DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Old Age Pension Health Care Program Concerning OAP Regulatory Review Updates
Rule Number: MSB 20-12-10-B
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

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 20-12-10-B, Revision to the Special Financing Division Old Age Pension Health Care Program Concerning OAP Regulatory Review Updates

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) 8.940, 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 8.940 with the proposed text beginning at 8.941.1 through the end of 8.943.6.B. This rule is effective June 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Old Age Pension Health Care Program Concerning OAP Regulatory Review Updates
Rule Number: MSB 20-12-10-B
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

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 rules for the Old Age Pension Health Care Program underwent a regulatory review during the summer of 2020. While no public comments were received during the review, the Special Financing Division found that changes needed to be made to ensure the rule is current and accurate. The rule has been reorganized to ensure that like information is grouped together, and definitions have been added and updated to match current information. Additionally, information that is no longer relevant or correct has been removed.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020);
   25.5-2-101, C.R.S. (2020)

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Special Financing Division Old Age Pension Health Care Program Concerning OAP Regulatory Review Updates
Rule Number: MSB 20-12-10-B
Division / Contact / Phone: Special Financing / Taryn Graf / 5634

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.

   The rule update keeps the current policies intact while bringing some of the processes up to date, including updating the lawful presence verification process, and the ability for eligibility technicians to accept copies of lawful presence documents. Updating these processes will help ease the burden of providing original documents for both eligibility technicians and applicants. No classes will be affected with monetary changes; however, both providers and applicants will benefit due to program processes being brought up to date.

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

   This rule update will make the process easier for providers and applicants to verify lawful presence by allowing a broader number of lawful presence documents to be utilized as well as allowing copies of those documents to be used without being notarized or previously seen by county caseworkers or medical assistance site workers.

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 of Health Care Policy and Financing will have no fiscal impact of this rule change for the Department. The funds for the Old Age Pension Health Care Program are appropriated, and this rule update will have no effect on the appropriation.

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

   The rule as it stands contains outdated information and processes. If left as is, applicants who have valid lawful presence documentation that is not specifically listed in the current rule could be found ineligible for the program. The rule also

currently references programs that no longer exist, specifically OAP-A and OAP-B, which as of March 1, 2020 have been combined into one single program.

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

   The Department of Health Care Policy and Financing does not foresee any fiscal impact of this rule change; there are not any less costly methods that were considered.

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.

   Making these updates to the rule is the only method available for achieving the intended results.

8.940 OLD AGE PENSION HEALTH CARE PROGRAM

8.941 EXTENT AND LIMITATIONS OF MEDICAL CARE

8.941.1 GENERAL DESCRIPTION - OLD AGE PENSION HEALTH CARE PROGRAM

In accordance with the Constitution of Colorado, Article XXIV, Section 7, and the Colorado Public Assistance ~~Social Services~~ Act, an Old Age Pension Health Care Program is established to provide necessary medical care for the Old Age Pension (OAP) recipients who do not qualify for Medicaid under Title XIX of the Social Security Act and Colorado statutes. The State Department is designated as the single State agency to administer the program.

A. The Old Age Pension Health Care Program provides optional benefits to clients who qualify for (State only) OAP ~~A and (State only) OAP B~~ pensions who do not qualify for Federal Financial Participation (FFP) in the Colorado Medicaid Program. These cases are coded with Supplemental Income Status Code (SISC) C.

B. Under the Old Age Pension Health Care Program, only the following State funded benefits are provided:

1. ~~p~~Physician and practitioner services~~,~~

2. ~~i~~Inpatient hospital~~,~~

3. ~~o~~Outpatient services~~,~~

4. ~~l~~Lab and x-ray~~,~~

5. ~~e~~Emergency transportation~~,~~

6. ~~e~~Emergency ~~dental,~~ services

7. ~~d~~Dental~~,~~

8. ~~p~~Pharmacy~~,~~

   i. ~~Effective January 1, 2006,~~ Medicare Part D prescription drugs provided pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (defined at 42 U.S.C. s~~S~~ections 1395w-102 and 141 and 42 C.F.R. Part~~Section~~ 423, et seq.) are~~shall~~ not ~~be~~ a benefit for those individuals who are eligible for both Medicare and the Old Age Pension Health Care Program. The pharmacy drug benefit under the Old Age Pension Health Care Program is subject to the requirements set forth at ~~shall follow Medsicaid regulations, as specified under 10 CCR 2505-10,~~ Section 8.800.

