. Documentation of training.

iii3. Documentation of supervision and performance evaluation.

iv4. Documentation that an employee was informed of all policies and procedures as set forth in Section 8.506.

v5. A copy of the employee's job description.

42. Ensure all care provided is coordinated with any other services the client is receiving.

a. ~~Documentation of communication with the client's case manager.~~

~~b. Documentation of communication/coordination with any additional providers.~~

8.506.9.C Responsibilities specific to IHSS Provider Agencies

1. Eligible IHSS Agencies will conform to all certification standards set forth at 10 C.C.R 2505-10, Section 8.552.5

2. IHSS Agencies will adhere to all responsibilities outlined at 10 C.C.R. 2505.10, Section 8.552.6

3. Ensure that only Health Maintenance Activities are delivered to CHCBS clients through the IHSS benefit.

8.506.9.D Responsibilities Specific to Case Management Agencies

1. Case Management Agencies will obtain a specific authorization to provide CHCBS case management benefits to clients as set forth in Provider Enrollment Section 8.487.

2. Verify that the IHSS care plan developed by IHSS providers is in accordance with both Sections 8.506.4.C and 8.552 of this volume.

8.506.10 Prior Authorization Requests

8.506.10.A The Case Manager shall complete and submit a Prior Authorization Request (PAR) form within one calendar month of determination of eligibility for the waiver.

8.506.10.B All units of service requested shall be listed on the ~~Service Plan~~Support Planning document.

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.

3. The date, on which the client's parent(s) and/or legal guardian signs the Support Planning document ~~Service Plan form~~ 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.

8.506.10.E The Case Manager shall submit a revised PAR if a change in the Support Planning document ~~Service Plan~~ results in a change in services.

8.506.10.F The revised Support Planning document ~~Service Plan~~ shall list the service being changed and state the reason for the change. Services on the r~~R~~evised Support Planning document~~Service Plan~~, plus all services on the original ~~-~~ document~~Service Plan~~, shall be entered on the revised PAR.

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

8.506.10.H A revised PAR shall not be submitted if services on the Support Planning document ~~Service Plan~~ are decreased, unless the services are being eliminated or reduced in order to add other services while maintaining cost-effectiveness.

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

8.506.11 Reimbursement

8.506.11.A Providers shall be reimbursed at the lower of:

1. Submitted charges; or
2. A fee schedule as determined by the Department.

8.506.12 Cost Containment

8.506.12.A The Department ~~shall be~~is responsible for ensuring that, on average, services delivered to the child are within the Department's cost containment requirements for the respective level of institutional care.

8.506.12.B The case manager must identify costs as part of the Support Planning document~~ervice Plan~~. This Cost Containment Record shall be on a Department prescribed form and include all estimated:

1. Waiver benefit services and units, as defined at 8.506.2.
2. State Plan benefit services and units.

8.506.12.C The costs of the benefit services identified in the Cost Containment Record shall be totaled and divided by the number of days remaining before the end of the child's current enrollment period.

8.506.12.D The cost per day for the child shall be compared against the Department designated cost per day of institutional care to determine cost effectiveness.

8.506.12.E The Case Manager will revise the child's Cost Containment Record anytime that a significant change in the Support Planning document ~~Service Plan~~ results in an increase or change in the services to be provided.

8.506.12.F The Case Manager will submit the Cost Containment Record to the Utilization Review Contractor for approval at the time of the child's initial enrollment onto the CHCBS

waiver, or any time that a revision to the Cost Containment Record increases by a Department prescribed amount.

8.506.12.G Approval of the Cost Containment Record by the Department only ensures that the cost of the services does not exceed the equivalent cost of the appropriate institutional care.

8.506.12.H Approval of the Cost Containment Record form does not constitute ~~automatic~~ approval of Medicaid reimbursement for authorized services identified within the record.

DO NOT PUBLISH THIS PAGE

Title of Rule: Colorado Healthcare Affordability and Sustainability Enterprise, Sections 8.300.8, 8.905, 8.2000, and 8.3000
Rule Number: MSB 17-06-29-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 17-06-29-A, Colorado Healthcare Affordability and Sustainability Enterprise, Sections 8.300.8, 8.905, 8.2000, and 8.3000
3. This action is an adoption of:	new rules

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.300.8, 8.905, 8.2000, and 8.3000, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)?	Yes
If yes, state effective date:	7/14/2017
Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.300.8 with the text beginning at 8.300.8.B through the end of 8.300.8.B Replace the current text at 8.905 with the proposed text beginning at 8.905.B through the end of 8.905.B.1. Delete the current text beginning at 8.2000 through the end of 8.2000 and insert the proposed text beginning at 8.3000 through the end of 8.3000. This rule is effective October 30, 2017.

*to be completed by MSB Board Coordinator

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Title of Rule: Colorado Healthcare Affordability and Sustainability Enterprise, Sections 8.300.8, 8.905, 8.2000, and 8.3000
Rule Number: MSB 17-06-29-A
Division / Contact / Phone: Special Financing / Nancy Dolson / 303-866-3698

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).

   Senate Bill 17-267 signed into law by the governor on May 30, 2017 creates the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) at § 25.5-4-402.4, C.R.S. effective July 1, 2017 to assess a healthcare affordability and sustainability fee to obtain federal financial participation to increase hospital reimbursement for care provided under Medicaid and the Colorado Indigent Care Program (CICP) and to fund health coverage under Medicaid and the Child Health Plan Plus (CHP+). The CHASE Act also repeals the hospital provider fee at 25.5-4-402.3, C.R.S. In accordance with statute, this proposed rule repeals the hospital provider fee rules at 10 CCR 2505-10, Section 8.2000, creates rules for the healthcare affordability and sustainability fee at Section 8.3000, and makes corresponding revisions to references under Sections 8.300.8 and 8.905.

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:

   Effective July 1, 2017, the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) at § 25.5-4-402.4, C.R.S. establishes a healthcare affordability and sustainability fee to obtain federal financial participation to increase hospital reimbursement for care provided under Medicaid and the CICP. Fee revenue also serves as the state share to fund health coverage for more than 480,000 Coloradans currently enrolled in Medicaid and the CHP+. To comply with the new state law and to comply with the State Plan with the Centers for Medicare and Medicaid Services, the CHASE must establish rules on an emergency basis in order to assess fees on hospitals to ensure continuing health care coverage for these Medicaid and CHP+ members and to make required payments to hospitals. Senate Bill 17-267 also repealed the Hospital Provider Fee program effective July 1, 2017.

3. Federal authority for the Rule, if any:

   42 CFR 433.68

Initial Review	**07/14/17**	Final Adoption	**09/08/17**
Proposed Effective Date	**10/30/17**	Emergency Adoption	

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-4-402.4(4)(g), C.R.S.

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Is rule to be made permanent? (If yes, please attach notice of hearing).	Yes

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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.

   Colorado hospitals benefit from increased Medicaid and CICP reimbursement made possible through the healthcare affordability and sustainability fee and matching federal funds and the reduction in the number of uninsured Coloradans from expanded Medicaid and CHP+ eligibility. Low-income persons benefit by having health care coverage through the expanded Medicaid and CHP+ eligibility.

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 healthcare affordability and sustainability fee and matching federal funds will result in more than $2 billion in annual health care expenditures for more than 480,000 Coloradans and will provide more than $200 million in net new federal funds to Colorado hospitals.

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.

   While there are administrative costs associated with CHASE, such costs are funded with fees and federal matching funds and no state general funds are expected to be used.

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

   If no action is taken, CHASE will not be ability to fund Medicaid and CHP+ expansions, affected over 480,000 currently enrolled persons. Inaction would also reduce CICP payments to hospitals, endangering access to discounted health care for low-income persons not eligible for Medicaid or CHP+, and reduce the federal revenue to hospitals.

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

The State does not have alternative resources to fund hospital payments and health coverage for the populations as provided under CHASE; therefore, no other methods are available to achieve the purpose of the proposed rule.

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.

   The CHASE Act directs the Medical Services Board to promulgate rules for the implementation of the healthcare affordability and sustainability fee; therefore, no alternatives to rule making are available.

8.300.8.B Colorado Determination of Individual Hospital Disproportionate Payment Adjustment

1. Eligible ~~H~~hospitals ~~deemed eligible for minimum disproportionate share payment and which participate in the Colorado Indigent Care Program~~ will receive a ~~CICP~~ Disproportionate Share Hospital Supplemental Payment according to the terms defined in 10 CCR 2505-10 section ~~8.2000~~8.3004.D.