9. ~~h~~Home health services and supplies~~, and~~

10. Medicare cost sharing~~.~~

   i. If Medicare pays for a medical service that is a non-benefit under the Old Age Pension Health Care Program, ~~for this group,~~ the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program.

~~Effective January 1, 2006, Medicare Part D prescription drugs provided pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (defined at 42 U.S.C. Sections 1395w-102 and 141 and 42 C.F.R. Section 423, et seq.) shall not be a benefit for those individuals who are eligible for both Medicare and the Old Age Pension Health Care Program. The pharmacy drug benefit under the Old Age Pension Health Care Program shall follow Medicaid regulations, as specified under10 CCR 2505-10, Section 8.800.~~

C. ~~_____~~For the benefits listed above, the Old Age Pension Health Care Program shall only be used to provide clients with health care services determined to be medically necessary by a qualified ~~the~~ health care provider.

D~~C~~. All other medical benefits not listed in paragraph B are excluded under the Old Age Pension Health Care Program. Inpatient care in an institution for tuberculosis or mental diseases, skilled and intermediate nursing facility services, and home and community~~-~~based services are also excluded.

E~~D~~. ~~The Old Age Pension Health Care Program e~~Eligibility shall not be retroactive and ~~. Eligibility~~ shall begin on~~with~~ the date of application or date eligibility is established, whichever is later.

~~E. _____The Executive Director of the Department of Health Care Policy and Financing, under the direction of the State Medical Services Board, shall manage the Old Age Pension Health and Medical Care fund to assure that utilization controls and other mechanisms are in place in order to hold expenditures within the constitutional and statutory limits.~~

~~Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will exceed the available funds, he/she shall take action to reduce expenditures as needed by reducing, suspending, or eliminating payments for covered benefits.~~

~~The Executive Director shall consider reducing, suspending or eliminating benefits, individually or in any combination, based upon the shortest duration of time and considering the least impact on the client. The Executive Director shall report to the Board whenever such action is required, specifying the dollar impact, length of time for the reduction, and the number of clients and providers affected. In addition, the Executive Director shall report to the Board on the feasibility of other cost reduction options.~~

~~Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will be less than the available funds, he/she may take action to increase expenditures up to constitutional and statutory limits by modifying the reimbursement methodology for covered benefits. In addition, the Executive Director shall report to the Board whenever such action is taken.~~

F. ~~F. _____~~Counties shall provide information to Old Age Pension Health Care Program clients regarding the disposal of excess resources in order to qualify for the Medicaid program. Such information shall include advisements concerning the prohibition of transfer of assets without fair consideration.

~~G. If Medicare pays for a medical service that is a non-benefit for this group, the co-insurance and deductible will not be paid by the Old Age Pension Health Care Program.~~

8.941.2 DEFINITIONS

A. Aid to the Needy Disabled-Colorado Supplement (AND-CS) – Program that provides a supplemental payment for individuals age zero (0) to fifty-nine (59) who are receiving Social Security Income (SSI) ~~SI~~ due to a disability or blindness, but are not receiving the full SSI benefit standard, as defined in 9 CCR 2503-5 3.510.

B. Aid to the Needy Disabled-State Only (AND-SO) – Program that provides interim assistance to individuals age eighteen (18) through fifty-nine (59) years of age (unless diagnosed with blindness, then age zero [0] through fifty-nine [59] years of age) who are disabled or blind but have not been approved for SSI or Social Security Disability Insurance (SSDI). Individuals are required to meet the total disability requirements of the program in addition to the non-financial and financial eligibility requirements. Individuals who are partially disabled or have a short-term disability are not eligible.

C. Federal Financial Participation (FFP) – The portion paid by the federal government to states for their share of expenditures for providing Medicaid services and for administering the Medicaid program and certain other human services programs.

D. Medical ID Card – The card issued to members and used by providers to verify member eligibility.

~~D. Medical – Throughout this section of the rules, all references to medical shall mean Tthe Old Age Pension Health Care Program. Exceptions will be noted in the specific rule.~~

E. Old Age Pension (OAP) – Program that provides financial assistance for low-income Colorado residents who are sixty (60) years of age or older who meet all financial and non-financial eligibility requirements.

F. Old Age Pension-C (OAP-C) – Program for individuals who are sixty (60) years of age or older who have been committed to the Colorado Mental Health Institute or to a Regional Center by order of the district or probate court.