2. ~~Hospitals deemed eligible for a minimum disproportionate share payment and which do not participate in the Colorado Indigent Care Program will receive an Uninsured Disproportionate Share Hospital Payment defined in 10 CCR 2505-10 section 8.2000.~~

8.905 DEPARTMENT RESPONSIBILITIES

A. Provider Application

1. The Department shall produce and publish a provider application annually.

   a. The application will be updated annually to incorporate any necessary changes and update any Program information.

   b. The application will include data and quality metric submission templates.

2. The Department shall determine Qualified Health Care Providers annually through the application process.

3. An agreement will be executed between the Department and Denver Health for the purpose of providing discounted health care services to the residents of the City and County of Denver, as required by Section 25.5-3-108 (5)(a)(I), C.R.S.

4. An agreement will be executed between the Department and University Hospital for the purpose of providing discounted health care services in the Denver Metropolitan Area and complex care that is not contracted for in the remaining areas of the state, as required by Section 25.5-3-108 (5)(a)(II), C.R.S.

5. The Department shall produce and publish a provider directory annually.

B. Payments to Providers

1. Funding for hospitals shall be distributed in accordance with 10 CCR 2505-10 Section 8.~~2000~~ 3000 and 8.905 B.~~5~~3.

2. Clinics

   a. Funding for Clinic Providers is appropriated through the Colorado General Assembly under the Children's Hospital, Clinic Based Indigent Care line item.

Effective July 1, 2018, funding for clinics shall be separated into two different groups, as follows:

I. Seventy-five (75) percent of the funding will be distributed based on Clinic Providers' write off costs relative to the total write off costs for all Clinic Providers.

II. Twenty-five (25) percent of the funding will be distributed based on a points system granted to Clinic Providers based on their quality metric scores multiplied by the Clinic Provider's total visits from their submitted Program data.

b. The quality metric scores will be calculated based on the following four metrics. The metrics are defined by the Health Resources & Services Administration (HRSA):

I. Preventative Care and Screening: Body Mass Index (BMI) Screening and Follow Up

II. Preventative Care and Screening: Screening for Clinical Depression and Follow-up Plan

III. Diabetes: Hemoglobin A1c Poor Control

IV. Controlling High Blood Pressure

c. Write off costs will be calculated as follows:

I. Distribution of available funds for indigent care costs will be calculated based upon historical data. Third-party liabilities and the patient liabilities will be deducted from total charges to generate medically indigent charges.

II. Clinic Providers shall deduct amounts due from third-party payment sources from total charges declared on the summary statistics submitted to the Department.

III. Clinic Providers shall deduct the full patient liability amount from total charges, which is the amount due from the Client as identified in the CICP Standard Client Copayment Table, as defined under Appendix A in these rules, or an alternative sliding fee scale that is submitted by the provider with the annual application for the CICP and approved by the Department. The summary information submitted to the Department by the provider shall include the full CICP patient liability amount even if the Clinic Provider receives the full payment at a later date or through several smaller installments or no payment from the Client.

IV. Medically indigent charges will be converted to medically indigent costs using the most recently available cost-to-charge ratio from the Clinic Provider's cost report or other financial documentation accepted by the Department.

d. The Department shall notify Clinic Providers of their expected payment no later than July 31 of each year. The notification shall include the total expected payment and a description of the methodology used to calculate the payment.

e. For the 2017-18 Program year, Clinic Provider payments will be based solely on calendar year 2016 write-off costs relative to the total write off costs for all Clinic Providers. Write off charges shall be calculated as described in part c of this section.

3. Pediatric Major Teaching Hospital Payment. Hospital Providers shall qualify for additional payment when they meet the criteria for being a major teaching hospital provider and when their Medicaid-eligible inpatient days combined with indigent care days (days of care provided under the Colorado Indigent Care Program) equal or exceed 30 percent of their total inpatient days for the most recent year for which data are available. A major teaching hospital provider is defined as a Colorado hospital, which meets the following criteria:

a. Maintains a minimum of 110 total Intern and Resident (I/R) F.T.E.'s;

b. Maintains a minimum ratio of .30 Intern and Resident (I/R) F.T.E.'s per licensed bed;

c. Qualifies as a Pediatric Specialty Hospital under the Medicaid Program, such that the hospital provides care exclusively to pediatric populations.

d. Has a percentage of Medicaid-eligible inpatient days relative to total inpatient days that equal or exceeds one standard deviation above the mean; and

e. Participates in the Colorado Indigent Care Program

The Major Teaching Hospital Rate is set by the Department such that the payment will not exceed the appropriation set by the General Assembly.

C. Provider Appeals

1. Any provider who submits an application to become a Qualified Health Care Provider whose application is denied may appeal the denial to the Department.

2. The provider’s first level appeal must be filed within five (5) business days of the receipt of the denial letter. The Department’s Special Financing Division Director will respond to any first level appeals within ten (10) business days of receipt of the appeal.

3. If a provider disagrees with the Department’s Special Financing Division Director’s first level appeal determination, they may file a second level appeal within five (5) business days of the receipt of the first level appeal determination. The Department’s Executive Director will respond to the second level appeal within ten (10) business days of the receipt of the second level appeal.

D. Advisory Council

The Department shall create a CICP Stakeholder Advisory Council, effective July 1, 2017. The Executive Director of the Department shall appoint 11 members to the CICP Stakeholder Advisory Council. Members shall include:

1. A member representing the Department;

2. Three consumers who are eligible for the Program or three representatives from a consumer advocate organization or a combination of each;

3. A representative from a federally qualified health center as defined at 42 U.S.C. 1395x (aa)(4);

4. A representative from a rural health clinic as defined at 42 U.S.C. 1395x (aa)(2), or a representative from a clinic licensed or certified as a community health clinic by the Department of Public Health and Environment, or a representative from an organization that represents clinics who are not federally qualified health centers;

5. A representative from either Denver Health or University Hospital;

6. A representative from an urban hospital;

7. A representative from a rural or critical access hospital;

8. A representative of an organization of Colorado community health centers, as defined in the federal “Public Health Service Act”, 42 U.S.C. sec. 254b;

9. A representative from an organization of Colorado hospitals.

Members shall serve without compensation or reimbursement of expenses. The Executive Director shall at least annually select a chair for the council to serve for a maximum period of twelve months. The Department shall staff the council. The council shall convene at least twice every fiscal year according to a schedule set by the chair. Members of the council shall serve three-year terms. Of the members initially appointed to the advisory council, the executive director shall appoint six for two-year terms and five for three-year terms. In the event of a vacancy on the advisory council, the executive director shall appoint a successor to fill the unexpired portion of the term of such member.

The council shall

1. Advise the Department of operation and policies for the Program

2. Make recommendations to the Medical Services Board regarding rules for the Program

E. Annual Report

1. The Department shall prepare an annual report concerning the status of the Program to be submitted to the Health and Human Services committees of the Senate and House of Representatives, or any successor committees, no later than February 1 of each year.

2. The report shall at minimum include charges for each Qualified Health Care Provider, numbers of Clients served, and total payments made to each Qualified Health Care Provider.

8.2000: HOSPITAL PROVIDER FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Health Care Affordability Act of 2009 (Act), C.R.S. 25.5-4-402.3, authorizes the Department of Health Care Policy and Financing (Department) to assess a hospital provider fee, pursuant to rules adopted by the State Medical Services Board, to generate additional federal Medicaid matching funds to improve reimbursement rates for inpatient and outpatient hospital services provided through Medicaid and the Colorado Indigent Care Program (CICP). In addition, the Act requires the Department to use the hospital provider fee to expand health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without dependent children; to provide a Medicaid buy-in program for people with disabilities; to implement twelve month continuous eligibility for Medicaid eligible children; and to pay the Department's administrative costs of implementing and administering the Act.

8.2001: DEFINITIONS

"Act" means the Colorado Health Care Affordability Act, C.R.S. § 25.5-4-402.3.

"CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

"CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

"CMS" means the federal Centers for Medicare and Medicaid Services.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a large number of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.

"Essential Access Hospital" means a Critical Access Hospital or General Hospital located in a Rural Area with 25 or fewer licensed beds.

"Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.

"Fund" means the hospital provider fee cash fund described in C.R.S. § 25.5-4-402.3(4).

"General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

~~"High Volume Medicaid and CICP Hospital" means a hospital with at least 30,000 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.~~

~~"Health Maintenance Organization" or "HMO" means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.~~

~~"Hospital-Specific Disproportionate Share Hospital Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.~~

~~"Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.~~

~~"Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.~~

~~"Long Term Care Hospital" means a General Hospital that is certified as a long term care hospital by the Colorado Department of Public Health and Environment.~~

~~"Managed Care Day" means an inpatient hospital day for which the primary payer is a managed care health plan, including a HMO, PPO, POS, and EPO days.~~

~~"Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.~~

~~"Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.~~

~~"Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.~~

~~"MMIS" means the Medicaid Management Information System, the Department's Medicaid claims payment system.~~

~~"MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospitals days.~~

~~"Non-Managed Care Day" means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.~~

~~"Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local government.~~

~~"Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges~~

~~"Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.~~

~~"Oversight and Advisory Board" means the hospital provider fee oversight and advisory board described in C.R.S. § 25.5-4-402.3(6).~~

~~"Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.~~

~~"POS" or "Point of Service" means a type of managed care health plan that charges patients less to receive services from providers in the plan's network and requires a referral from a primary care provider to receive services from a specialist.~~

~~"PPO" or "Preferred Provider Organization" means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost ."Privately-Owned Hospital" means a hospital that is privately owned and operated.~~

~~"Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.~~

~~"Rehabilitation Hospital" means an inpatient rehabilitation facility.~~

~~"Rural Area" means a county outside a Metropolitan Statistical Area or an area within an outlying county of a Metropolitan Statistical Area designated by the United States Office of Management and Budget.~~

~~"State-Owned Government Hospital" means a hospital that is either owned or operated by the State.~~

~~"State University Teaching Hospital" means a High Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.~~

~~"Uninsured Cost" means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.~~

~~"Urban Center Safety Net Specialty Hospital" means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days, rounded to the nearest percent, equals or exceeds 65%.~~

~~8.2002: RESPONSIBILITIES OF THE DEPARTMENT AND HOSPITALS~~

~~8.2002.A. DATA REPORTING~~

~~1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Department shall distribute a data reporting template to all hospitals no later than April 30 of each year. The Department shall include instructions for completing the data reporting template, including definitions and descriptions of each data element to be reported. Hospitals shall submit the requested data to the Department within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Department may estimate any data element not provided directly by the hospital.~~

~~2. Hospitals shall submit days and charges for Medicaid Managed Care, out-of-state Medicaid, and uninsured patients, Managed Care Days, and any additional elements requested by the Department.~~

~~3. The Department shall distribute a data confirmation report to all hospitals annually. The data confirmation report shall include a listing of relevant data elements used by the Department in calculating the Outpatient Services Fee, the Inpatient Services Fee and the supplemental payments. The data confirmation report shall clearly state the manner and timeline in which~~

hospitals may request revisions to the data elements recorded by the Department. Revisions to the data will not be permitted by a hospital after the dates outlined in the data confirmation report.

4. An authorized hospital signatory shall certify that the data included in the data reporting template are correct, are based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years.

8.2002.B. FEE ASSESSMENT AND COLLECTION

1. Establishment of Electronic Funds Process. The Department shall utilize an Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental payments in financial accounts authorized by hospitals. The Department shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

2. The Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve monthly installments. Payments to hospitals will be calculated on an annual basis and disbursed in twelve monthly installments.

    a. For those hospitals that participate in the electronic funds process utilized by the Department, fees will be assessed and payments will be disbursed on the second Friday of the month, except when State offices are closed during the week of the second Friday, then fees will be assessed and payment will be disbursed on the following Friday of the month. If the Department must diverge from this schedule due to unforeseen circumstances, the Department shall notify hospitals in writing or by electronic notice as soon as possible.

        i. The Department may assess fees and disburse payments for Urban Center Safety Net Specialty Hospitals on an alternate schedule determined by the Department.

    b. At no time will the Department assess fees or disburse payments prior to the state fiscal year for which they apply.

3. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Department for the collection of fees and the disbursement of payments unless the Department has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Department describing an alternative fee collection process and/or payment process. The Department shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

    a. For hospitals that do not participate in the electronic funds process utilized by the Department for the collection of fees, payments to hospitals shall be processed by the Department within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

    b. For hospitals that do not participate in the electronic funds process utilized by the Department for the disbursement of payments, payments to hospitals shall be processed through a warrant (paper check) by the Department within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

8.2003: HOSPITAL PROVIDER FEE

8.2003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.534% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.2003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Department shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. 1302 Sections 1903(w), 1903(w)(3)(E), and 1903(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $79.54 per day for Managed Care Days and $355.49 per day for all Non-Managed Care Days with the following exceptions:

    a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $41.53 per day for Managed Care Days and $185.60 per day for all Non-Managed Care Days, and.

    b. Essential Access Hospitals' Inpatient Services Fee is discounted to $31.82 per day for Managed Care Days and $142.20 per day for Non-Managed Care Days.

8.2003.C. ASSESSMENT OF FEE

1. The Department shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Oversight and Advisory Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Department shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed.

2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Department will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2003.D. REFUND OF EXCESS FEES

1. If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Department shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Department shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.2002.B.

2. After the close of each State fiscal year and no later than the following August 31, the Department shall present a summary of fees collected, expenditures made or encumbered, and interest earned in the Fund during the State fiscal year to the Oversight and Advisory Board.

    a. If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Department has not expended or encumbered those fees at the close of each State fiscal year:

        i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less four percent of the estimated expenditures for health coverage expansions authorized by the Act for the subsequent State fiscal year as most recently published by the Department.

        ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the State fiscal year.

        iii. The Department shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.2002.B.

8.2004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.2004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

1. All supplemental payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Department.

2. No hospital shall receive a DSH payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.2004.D, exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the hospital's payment shall be reduced to the Hospital-Specific Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific Disproportionate Share Hospital Limit.

3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.2004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado MMIS are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient Hospital Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

8.2004.C. INPATIENT HOSPITAL BASE RATE SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment equals the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate before add-ons, multiplied by a percentage adjustment factor. The percentage adjustment factor may vary by hospital such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

8.2004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

   a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) shall receive this payment; or.

b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals shall not receive this payment.

3. Calculation methodology for payment.

a. Qualified hospitals whose CICP write-off costs are greater than or equal to 750% of all CICP hospitals write-off costs as published in the most recent CICP annual report will receive a DSH payment equal to 100% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.

b. Qualified hospitals whose CICP write-off costs are less than 750% and more than 200% of all CICP hospitals write-off costs as published in the most recent CICP annual report will receive a DSH payment equal to 96% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.

c. All other qualified hospitals will receive a DSH payment calculated as the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all remaining qualified hospitals multiplied by the remainder of the state's total annual Disproportionate Share Hospital allotment to not exceed 96% of the estimated Hospital-Specific Disproportionate Share Hospital Limit.

8.2004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. General Hospitals and Critical Access Hospitals shall receive this payment.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals shall not receive this payment.

3. Calculation methodology for payment. For each qualified hospital with twenty-five or fewer beds, the annual payment equals the hospital's percentage of beds compared to total beds for all qualified hospitals with twenty-five beds or fewer multiplied by twenty three million five hundred thousand dollars ($23,500,000). For each qualified hospital with greater than twenty-five beds, the annual payment equals the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals with greater than twenty-five beds multiplied by ninety one million nine hundred eighty thousand one hundred seventy six dollars ($91,980,176).

8.2004.F. HOSPITAL QUALITY INCENTIVE PAYMENT

1. Qualified hospitals. Hospitals with an established Medicaid inpatient base rate and that meet the minimum criteria for one or more of the selected measures may qualify to receive this payment.

2. Excluded hospitals. Psychiatric Hospitals.

3. Measures. Quality incentive payment measures include five base measures and four optional measures. Hospitals can report data on up to five measures annually. Qualified hospitals must report all of the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed.

a. The base measures for the quality incentive payment are:

i. Emergency department process measure, which includes communicating information about the Medicaid nurse advice line, primary care providers, and Regional Care Collaborative Organizations (RCCO) to Medicaid clients when they are seen in the emergency department and establishing emergency department policies or guidelines for prescribing opioids,

ii. Rate of elective deliveries between 37 and 39 weeks gestation,

iii. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,

iv. Rate of thirty (30) day all-cause hospital readmissions, and

v. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey.

b. The optional measures for the quality incentive payment are:

i. Culture of safety,

ii. Active participation in the RCCO,

iii. Advance care planning, and

iv. Screening for tobacco use.

4. Calculation methodology for payment.

a. Determine available points by hospital to a maximum of 10 points per measure.

i. Available points are defined as the number of measures for which a hospital qualifies multiplied by the number of points designated for the measure.

b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department.

c. Normalize the total points earned per measure to total possible points for all measures by hospital.

d. Calculate adjusted Medicaid discharges by hospital.

i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by the adjusted discharge factor.

For hospitals with less than 200 annual Medicaid discharges, the total number of discharges is multiplied by 125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare Prospective Payment System calculation.

ii. The adjusted discharge factor is defined as the most recently available annual total gross Medicaid billed charges divided by the inpatient gross Medicaid billed charges.

e. Calculate total adjusted discharge points

i. Adjusted discharge points are defined as the total number of points earned for all measures multiplied by the number of adjusted Medicaid discharges.

f. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality point scores receive higher points per discharge. The dollar amount per discharge point for five tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	$13.18
2	11-20	$14.50
3	21-30	$15.82
4	31-40	$17.13
5	41-50	$18.45

g. Calculate payment by hospital by multiplying the adjusted discharge points for that hospital by the dollars per discharge point.

5. The total funds for the quality incentive payment for the year ending September 30, 2016 is $84,810,386.

8.3000: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE COLLECTION AND DISBURSEMENT

PURPOSE: Subject to federal approval by the Centers for Medicare and Medicaid Services (CMS), the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017 (Act), C.R.S. § 25.5-4-402.4, authorizes the Colorado Healthcare Affordability and Sustainability Enterprise (CHASE) to assess a healthcare affordability and sustainability fee, pursuant to rules adopted by the State Medical Services Board, to provide a business services to hospitals as described in C.R.S. § 25.5-4-402.4(4)(a). These business services include but are not limited to obtaining federal financial participation to increase reimbursement to hospitals for care provided under the state medical assistance program (Medicaid) and the Colorado Indigent Care Program (CICP); expanding health coverage for parents of Medicaid eligible children, for children and pregnant women under the Child Health Plan Plus (CHP+), and for low-income adults without dependent children; providing a Medicaid buy-in program for people with disabilities; implementing twelve month continuous eligibility for Medicaid eligible children; paying CHASE's administrative costs of implementing and administering the Act; consulting with hospitals to help them improve cost efficiency, patient safety, and clinical effectiveness; advising hospitals regarding potential changes to federal and state laws and regulations governing Medicaid; providing coordinating services to hospitals to help them adapt and transition to any new or modified performance tracking and payment systems for the Medicaid program; and providing funding for a health care delivery system reform incentive payments program.

8.3001: DEFINITIONS

"Act" means the Colorado Healthcare Affordability and Sustainability Enterprise Act of 2017, § 25.5-4-402.4, C.R.S.

"CHASE" or "Enterprise" means the Colorado Healthcare Affordability and Sustainability Enterprise described in C.R.S. § 25.5-4-402.4(3).

"CICP" means the Colorado Indigent Care Program, as described in 10 CCR 2505-10, Section 8.900.

"CICP Day" means an inpatient hospital day for a recipient enrolled in the CICP.

"CMS" means the federal Centers for Medicare and Medicaid Services.

"Critical Access Hospital" means a hospital qualified as a critical access hospital under 42 U.S.C. § 1395i-4(c)(2) and certified as a critical access hospital by the Colorado Department of Public Health and Environment.

"Disproportionate Share Hospital Payment" or "DSH Payment" means the payments made to qualified hospitals that serve a disproportionate share of Medicaid and uninsured individuals as required under 42 U.S.C. § 1396r-4. Federal law establishes an annual DSH allotment for each state that limits federal financial participation for total statewide DSH payments made to hospitals.

"Enterprise Board" means the Colorado Healthcare Affordability and Sustainability Enterprise Board described in C.R.S. § 25.5-4-402.4(7).

"Essential Access Hospital" means a Critical Access Hospital or General Hospital located in a Rural Area with 25 or fewer licensed beds.

"Exclusive Provider Organization" or "EPO" means a type of managed care health plan where members are not required to select a primary care provider or receive a referral to receive services from a specialist. EPOs will not cover care provided out-of-network except in an emergency.

"Fund" means the healthcare affordability and sustainability fee cash fund described in C.R.S. § 25.5-4-402.4(5).

"General Hospital" means a hospital licensed as a general hospital by the Colorado Department of Public Health and Environment.

"High Volume Medicaid and CICP Hospital" means a hospital with at least 30,000 Medicaid Days per year that provides over 30% of its total days to Medicaid and CICP clients.

"Health Maintenance Organization" or "HMO" means a type of managed care health plan that limits coverage to providers who work for or contract with the HMO and requires selection of a primary care provider and referrals to receive services from a specialist. HMOs will not cover care provided out-of-network except in an emergency.

"Hospital-Specific Disproportionate Share Hospital Limit" or "Hospital-Specific DSH Limit" means a hospital's maximum allowable Disproportionate Share Hospital payment eligible for Medicaid federal financial participation allowed under 42 U.S.C. § 1396r-4.

"Inpatient Services Fee" means an assessment on hospitals based on inpatient Managed Care Days and Non-Managed Care Days.

"Inpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for inpatient hospital services and still receive federal financial participation.

"Long Term Care Hospital" means a General Hospital that is certified as a long term care hospital by the Colorado Department of Public Health and Environment.

"Managed Care Day" means an inpatient hospital day for which the primary payer is a managed care health plan, including a HMO, PPO, POS, and EPO days.

"Medicaid Day" means a Managed Care Day or Non-Managed Care Day for which the primary or secondary payer is Medicaid.

"Medicaid Managed Care Day" means a Managed Care Day for which the primary payer is Medicaid.

"Medicare Cost Report" means the Medicare hospital cost report, form CMS 2552-96 or CMS 2552-10, or any successor form created by CMS.

"MMIS" means the Medicaid Management Information System, the Department's Medicaid claims payment system.

"MIUR" means Medicaid inpatient utilization rate which is calculated as Medicaid Days divided by total hospitals days.

"Non-Managed Care Day" means an inpatient hospital day for which the primary payer is an indemnity insurance plan or other insurance plan not serving as an HMO, PPO, POS, or EPO.

"Non-State-Owned Government Hospital" means a hospital that is either owned or operated by a local government.

"Outpatient Services Fee" means an assessment on hospitals based on outpatient hospital charges.

"Outpatient Upper Payment Limit" means the maximum amount that Medicaid can reimburse a provider for outpatient hospital services and still receive federal financial participation.

"Pediatric Specialty Hospital" means a hospital that provides care exclusively to pediatric populations.

"POS" or "Point of Service" means a type of managed care health plan that charges patients less to receive services from providers in the plan's network and requires a referral from a primary care provider to receive services from a specialist.

"PPO" or "Preferred Provider Organization" means a type of managed care health plan that contracts with providers to create a network of participating providers. Patients are charged less to receive services from providers that belong to the network and may receive services from providers outside the network at an additional cost.

"Privately-Owned Hospital" means a hospital that is privately owned and operated.

"Psychiatric Hospital" means a hospital licensed as a psychiatric hospital by the Colorado Department of Public Health and Environment.

"Rehabilitation Hospital" means an inpatient rehabilitation facility.

"Respiratory Hospital" means a hospital that primarily specializes in respiratory related diseases.

"Rural Area" means a county outside a Metropolitan Statistical Area or an area within an outlying county of a Metropolitan Statistical Area designated by the United States Office of Management and Budget.

"State-Owned Government Hospital" means a hospital that is either owned or operated by the State.

"State University Teaching Hospital" means a High Volume Medicaid and CICP Hospital which provides supervised teaching experiences to graduate medical school interns and residents enrolled in a state institution of higher education, and in which more than fifty percent (50%) of its credentialed physicians are members of the faculty at a state institution of higher education.