G. State Department or Department – ~~Throughout this section of the rules, State Department shall mean t~~The Colorado Department of Health Care Policy and Financing.

H. Supplemental Income Status Code (SISC) – System codes used to distinguish the different types of state supplementary benefits (such as OAP) a recipient may receive. Supplemental Income Status Codes determine the FFP for benefits paid on behalf of groups covered under the Medical Assistance program.

I. Supplemental Security Income (SSI) – A Federal income ~~supplemental~~ supplement program funded by general tax revenues (not Social Security taxes) that provides income to aged, blind, or disabled individuals with little or no income and resources.

~~Throughout this section of the rules, all references to "medical" shall mean the Old Age Pension Health Care Program. Exceptions will be noted in the specific rule. All forms of communication to providers, counties and recipients (Provider bulletins, claim forms, authorization forms, Medicaid Authorization Card (MAC etc.), shall include Colorado Medical Assistance Program, and Old Age Pension Health Care Program.~~

8.941.3 GROUPS ASSISTED UNDER THE OLD AGE PENSION HEALTH CARE PROGRAM

Old Age Pension Health Care Program benefits are provided to persons receiving OAP ~~A, OAP-B, and OAP refugees~~ who do not meet SSI eligibility criteria~~,~~ but do meet the State eligibility criteria for the Old Age Pension Health Care Program. These persons qualify for a SISC ~~Code~~ C.

A. SISC ~~Code~~ C – this code is for persons eligible to receive financial assistance under OAP ~~A, OAP-B, or OAP Refugee Assistance,~~ who do not receive an SSI payment, and do not otherwise qualify for the Colorado Medicaid Program. ~~Code~~ SISC C signifies that no FFP is available in medical assistance program expenditures.

B. Recipients of financial assistance under ~~State AND~~AND-CS, ~~State AB~~AND-SO, or OAP~~-"~~C~~"~~ are not eligible for assistance under the Old Age Pension Health Care Program.

8.941.4 FINANCIAL ASSISTANCE

All rules applicable to Old Age Pension financial assistance program payments (as set forth in the Department of Human Services rules at 9 CCR 2503-~~3~~5) shall apply to the Old Age Pension Health Care Program.

8.941.5 CERTIFICATION OF PAYMENT FOR PROVIDERS

When submitting a claim for ~~All providers of~~ medical services ~~in their submission of claims~~ to the Old Age Pension Health Care Program providers must submit a certification that states the following: ~~certify that,~~ "I will accept as payment in full, payment made under the Old Age Pension Health Care Program, and certify that no supplemental charges have been, or will be, billed to the patient, except for those non-covered items, or services, if any, which are not reimbursable under the Old Age Pension Health Care Program."

~~**8.941.6 GENERAL EXCLUSIONS**~~

~~In addition to any specific exclusion defined in this manual, the general exclusions from coverage of the Old Age Pension Health Care Program defined by the rules of the Department of Human Services (9 CCR 2503-1) are also excluded.~~

8.941.~~7~~6 OUT-OF-STATE MEDICAL CARE

All requirements for out-~~-~~of-~~-~~state medical care as defined by ~~10 CCR 2505-10,~~ Section 8.013 apply to the Old Age Pension Health Care Program for covered services with the exception that any reduction, suspension or elimination of benefits must be applied.

8.941.~~8~~7 SUBMISSION OF CLAIMS

Rules governing the submission or payment of claims, provider or recipient appeals, third party liability, overpayment, fraud and abuse, and State identification numbers as defined in ~~10 CCR 2505-10,~~ Section 8.1~~0~~00, ~~, et seq.~~ apply to the Old Age Pension Health Care Program for covered services with the exception that any reduction, suspension or elimination of benefits provided must also be applied.

8.941.~~9~~8 REIMBURSEMENT TO PROVIDERS

T~~In accordance with 8.941.1(E), t~~he ~~Executive Director may alter the reimbursement for any service with the condition that expenditures remain within the constitutional and statutory limits.~~ When ~~R~~reimbursement rates are modified, notifications shall be published on the Department's website and ~~.~~ ~~When reimbursement rates are modified, notification~~ will be published in the Provider Bulletin.