"Supplemental Medicaid Payment" means any of the payments described in 10 CCR 2505-10, Sections 8.3004.B., 8.3004.C., 8.3004.E., and 8.3004.F.

"Uninsured Cost" means uninsured days and charges allocated to routine and ancillary cost centers and multiplied by the most recent provider-specific per diem cost and cost-to-charge ratio from the Medicare Cost Report.

"Urban Center Safety Net Specialty Hospital" means a hospital located in a Metropolitan Statistical Area designated by the United States Office of Management and Budget where its Medicaid Days plus CICP Days relative to total inpatient hospital days, rounded to the nearest percent, equals or exceeds 65%.

8.3002: RESPONSIBILITIES OF THE ENTERPRISE AND HOSPITALS

8.3002.A. DATA REPORTING

1. For purposes of calculating the Outpatient Services Fee, Inpatient Services Fee and the distribution of supplemental payments, the Enterprise shall distribute a data reporting template to all hospitals no later than April 30 of each year. The Enterprise shall include instructions for completing the data reporting template, including definitions and descriptions of each data element to be reported. Hospitals shall submit the requested data to the Enterprise within thirty (30) calendar days after receiving the data reporting template or on the stated due date, whichever is later. The Enterprise may estimate any data element not provided directly by the hospital.

2. Hospitals shall submit days and charges for Medicaid Managed Care, out-of-state Medicaid, and uninsured patients, Managed Care Days, and any additional elements requested by the Enterprise.

3. The Enterprise shall distribute a data confirmation report to all hospitals annually. The data confirmation report shall include a listing of relevant data elements used by the Enterprise in calculating the Outpatient Services Fee, the Inpatient Services Fee and the supplemental payments. The data confirmation report shall clearly state the manner and timeline in which hospitals may request revisions to the data elements recorded by the Enterprise. Revisions to the data will not be permitted by a hospital after the dates outlined in the data confirmation report.

4. ~~An authorized~~The hospital ~~signatory~~ shall certify that based on best information, knowledge, and belief, the data included in the data reporting template ~~are~~ is accurate, complete, and truthful~~correct~~, is~~are~~ based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.,

8.3002.B. FEE ASSESSMENT AND COLLECTION

1. Establishment of Electronic Funds Process. The Enterprise shall utilize an Automated Clearing House (ACH) debit process to collect the Outpatient Services Fee and Inpatient Services Fee from hospitals and an Electronic Funds Transfer (EFT) payment process to deposit supplemental payments in financial accounts authorized by hospitals. The Enterprise shall supply hospitals with all necessary information, authorization forms and instructions to implement this electronic process.

2. The Outpatient Services Fee and Inpatient Services Fee will be assessed on an annual basis and collected in twelve monthly installments. Payments to hospitals will be calculated on an annual basis and disbursed in twelve monthly installments.

    a. For those hospitals that participate in the electronic funds process utilized by the Enterprise, fees will be assessed and payments will be disbursed on the second Friday of the month, except when State offices are closed during the week of the second Friday, then fees will be assessed and payment will be disbursed on the following Friday of the month. If the Enterprise must diverge from this schedule due to unforeseen circumstances, the Enterprise shall notify hospitals in writing or by electronic notice as soon as possible.

        i. The Enterprise may assess fees and disburse payments for Urban Center Safety Net Specialty Hospitals on an alternate schedule determined by the Department.

    b. At no time will the Enterprise assess fees or disburse payments prior to the state fiscal year for which they apply.

3. Electronic Funds Process Waiver. Hospitals not exempt from the Outpatient Services Fee and Inpatient Services Fee must participate in the electronic funds process utilized by the Enterprise for the collection of fees and the disbursement of payments unless the Enterprise has approved an alternative process. A hospital requesting to not participate in the electronic fee collection process and/or payment process must submit a request in writing or by electronic notice to the Enterprise describing an alternative fee collection process and/or payment process. The Enterprise shall approve or deny the alternative process in writing or by electronic notice within 30 calendar days of receipt of the request.

a. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the collection of fees, payments to hospitals shall be processed by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

b. For hospitals that do not participate in the electronic funds process utilized by the Enterprise for the disbursement of payments, payments to hospitals shall be processed through a warrant (paper check) by the Enterprise within two business days of receipt of the Outpatient Services Fee and Inpatient Services Fee.

8.3003: HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

8.3003.A. OUTPATIENT SERVICES FEE

1. Federal requirements. The Outpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Outpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Outpatient Services Fee.

3. Calculation methodology. The Outpatient Services Fee is calculated on an annual basis as 1.8208% of total hospital outpatient charges. High Volume Medicaid and CICP Hospitals' Outpatient Services Fee is discounted by 0.84%.

8.3003.B. INPATIENT SERVICES FEE

1. Federal requirements. The Inpatient Services Fee is subject to federal approval by CMS. The Enterprise shall demonstrate to CMS, as necessary for federal financial participation, that the Inpatient Services Fee is in compliance with 42 U.S.C. §§ 1396b(w), 1396b(w)(3)(E), and 1396b(w)(4).

2. Exempted hospitals. Psychiatric Hospitals, Long Term Care Hospitals and Rehabilitation Hospitals are exempted from the Inpatient Services Fee.

3. Calculation methodology. The Inpatient Services Fee is calculated on an annual per inpatient day basis of $86.22 per day for Managed Care Days and $385.35 per day for all Non-Managed Care Days with the following exceptions:

   a. High Volume Medicaid and CICP Hospitals' Inpatient Services Fee is discounted to $45.02 per day for Managed Care Days and $201.19 per day for all Non-Managed Care Days, and.

   b. Essential Access Hospitals' Inpatient Services Fee is discounted to $34.49 per day for Managed Care Days and $154.14 per day for Non-Managed Care Days.

8.3003.C. ASSESSMENT OF HEALTHCARE AFFORDABILITY AND SUSTAINABILITY FEE

1. The Enterprise shall calculate the Inpatient Services Fee and Outpatient Services Fee under this section on an annual basis in accordance with the Act. Upon receiving a favorable recommendation by the Enterprise Board, the Inpatient Services Fee and Outpatient Services Fee shall be subject to approval by the CMS and the Medical Services Board. Following these approvals, the Enterprise shall notify hospitals, in writing or by electronic notice, of the annual fee to be collected each year, the methodology to calculate such fee, and the fee assessment

schedule. Hospitals shall be notified, in writing or by electronic notice, at least thirty calendar days prior to any change in the dollar amount of the Inpatient Services Fee and the Outpatient Services Fee to be assessed.

2. The Inpatient Services Fee and the Outpatient Services Fee will be assessed on the basis of the qualifications of the hospital in the year the fee is assessed as confirmed by the hospital in the data confirmation report. The Enterprise will prorate and adjust the Inpatient Services Fee and Outpatient Services Fee for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.3003.D. REFUND OF EXCESS FEES

1. If, at any time, fees have been collected for which the intended expenditure has not received approval for federal Medicaid matching funds by CMS at the time of collection, the Enterprise shall refund to each hospital its proportion of such fees paid within five business days of receipt. The Enterprise shall notify each hospital of its refund amount in writing or by electronic notice. The refunds shall be paid to each hospital according to the process described in Section 8.3002.B.

2. After the close of each State fiscal year and no later than the following August 31, the Enterprise shall present a summary of fees collected, expenditures made or encumbered, and interest earned in the Fund during the State fiscal year to the Enterprise Board.

   a. If fees have been collected for which the intended expenditure has received approval for federal Medicaid matching funds by CMS, but the Enterprise has not expended or encumbered those fees at the close of each State fiscal year:

      i. The total dollar amount to be refunded shall equal the total fees collected, less expenditures made or encumbered, plus any interest earned in the Fund, less the minimum Fund reserve recommended by the Enterprise Board.

      ii. The refund amount for each hospital shall be calculated in proportion to that hospital's portion of all fees paid during the State fiscal year.

      iii. The Enterprise shall notify each hospital of its refund in writing or by electronic notice by September 15 each year. The refunds shall be paid to each hospital by September 30 of each year according to the process described in Section 8.3002.B.

8.3004: SUPPLEMENTAL MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL PAYMENTS

8.3004.A. CONDITIONS APPLICABLE TO ALL SUPPLEMENTAL PAYMENTS

1. All Supplemental Medicaid Payments are prospective payments subject to the Inpatient Upper Payment Limit and Outpatient Upper Payment Limit, calculated using historical data, with no reconciliation to actual data for the payment period. In the event that data entry or reporting errors, or other unforeseen payment calculation errors are realized after a supplemental payment has been made, reconciliations and adjustments to impacted hospital payments may be made retroactively, as determined by the Enterprise.

2. No hospital shall receive a DSH Payment exceeding its Hospital-Specific Disproportionate Share Hospital Limit. If upon review, the Disproportionate Share Hospital Payment, described in 10 CCR 2505-10, Section 8.3004.D**,** exceeds the Hospital-Specific Disproportionate Share Hospital Limit for any qualified hospital, the hospital's payment shall be reduced to the Hospital-Specific

Disproportionate Share Hospital Limit retroactively. The amount of the retroactive reduction shall be retroactively distributed to other qualified hospitals by each hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all qualified hospitals not exceeding their Hospital-Specific Disproportionate Share Hospital Limit.

3. In order to receive a Supplemental Medicaid Payment or Disproportionate Share Hospital Payment, hospitals must meet the qualifications for the payment in the year the payment is received as confirmed by the hospital during the data confirmation report. Payments will be prorated and adjusted for the expected volume of services for hospitals that open, close, relocate or merge during the payment year.

8.3004.B. OUTPATIENT HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing outpatient hospital services to Medicaid clients ~~shall~~are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals ~~shall not~~are not qualified to receive this payment.

3. Calculation methodology for payment. Hospital-specific outpatient billed charges from the Colorado MMIS are multiplied by the hospital's Medicare cost-to-charge ratio to arrive at hospital-specific outpatient billed costs. For each qualified hospital, the annual Outpatient Hospital Supplemental Medicaid Payment equals hospital-specific outpatient billed costs, adjusted for utilization and inflation, multiplied by a percentage adjustment factor. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Major Pediatric Teaching Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. Total payments to hospitals shall not exceed the Outpatient Upper Payment Limit. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.C. INPATIENT HOSPITAL BASE RATE SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. Hospitals providing inpatient hospital services to Medicaid clients ~~shall~~are qualified to receive this payment, except as provided below.

2. Excluded hospitals. Psychiatric Hospitals ~~shall not~~are not qualified to receive this payment.

3. Calculation methodology for payment. For each qualified hospital, the annual payment equals the hospital's expected Medicaid discharges, multiplied by the hospital's average Medicaid case mix, multiplied by the hospital's Medicaid base rate before add-ons, multiplied by a percentage adjustment factor. The percentage adjustment factor may vary by hospital such that total payments to hospitals do not exceed the available Inpatient Upper Payment Limit. The percentage adjustment factor may vary for State-Owned Government Hospitals, Non-State-owned Government Hospitals, and Privately-Owned Hospitals, for urban and rural hospitals, for State University Teaching Hospitals, for Pediatric Specialty Hospitals, for Urban Center Safety Net Specialty Hospitals, or for other hospital classifications. The percentage adjustment factor for each qualified hospital will be published annually in the Colorado Medicaid Provider Bulletin.

8.3004.D. DISPROPORTIONATE SHARE HOSPITAL SUPPLEMENTAL PAYMENT

1. Qualified hospitals.

   a. Hospitals that are Colorado Indigent Care Program providers and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide

obstetric care for Medicaid clients or is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) ~~shall~~ are qualified to receive this payment.~~; or~~

b. Hospitals with a MIUR equal to or greater than the mean plus one standard deviation of all MIURs for Colorado hospitals and have at least two obstetricians who have staff privileges at the hospital and who have agreed to provide obstetric care for Medicaid clients or is exempt from the obstetrician requirement pursuant to 42 U.S.C. § 1396r-4(d)(2)(ii) ~~shall~~are qualified to receive this payment.

2. Excluded hospitals. Psychiatric Hospitals ~~shall not~~are not qualified to receive this payment.

3. Calculation methodology for payment.

a. Qualified hospitals will receive a DSH Payment calculated as the hospital's percentage of Uninsured Costs compared to total Uninsured Costs for all remaining qualified hospitals multiplied by the state's total annual Disproportionate Share Hospital allotment to not exceed the estimated Hospital-Specific Disproportionate Share Hospital Limit.

b. DSH Payments to a Respiratory Hospital shall be limited to 60% of its estimated Hospital-Specific Disproportionate Share Hospital Limit. DSH Payments to a hospital that opened within the last two state fiscal years shall be limited to 20% of its estimated Hospital-Specific Disproportionate Share Hospital Limit.

8.3004.E. UNCOMPENSATED CARE HOSPITAL SUPPLEMENTAL MEDICAID PAYMENT

1. Qualified hospitals. General Hospitals and Critical Access Hospitals ~~shall~~are qualified to receive this payment except as provided below.

2. Excluded hospitals. Psychiatric Hospitals, Long Term Care Hospitals, and Rehabilitation Hospitals ~~shall not~~are not qualified are not qualified to receive this payment.

3. Measures. Quality incentive payment measures include five base measures and three optional measures. Hospitals can report data on up to five measures annually. Qualified hospitals must report all the base measures that apply to the hospital's services. If any base measure does not apply, a hospital may substitute an optional measure. Optional measures must be selected in the order listed.

a. The base measures for the quality incentive payment are:

i. Emergency department process measure, which includes communicating information about the Medicaid nurse advice line, primary care providers, and Regional Care Collaborative Organizations (RCCO) to Medicaid clients when they are seen in the emergency department and establishing emergency department policies or guidelines for prescribing opioids,

ii. Rate of Cesarean section deliveries for nulliparous women with a term, singleton baby in a vertex position,

iii. Rate of thirty (30) day all-cause hospital readmissions,

iv. Percentage of patients who gave the hospital an overall rating of "9" or "10" on the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey, and

v. Culture of safety.

b. The optional measures for the quality incentive payment are:

i. Active participation in the RCCO,

ii. Advance care planning, and

iii. Screening and intervention for tobacco use.

4. The hospital shall certify that based on best information, knowledge, and belief, the data included in the data reporting template is accurate, complete, and truthful, is based on actual hospital records, and that all supporting documentation will be maintained for a minimum of six years. The certification shall be made by the hospital's Chief Executive Officer, Chief Financial Officer, or an individual who reports directly to the Chief Executive Officer or Chief Financial Officer with delegated authority to sign for the Chief Executive Officer or Chief Financial Officer so that the Chief Executive Officer or Chief Financial Officer is ultimately responsible for the certification.,

5. Calculation methodology for payment.

a. Determine available points by hospital to a maximum of 10 points per measure.

i. Available points are defined as the number of measures for which a hospital qualifies multiplied by the number of points designated for the measure.

b. Determine the total points earned per measure by hospital based on scoring criteria established by the Department.

c. Normalize the total points awarded by dividing total points earned by total points eligible, multiplied by 50.

d. Calculate adjusted Medicaid discharges by hospital.

i. Adjusted Medicaid discharges are calculated by multiplying the number of Medicaid inpatient discharges by gross Medicaid billed charges divided by gross inpatient Medicaid billed charges.

ii. For hospitals with fewer than 200 annual Medicaid discharges, the total number of discharges is multiplied by 125% to arrive at the number of Medicaid discharges for use in this calculation, consistent with the Medicare prospective payment system calculation.

e. Calculate total adjusted discharge points

i. Adjusted discharge points are defined as the total number of points earned for all measures multiplied by the number of adjusted Medicaid discharges.

f. Determine the dollars per discharge point.

i. Dollars per discharge point are tiered such that hospitals with higher quality point scores receive higher points per discharge. The dollar amount per discharge point for five tiers of quality points between 1 and 50 are shown in the table below:

Tier	Hospital Quality Points Earned	Dollars per Discharge Point
1	1-10	$5.95

2	11-20	$8.93
3	21-30	$11.90
4	31-40	$14.88
5	41-50	$17.85

g. Calculate payment by hospital by multiplying the adjusted discharge points for that hospital by the dollars per discharge point.

5. The total funds for the quality incentive payment for the year ending September 30, 2017 is eighty-nine million six hundred ~~sixty nine~~sixty-nine thousand five hundred two dollars ($89,669,502).