~~The Executive Director of the Department of Health Care Policy and Financing, under the direction of the State Medical Services Board (Board), shall manage the Old Age Pension Health and Medical Care fund to assure that utilization controls and other mechanisms are in place in order to hold expenditures within the constitutional and statutory limits.~~

~~Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will exceed the available funds, they shall take action to reduce expenditures as needed by reducing, suspending, or eliminating payments for covered benefits.~~

~~The Executive Director shall consider reducing, suspending or eliminating benefits, individually or in any combination, based upon the shortest duration of time and considering the least impact on the client. The~~

Executive Director shall report to the Board whenever such action is required, specifying the dollar impact, length of time for the reduction, and the number of clients and providers affected. In addition, the Executive Director shall report to the Board on the feasibility of other cost reduction options.

Should the Executive Director, at any time during the course of a fiscal year, determine that expenditures will be less than the available funds, they may take action to increase expenditures up to constitutional and statutory limits by modifying the reimbursement methodology for covered benefits. In addition, the Executive Director shall report to the Board whenever such action is taken.

8.941.109 CLIENT CO-PAYMENT

Clients Recipients of benefits under the OAP Health Care Program shall be are responsible for paying directly to providers a co-payment set portion of the cost of services according to the regulations and fee schedule as set forth under defined for the Medical Assistance and described in 10 CCR 2505-10, Section 8.754.1. This charge to the recipient will be called co-payment.

Clients Those recipients whose co-payments reach a limit of $300.00 within a January 1 through December 31 calendar year will be exempted from further co-payments during that year. The exemption will begin on the date of payment that the $300 limit for the claim, which indicates that the cumulative maximum has been reached.

A client must It will be a recipient's responsibility to present the Medical ID Card to the provider at the time a service is rendered in order to claim exemption from copayment for that service.

8.942 CHANGE OF SUPPLEMENTAL INCOME STATUS CODE (SISC) TO MEDICAID

8.942.1 MEDICAID QUALIFICATION

When a recipient of OAP-A or OAP-B and the Old Age Pension Health Care Program or Old Age Pension Health Care Supplemental Program subsequently qualifies for Medicaid, his/hertheir SISC code must be changed to indicate Medicaid benefits. Additionally, the county must backdate the Medicaid benefits to the date the individual became eligible for Medicaid even if the recipient was eligible for the Old Age Pension Health Care Program or the Old Age Pension Health Care Supplemental Program at the time. Some reasons for Medicaid eligibility are: receipt of Supplemental Security Income, receipt of Social Security disability benefits, attainment of age 65, changes in alien status or reduction of resources that caused the individual to be ineligible for Medicaid.

8.943 IDENTIFICATION AND AFFIDAVIT REQUIREMENTS [Emer. Rule eff. 10/1/06; Perm. Rule eff. 10/30/06]

8.943.1 Effective August 1, 2006, each applicant eighteen (18) years of age or older shall produce the following identification:Lawful Presence Documentation

A. Each applicant eighteen (18) years of age or older, shall be considered lawfully present in the country if they produce a document or waiver in accordance with 1 CCR 204-30 Rule 5 (effective September 17, 2020), which is hereby incorporated by reference. This incorporation of 1 CCR 204-30 Rule 5 excludes later amendments to, or editions of, the referenced material. Pursuant to Section 24-4-103 (12.5), C.R.S., the Department maintains copies of this 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, Colorado 80203. Certified copies of incorporated materials are provided at cost upon request.A valid Colorado Driver's License or a Colorado Identification Card, issued pursuant to Article 2 of Title 42, C.R.S.;

B. If an applicant does not have the required documentation, he or she must be given a reasonable opportunity period of up to ten (10) business days to provide the required documentation. If the

applicant does not provide the required documentation within those ten (10) business days, then the application shall be denied.

C. If an applicant whose benefits are terminated on the basis of not having the documents required by this section provides such documentation within ten (10) weeks of the date of denial, the denial shall be rescinded, and the client made eligible back to the data of application, provided he or she meet all other eligibility requirements.

~~B. A United States Military Card or a Military Dependents' Identification Card;~~

~~C. A United States Coast Guard Merchant Mariner Card;~~

~~D. A Native American Tribal Document; OR~~

~~E. Other forms of identification or a waiver process to ensure that an individual proves lawful presence in the United States as authorized by the Executive Director of the Colorado Department of Revenue pursuant to Section 24-76.5-130(5)(a), C.R.S.~~

8.943.2 ~~Effective August 1, 2006, e~~Each applicant eighteen (18) years of age or older shall execute an affidavit stating:

A. That he or she is a United States Citizen or legal permanent resident; OR

B. That he or she is a legal permanent resident or otherwise lawfully present in the United States pursuant to 1 CCR 204-30 Rule 5~~Federal Law~~.