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Program Rules Concerning Pharmaceutical PAR Letters, Section 8.800
Rule Number: MSB 17-07-06-A
Division / Contact / Phone: Client and Clinical Care Office/Pharmacy Unit / January Montano / 303-866-6977

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 17-07-06-A, Revision to the Medical Assistance Program Rules Concerning Pharmaceutical PAR Letters, Section 8.800

3. This action is an adoption of: an amendment

4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.800.7, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text beginning at 8.800.7.B with the proposed text beginning at 8.800.7.B through the end of 8.800.7.B. This rule is effective October 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Program Rules Concerning Pharmaceutical PAR Letters, Section 8.800
Rule Number: MSB 17-07-06-A
Division / Contact / Phone: Client and Clinical Care Office/Pharmacy Unit / January Montano / 303-866-6977

STATEMENT OF BASIS AND PURPOSE

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

   The Department has identified an inefficiency in its noticing providers of prior authorization determinations. The rule is being updated to allow the Department to address the inefficiency in its operations and reduce the amount of duplicative coorespondence sent to providers.

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:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015);
   25.5-5-202(1)(a)(I) and (3), C.R.S. (2016)

Initial Review	**08/11/17**	Final Adoption	**09/08/17**
Proposed Effective Date	**10/30/17**	Emergency Adoption	

DOCUMENT #09

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Program Rules Concerning Pharmaceutical PAR Letters, Section 8.800
Rule Number: MSB 17-07-06-A
Division / Contact / Phone: Client and Clinical Care Office/Pharmacy Unit / January Montano / 303-866-6977

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.

   Providers will be affected by the proposed rule as they will experience a reduction in the number of unnecessary and duplicative correspondence notifying them of prior-authorization determinations.

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

   There will be no impact to the affected classes of persons since providers will continue to receive a response to prior authorization requests. For prior authorization requests via telephone, providers receive a verbal response at the conclusion of the call. A letter can also be manually generated and mailed if a provider requests additional documentation of a prior authorization request determination. For prior authorization requests submitted via fax, a fax response is sent back to the provider.

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

   The reduction in unnecessary correspondence sent to providers will result in an estimated $54,430 annual reduction in Department operating costs. The resultant savings to the Departments Operations Budget will be reallocated to other areas of need within the Department.

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

   The benefits of the proposed rule are a reduction in the number of unnecessary letters sent to providers, as well as a reduction in Department operation costs.

   Inaction would yield no benefit.

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

   None.

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.

   Not Applicable.

8.800.7 PRIOR AUTHORIZATION REQUIREMENTS

8.800.7.A. Prior authorization shall be obtained before drugs that are subject to prior authorization restrictions may be provided as a benefit. Prior authorization requests may be made by the member's physician, any other health care provider who has authority under Colorado law to prescribe the medication being requested or any long-term-care pharmacy or infusion pharmacy that fills prescriptions on behalf of the member and is acting as the agent of the prescriber. The prior authorization request shall be made to the Fiscal Agent. The prescriber shall provide any information requested by the Fiscal Agent including, but not limited to, the following:

1. Member name, Medical Assistance Program state identification number, and birth date;

2. Name of the drug(s) requested;

3. Strength and quantity of drug(s) requested; and

4. Prescriber's name and medical license number, Drug Enforcement Administration number, or National Provider Identifier.

8.800.7.B. When the prior authorization request is received, it shall be reviewed to determine if the request is complete. If it is complete, the requesting provider shall be notified of the approval or denial of the prior authorization request via telephone and/or facsimile at the time the request is made, if possible, but in no case later than 24 hours after the request is made. ~~Any verbal decision shall be confirmed in writing.~~ If the prior authorization request is incomplete or additional information is needed, an inquiry to the party requesting the prior authorization shall be initiated within one working day from the day the request was received. If no response is received from that party within 24 hours of the Department's inquiry, the prior authorization shall be denied.

8.800.7.C. In an emergency situation, the pharmacy may dispense up to a 72-hour supply of a covered drug that requires a prior authorization if it is not reasonably possible to request a prior authorization for the drug before it must be dispensed to the member for proper treatment. The pharmacist may call the prior authorization help desk to receive override approval. Prescriptions dispensed under the override approval are eligible for reimbursement.

8.800.7.D. The Department shall solicit and maintain a list of any interested parties who wish to comment on any proposed additions to the drugs that are subject to prior authorization. The list of interested parties shall be notified of any proposal and shall be given reasonable time, not to exceed 30 days, to comment or recommend changes before any drugs become subject to prior authorization. Notwithstanding the foregoing, if a new drug is approved by the FDA and that drug is in a class of drugs already subject to prior authorization, the new drug shall also be subject to prior authorization without any comment period.

8.800.7.E. Any changes to the drugs that are subject to prior authorization or any documentation required to obtain a prior authorization shall be published in the Provider Bulletin. Notification in the Provider Bulletin shall satisfy any notification requirements of any such changes.

Title of Rule: Revision to the Medical Assistance Rules concerning the Guidelines for Long Term Care Services, Section 8.401.1
Rule Number: MSB 17-06-22-C
Division / Contact / Phone: Office of Community Living, Long Term Supports & Services Division / Dennis Roy / 303-866-4828

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board
2. Title of Rule: MSB 17-06-22-C, Revision to the Medical Assistance Rules concerning the Guidelines for Long Term Care Services
3. This action is an adoption of: an amendment
4. Rule sections affected in this action (if existing rule, also give Code of Regulations number and page numbers affected):

   Sections(s) 8.401.1, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).
5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.401.01 with the proposed text beginning at 8.401.1 through the end of 8.401.1. Insert Appendix A at the end of section 8.400, this is new text to be included. This rule is effective October 30, 2017.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules concerning the Guidelines for Long Term Care Services, Section 8.401.1
Rule Number: MSB 17-06-22-C
Division / Contact / Phone: Office of Community Living, Long Term Supports & Services Division / Dennis Roy / 303-866-4828

STATEMENT OF BASIS AND PURPOSE

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

   The purpose of this rule change is to incorporate the Department created Age Appropriate Guidelines document into the rules concerning Long Term Care eligibility. The Age Appropriate Guidelines document will provide Case Managers with guidance when completing the ULTC 100.2 assessment on children ages 18 and under.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

   42 U.S.C. §1396n(c)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2015); 25.5-6-106(1) and 25.5-6-313(1), C.R.S.

Initial Review	**08/11/17**	Final Adoption	**09/08/17**
Proposed Effective Date	**10/30/17**	Emergency Adoption	

DOCUMENT #08

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rules concerning the Guidelines for Long Term Care Services, Section 8.401.1
Rule Number: MSB 17-06-22-C
Division / Contact / Phone: Office of Community Living, Long Term Supports & Services Division / Dennis Roy / 303-866-4828

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.

   Children under the age of 18 will benefit from Case Managers utilizing age appropriate standards when the ULTC 100.2 is administered.

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

   Children and their families will now benefit from age appropriate scoring when a child under the age of 18 is assessed for long term care eligibility.

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

   The Department does not expect any costs to be associated with the implementation of the proposed rule change.

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

   Inaction of the propBosed rule change would maintain the current business processes of Case Managers completely the ULTC 100.2 assessment on children without respect to the child's age and developmental milestones.

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

   The proposed rule change is the least costly method for providing case managers with age appropriate guidance for assessing a child's functional ability to complete Activities of Daily Living.

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

   The alternative method for achieving this rule change's purpose would be to develop a new long term care assessment specifically designed for children. This process is actually taking place right now. However, the timeline for implementation of that assessment has an end date of 2020. This proposed rule change will provide guidance to case managers in the interim.

Community Based Services provided under waivers granted by the Federal government.

.101 Nursing facility services and Home and Community Based Services are benefits only under Medicaid. Nursing Facility Services and Home and Community Based Services are non-benefits under the Modified Medical Program.

.102 State only funding will pay for nursing facility services for October 1988 and November 1988 for clients under the Modified Medical Program who were residing in a nursing facility October 1, 1988. This is intended to give clients time to qualify for Medicaid.

.103 Until the implementation of SB 03-176 a legal immigrant, as defined in C.R.S. section 25.5-4-103, who received Medicaid services in a nursing facility or through Home and Community Based Services for the Elderly, Blind and Disabled on July 1, 1997, who would have lost Medicaid eligibility due to his/her immigrant status, shall continue to receive services under State funding as long as he/she continues to meet Medicaid eligibility requirements.