8.943.3 . ~~For~~ For an applicant who has executed an affidavit stating that he or she is an alien lawfully present in the United States under 8.943.2.B, the following shall apply:

A. Verification of lawful presence shall be made through the Federal Systematic Alien Verification ~~of~~ for Entitlements (SAVE) Program operated by the United States Department of Homeland Security or a successor program designated by the United States Department of Homeland Security.

~~B. Until such verification of lawful presence is made, the affidavit may be presumed to be proof of lawful presence.~~

~~C~~B. The county or medical assistance site shall perform the verification of lawful presence no more than three business~~30~~ days after receipt of the affidavit stating that the applicant is otherwise lawfully present in the United States pursuant to 1 CCR 204-30 Rule 5~~Federal Law~~. A SAVE verification is not needed for Applicants who provide an ID issued by a REAL ID Act compliant state that bears the REAL ID Act indicator.

8.943.4 Photocopies of the identification listed in 8.943.1 shall be acceptable identification. ~~if the photocopies meet the following criteria:~~

~~**A. A notary public must have certified on the photocopy or an attachment that individually identifies the original document that he or she saw the original document and that the photocopy is a true copy of that original; OR**~~

~~**B. Photocopies made by a county caseworker or medical assistance site worker who attests in writing on the photocopy that he or she saw the original documentation and that the photocopy is a true copy of that original.**~~

~~8.943.5~~A. The county shall retain a photocopy of the documentation required under section 8.943.

~~8.943.6.A. If an applicant does not have the required documentation, he or she must be given a reasonable opportunity period of up to ten (10) business days to provide the required documentation. If the applicant does not provide the required documentation within those ten (10) business days, then the application shall be denied.~~

~~8.943.6.B. If an applicant whose benefits are terminated on the basis of not having the documents required by 8.943.1 provides such documentation within ten (10) weeks of the date of denial, the denial shall be rescinded, and the client made eligible back to the data of application, provided he or she meet all other eligibility requirements.~~

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Adult Day Services, Section 8.491 and 8.515.70
Rule Number: MSB 20-10-27-A
Division / Contact / Phone: OCL / Cassandra Keller / 5181

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 20-10-27-A, Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Adult Day Services, Section 8.491 and 8.515.70

3. This action is an adoption of: amendment

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

   Sections(s) 8.491 and 4.515.70, 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 8.491 with the proposed text beginning at 8.491.1 through the end of 8.491.5. Replace the current text at 8.515.70 with the proposed text beginning at 8.815.70.A through the end of 8.815.70.F. This rule is effective June 10, 2021.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Adult Day Services, Section 8.491 and 8.515.70
Rule Number: MSB 20-10-27-A
Division / Contact / Phone: OCL / Cassandra Keller / 5181

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 is revising this section of the rule, 10 CCR 2505-10 8.491 and 8.515.70 to implement a new 3-Tiered service delivery model. Under the tiered system, members have a choice about how they would like to receive services, based on their needs and preferences including a 15-minute unit which can be utilized for Telehealth or in-person Adult Day Services. These provisions will allow for day program services to be delivered using a more flexible, person-centered approach. These changes are being used on a temporary basis during the pandemic but have been included in the waivers for long-term utilization. The changes to the regulations will provide definitions and regulatory parameters for providers and stakeholders of this service.

2. An emergency rule-making is imperatively necessary

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

   Explain:

3. Federal authority for the Rule, if any:

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2020); 25.5-6-303 C.R.S.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports HCBS Benefit Rule Concerning Adult Day Services, Section 8.491 and 8.515.70
Rule Number: MSB 20-10-27-A
Division / Contact / Phone: OCL / Cassandra Keller / 5181

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.

   Individuals who will be affected by this rule are individuals who use Adult Day Services under the Elderly Blind and Disabled (EBD), Community Mental Health Supports (CMHS), Spinal Cord Injury (SCI), and Brain Injury (BI) waivers. Members and providers will benefit from this rule change, but they will not bear any cost from this rule change.

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

   Qualitatively, these provisions will allow for day program services to be delivered using a more flexible, person-centered approach and will have a positive impact on members. Members have enjoyed flexibility in the way services may be utilized during this pandemic and would like to continue that flexibility on a long-term basis.

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 be no additional cost to the Department outside of the appropriation for these services. All changes will remain budget neutral; changes simply allow for a different delivery option and unit for this service.

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

   Under the tiered approach, HCBS waiver members have a choice about how they would like to receive services, based on their needs and preferences. With this change, waiver members can receive ADS using alternative delivery methods, for shorter time spans, or return to the day center to receive regular day programming, or they can receive a combination of both. By implementing these changes, the

benefits include allowing day program services to be delivered using a more flexible, person-centered approach. Without these changes, members would no longer be able to enjoy the flexibility in the provision of services offered during the pandemic.

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

   There is no additional fiscal impact from these changes, as they are keeping within the current appropriation for this service.

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.

8.491 ADULT DAY SERVICES

8.491.1 Definitions

Adult Day Services (ADS) Center is a certified center that provides Basic Adult Day Services and Specialized Adult Day Services to participants.

Adult Day Services (ADS) are provided in an Adult Day Services Center or through Non-Center-Based means including Telehealth, on a regularly scheduled basis, as specified in the Person Centered Care Plan, promoting social, recreational, physical, and emotional well-being that encompasses the supportive services needed to ensure the optimal wellness of the participant.

A. Basic Adult Day Services (ADS) Center means a community-based entity that provides basic Adult Day Services in conformance with all state established requirements as described in 10 CCR 2505-10 section 8.130 and 10 CCR 2505-10 section 8.491.

B. Center-Based Adult Day Services are services provided in a certified ADS Center.

C. Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where participants can engage in activities and community life, either in-person or through virtual means.

~~B.~~D. Specialized Adult Day Services (SADS) Center means a community-based entity providing Adult Day Services for participants with a primary diagnosis of dementia related diseases, Multiple Sclerosis, Brain Injury, chronic mental illness, Intellectual and Developmental Disabilities, Huntington's Disease, Parkinson's, or post-stroke participants, who require extensive rehabilitative therapies. To be designated as specialized, two-thirds of an ADS Center's population must have a diagnosis which is one of any of the above diagnoses. Each diagnosis must be verified by a Licensed Medical Professional, either directly or through Case Management Agency documentation, in accordance with Section 8.491.14.A.

E. Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for participants to engage in activities, with their community, and connect to staff and other ADS participants virtually or over the phone, only if a participant does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services.

Care Plan means the individualized goal-oriented plan of services, supports, and preferences developed collaboratively with the participant and/or the designated or legal representative and the service provider, as outlined in 10 CCR 2505-10 8.495.6.F.

Designated Representative means a representative who is designated by the participant to act on the participant's behalf, as defined in 10 CCR 2505-10 Section 8.500.1.

Direct Care Staff means staff who provide hands-on care and services, including personal care, to participants. Direct Care Staff must have the appropriate knowledge, skills and training to meet the individual needs of the participants before providing care and services. Training must be completed prior to the provision of services, as outlined in 10 CCR 2505-10 8.491.4.I.

Director means any person who owns and operates an ADS Center or SADS Center or is a managing employee with delegated authority by ownership to manage, control, or perform the day-to-day tasks of operating the Center as described in 10 CCR 2505-10 Section 8.491.

Licensed Medical Professional (LMP) means a medical professional that possesses one or more of the following Colorado licenses, which must be active and in good standing: Physician, Physician Assistant, Registered Nurse (RN) or Licensed Practical Nurse (LPN) governed by the Colorado Medical License Act, and as defined in 10 CCR 2505-10 Section 8.503.

Participant means any individual found to be eligible for and enrolled in Center-Based or Non-Center-Based Adult Day Services regardless of payment source.

Provider means a service agency enrolled with the Department to provide Center-Based and/or Non-Center-Based Adult Day Services.

Qualified Medication Administration Personnel (QMAP) means an individual that has completed training, passed a competency evaluation, and is included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the requisite competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

Restraint means any physical or chemical device, application of force, or medication, which is designed or used for restricting freedom of movement, and/or modifying, altering, or controlling behavior, excluding medication prescribed by a physician as part of an ongoing treatment plan or pursuant to a diagnosis.

Staff means a paid or voluntary employee or contracted professional of the ADS Center or SADS Center.

Universal Precautions refers to a system of infection control that prevents the transmission of communicable diseases. Precautions include, but are not limited to, disinfecting of instruments, isolation and disinfection of environment, use of personal protective equipment, hand washing, and proper disposal of contaminated waste.