.104 If a nursing facility client, who is only eligible for the Modified Medical Program, is making a valid effort to dispose of excess resources but legal constraints do not allow the conversion to happen by December 1, 1988, the client may have 60 additional days to meet SSI eligibility requirements.

.11 Standard Medicaid long term care services are services provided in:

- Skilled care facilities (SNF)
- Intermediate care facilities (ICF)
- Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)

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*, and Long Term Home Health)

.11 The guidelines for long term care are based on a functional needs assessment 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 Utilization Review Contractor shall certify as to the functional need for the nursing facility level of care. A Utilization Review Contractor reviews the information submitted on the ULTC 100.2 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 based on a set of criteria and weights approved by the State which measures the degree of impairment in 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 Utilization Review Contractor may certify that the person being reviewed is eligible for nursing facility level of care.

B. The Utilization Review Contractor's review shall include the information provided by the functional assessment screen.

C. A person's need for basic Medicaid benefits 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**:**	☐Open Wound
☐Pain	☐Stoma Site
☐Sensory Impairment	Supervision:
☐Limited Range of Motion	☐*Cognitive Impairment*
☐Weakness	☐Memory Impairment
☐Balance Problems	☐Behavior Issues
☐Shortness of Breath	☐Lack of Awareness
☐Decreased Endurance	☐Difficulty Learning
☐Falls	☐Seizures
☐Paralysis	Mental Health:
☐Neurological Impairment	☐Lack of Motivation/Apathy
☐Oxygen Use	☐Delusional
☐Muscle Tone	☐Hallucinations
☐Amputation	☐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	☐ Ostomy
☐ Sensory Impairment	☐ Catheter
☐ Limited Range of Motion	Supervision Need:
☐ Weakness	☐ Cognitive Impairment
☐ Shortness of Breath	☐ Memory Impairment
☐ Decreased Endurance	☐ Behavior Issues
☐ Fine Motor Impairment	☐ Lack of Awareness
☐ Paralysis	☐ Difficulty Learning
☐ Neurological Impairment	☐ Seizures
☐ Bladder Incontinence	Mental Health:
☐ Bowel Incontinence	☐ Lack of Motivation/Apathy
☐ Amputation	☐ Delusional
☐ Oxygen Use	☐ Hallucinations
☐ Physiological defect	☐ Paranoia
☐ Balance	
☐ Muscle Tone	
☐ Impaction	

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

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

Comments:

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

These guidelines provide instructions for using the Uniform Long Term Care (ULTC) – 100.2 assessment to assess the needs of children for the following Home and Community-Based Services (HCBS) Waivers: Children's Extensive Support (CES), Children's HCBS (CHCBS), Children's Habilitation Residential Program (CHRP), Children with Life Limiting Illness (CLLI) and Children with Autism (CWA). Each individual and their circumstances must be considered when completing the assessment. Case Managers must score each child according to his/her age and individual needs.
Please consult evidence based resources and references to further your understanding of child development.

A. What is child development?

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

B. What are developmental milestones?

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

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

The ULTC 100.2 is an assessment to determine the functional needs of a client by evaluating the client's ability to independently complete Activities of Daily Living (ADLs). ADLs are activities performed in the course of a typical day in a person's life such as: bathing, dressing, toileting, mobility, transferring, and eating. ADLs also include behavior and memory supervision activities needed for daily life. The ULTC 100.2 is a foundational component of the service planning process that helps:

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

The assessment measures what the child is able to do, not what he/she prefers to do. In other words, assess the child's ability to do particular activities, even if he/she doesn't usually do the activity.
Consider age-appropriate behavior when assessing the child's ability to complete any ADL. If the child is not able to complete the ADL due to his or her age, then the child will not score in the ADL. However, if a child needs

assistance in completing an ADL that is above and beyond the assistance a typically developing peer would require, then a score above 0 may be warranted.

D. Scoring

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

0 = Independent:

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

1 = Minimal Assistance:

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

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

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

2 = Moderate Assistance:

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

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

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

3 = Total Assistance:

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

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

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

E. Justification of Scoring (Due To's)

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

1. **Physical Impairment**
    a. **Example: client requires assistance due to paralysis**
2. **Supervision**
    a. **Example: client requires assistance due to lack of awareness**
3. **Mental Health**
    a. **Example: client requires assistance due to hallucinations**

D. Comment Box (Narratives)

Narratives are required in the "Comment box" to support each score and to help others who read the assessment understand a client's over all need. Descriptions should be person-centered, meaningful

and should justify level of assistance required based on "due to's." Comment descriptions should include:

a. How/Source: How the information obtained: Individual/caregiver, Case Manager Observation, or other?

b. What: What type of assistance is required to complete the task and how does the child manage to complete the task?

c. Who: Who is providing assistance?

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

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

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

a. Writing Narrative Statements in the Assessment
b. Dear Administrator Letter – May 11, 2015

E. Activities of Daily Living (ADL)

1. BATHING

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

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

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

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

Considerations for a child from birth to 59 months:

a. A child younger than 12 months is dependent on a caregiver for bathing.
b. A child 12-24 months can typically sit-up in the bath and begin to participate, however, the child still requires assistance and supervision.
c. A child 24-59 months typically participates in bathing, however, still requires assistance and supervision.

Considerations for a child from 5 to 18 years:

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

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

2. DRESSING

Definition: The ability to dress and undress as appropriate.

This includes the ability to put on and remove basic garments such as underwear, shirts, sweaters, pants, socks, hats, and jackets. It also includes fine motor coordination for buttons, snaps, zippers, and the ability to choose appropriate clothing for the weather. For older children, this activity includes the ability to put on prostheses, braces, anti-embolism hose or other assistive devices.

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

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

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for dressing.
b. A child 12-24 months can typically pull off hat, socks, and mittens.
c. A child 24-35 months can typically begin to help dress self.

d. A child 36-47 months can typically put on shoes (but cannot tie laces) and dress self with some help (buttons, snaps, zippers).

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

Considerations for a Child from 5 to 18 Years:

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

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

3. TOILETING

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

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

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

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

Considerations for a Child from Birth to 59 Months:

a. A child younger than 12 months is dependent on a caregiver for toileting.
b. A child 12-42 months typically requires the use of diapers, though begins to gain some control of bowels/bladder.
c. A child 43-59 months is typically toilet trained; however occasional night time bedwetting or accidents may occur.

Considerations for a Child from 5 to 18 Years:

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

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

4. MOBILITY

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

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

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

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

Considerations for a Child from Birth to 59 Months:

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

Considerations for a Child from 5 to 18 Years:

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

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

5. TRANSFERS

Definition: The physical ability to move between surfaces.

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

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

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

Considerations for a Child from Birth to 59 Months:

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

Considerations for a Child from 5 to 18 Years:

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

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

6. EATING

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

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

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

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

Considerations for a Child from Birth to 59 Months:

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

Considerations for a Child from 5 to 18 Years:

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

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

7. SUPERVISION: (Behavioral)

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

Considerations for a Child from Birth to 59 Months:

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

Considerations for a Child from 5 to 18 Years:

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

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

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

a. Verbal or physical threats and/or actions against self and/or others.
b. Socially inappropriate or sexually aggressive behaviors.
c. Wandering with little safety awareness.
d. Removing or destroying property.

8. SUPERVISION: (Memory/Cognition)

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

Considerations for a Child from Birth to 59 Months:

a. A child 12-18 months typically says 8-20 words, identifies objects in a book, and follows simple one step directions.
b. A child 18-24 months typically uses two to three word phrases, refers to self by name, and points to parts of face when asked.
c. A child 25-36 months typically enjoys simple make-believe games and enjoys simple stories or songs.
d. A child 36-59 months typically begins counting; identifying colors and letters; and can follow simple rules of a game.

Considerations for a Child from 5 to 18 years:

a. A child 5-9 years old may require occasional supervision necessary to acquire and use information, reason, problem-solve, complete tasks, or communicate needs in order to care for oneself safely.
b. A child 5-18 years old has the ability to recognize and adjust to daily routines, interact with peers and others appropriately, understand directions, understand basic home safety and stranger awareness.

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

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

a. Failure to recognize and adjust to daily routines.
b. Inappropriate interactions with peers and other.
c. Lack of basic home safety understanding and stranger awareness.

F. Activities of Daily Living Scores

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

G. Assessment Demographic

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

F. Summary

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