8.491.2 PARTICIPANT BENEFITS

8.491.2.A. Adult Day Services

1. Only participants whose needs can be met by the ADS provider within its certification category and populations served may be admitted by the ADS provider.

2. ADS shall include, but are not limited to, the following:

   a. ~~Daily m~~Monitoring to ensure participants are maintaining activity levels and goals set forth in the Care Plan, pursuant to Section 8.491.4.E; and assistance with activities of daily living (ADL) as needed when ADS is provided in-person. (ADLs include but are not limited to eating, ambulation, positioning, transferring, toileting, and incontinence care).

   b. ~~Daily s~~Services provided to monitor the participant's health status, monitor or administer medications (administration of medication only during the in-person delivery of services), and carry out physicians' orders as set forth in participant's individual Care Plan.

   c. Center-Based ADS must be provided in an integrated, community-~~-~~based setting, which, supports participation and engagement in community life and gaining access to the greater community; participants may engage in meaningful activities in integrated and community settings.

   d. Emergency services including written procedures to meet medical crises.

e. Activities that assist in the development of self-care capabilities, personal hygiene, and social support services.

f. Nutrition services including therapeutic diets and snacks in accordance with the participant's individual Care Plan and hours of attendance. Nutrition services are not required during the delivery of Non-Center-Based ADS.

g. Social and recreational supportive services as appropriate for each participant and their needs, as documented in the participant's Care Plan. Activities shall take into consideration individual differences in age, health status, sensory deficits, religious affiliation, interests, abilities, and skills by providing opportunities for a variety of types and levels of involvement.

h. Participants have the right to choose not to participate in social and recreational activities.

8.491.2.B. Adult Day Service Requirements

1. The participant's Care Plan must include documentation of their diagnosis(es) and service goals.

2. A Specialized Adult Day Services (SADS) provider must verify all Medicaid participant's diagnosis(es) using the Professional Medical Information Page (PMIP) which shall be supplied by the case manager~~,~~ or documentation from the participant's Licensed Medical Professional (LMP). Documentation must be verified at the time of admission~~, on reassessment by the case manager,~~ and ~~or~~ whenever there is a significant change in the participant's condition. Any significant change must be recorded in the participant's record or Care Plan.

   a. For participants from other payment sources, diagnosis(es) must be documented in a care plan, or other admission form, and verified by the participant's physician or LMP. This documentation must be verified at the time of admission, and whenever there is a significant change in the participant's condition.

8.491.3 PROVIDER REQUIREMENTS

A. General

1. ADS~~-~~ providers shall conform to all provider participation requirements, as defined in 10 CCR 2505-10 Section 8.130. ADS Centers shall have in effect all required licenses, certifications, and insurance, as applicable. ADS Center providers shall comply with ADS Center regulations and Life Safety Code (LCS) regulations, as determined by the Colorado Division of Fire Protection and Control.

2. ADS ~~Center~~ providers shall be Medicaid certified by the Department as an ADS provider, in accordance with 10 CCR, 2505-10 Section 8.487.20. Proof of Medicaid certification consists of a completed Provider Agreement approved by the Department and the Department's fiscal agent, and recommendation for certification by CDPHE.

   a. Certification shall be denied, revoked, suspended, or terminated when a Provider is unable to meet, or adequately correct deficiencies relating to, certification standards as defined at 10 CCR 2505-10 section 8.491.

3. The Department or its designee will review an ADS Center's designation as a Specialized Adult Day Services (SADS) Center at the time of initial approval and during the recertification survey.

4. Denial, termination, or non-renewal of the Provider Agreement shall be for "Good Cause" as defined in 10 CCR 2505-10 section 8.076.

5. All providers of ADS shall operate in full compliance with all applicable federal, State and local laws, ordinances and regulations related to fire, health, safety, zoning, sanitation and other standards prescribed in law or regulations. This includes certification of building use occupancy.

8.491.4 PROVIDER ROLES AND RESPONSIBILITIES

A. Environment

1. All ADS providers must comply with the Centers for Medicare and Medicaid Services (CMS) Home and Community Based Settings Final Rule requirements, 42 C.F.R. § 441.301(c)(4). This includes:

   a. ADS Center must be integrated in and supports full access of individuals to the greater community;

   b. ADS provider is selected by the individual from among setting options including non-disability specific settings;

   c. ADS provider ensures an individual's rights of privacy, dignity and respect, and freedom from coercion and restraint;

   d. ADS provider optimizes individual initiative, autonomy, and independence in making life choices, including, but not limited to, daily activities, physical environment, and with whom to interact; and

   e. ADS provider facilitates individual choice regarding services and supports, and who provides them.

2. ADS Centers presumed to have institutional qualities will be subject to heightened scrutiny and reviewed by the Department and CMS, per 42 C.F.R. § 441.301(a)(2)(v). Settings in which this may apply include but are not limited to those where:

   a. The provision of inpatient institutional treatment within a publicly or privately-operated facility happens within the same building.

   b. Located on the grounds of, or adjacent to, a public institution.

   c. The effect of isolating participants receiving Medicaid Home and Community Based Services (HCBS) from the broader community.

2. If an ADS Center is subject to heightened scrutiny, Medicaid reimbursement by the Department may not be issued if the center fails CMS's heightened scrutiny review or until CMS approves the center.

3. ADS Centers shall provide a clean and sanitary environment that is free of obstacles that could pose a hazard to participant health and safety, allowing individuals the freedom to safely move about inside and outside the ADS Center.

4. ADS Centers shall provide lockers or a safe and secure place for participants' personal items.

5. ADS Centers shall provide recreational areas and recreational activities appropriate to the number and needs of the participants, at the times desired by the participants.

6. ADS Centers shall ensure the following are physically accessible to the participants at all times during hours of operation:

    a. Access to drinking water and other beverages;

    b. Bathrooms, sinks, and paper towel dispensers or hand dryers;

    c. Appliances and equipment used by or in the delivery of activities offered by the ADS Center, such as, tables/desks and chairs at a convenient height and location; and

    d. Free from obstructions such as steps, lips in doorways, narrow hallways, limiting individuals' mobility in the ADS Center. If obstructions are present, environmental adaptations are to be made to allow for participant access.

7. ADS Centers must provide for a private shower and/or bathing area located on site to address the emergency hygiene needs of participants as needed.

8. To accommodate the activities and program needs of the ADS Center, the center must provide eating and activity areas that are consistent with the number and needs of the participants being served, which is at a minimum of 40 square feet per participant.

9. ADS Centers shall maintain a comfortable temperature throughout the center. At no time shall the temperature fall outside the range of 68 degrees to 76 degrees Fahrenheit.

10. ADS Centers must provide an environment free from restraints.

11. ADS Centers, in accordance with 10 CCR 2505-10 section 8.491.4.A above, must provide a safe environment for all participants, including participants exhibiting behavioral problems, wandering behavior, or limitations in mental/cognitive functioning.

B. Food Safety Requirements

1. ADS providers shall comply with all applicable local food safety regulations. In addition, all ADS Centers must ensure:

    a. Access to a handwashing sink, soap and disposable paper towels;

    b. Food handlers, cooks and servers, including participants engaged in food preparation, properly wash their hands using proper hand-washing guidelines;

    c. The ADS Centers do not allow any staff or participants who are not in good health and free of communicable disease to handle, prepare or serve food or handle utensils;

    d. Refrigerated foods opened or prepared and not used within 24 hours are marked with a “use by” or “discard by” date. The “use by” or “discard by” date may not exceed 7 days following opening or preparation, or exceed or surpass the manufacturer’s expiration date for the product or its ingredients;

e. For food service, foods are maintained at the proper temperatures at all times. Foods that are stored cold must be held at or below 41 degrees Fahrenheit and foods that are stored hot must be held at or above 135 degrees Fahrenheit in order to control the growth of harmful bacteria;

f. Kitchen and food preparation equipment are maintained in working order and cleanable; and

g. Any equipment or surfaces used in the preparation and service of food are washed, rinsed and sanitized before use or at least every 4 hours of continual use. Dish detergent must be labeled for its intended purpose. Sanitizer must be approved for use as a no-rinse food contact sanitizer. Sanitizers must be registered with the Environmental Protection Agency (EPA) and used in accordance with labeled instructions.

C. Medication Administration and Monitoring

1. All medications shall be administered by Qualified Medication Administration Personnel (QMAP) staff, LMP staff or self-administered, regardless of the location where services are rendered.

2. Center-Based and Non-Center-Based ADS providers shall require each staff person who administers medication, that is not a LMP, to have completed training, passed a competency evaluation and be included in the Colorado Department of Public Health and Environment's (CDPHE) public list of individuals who have passed the QMAP competency evaluation, as outlined in 6 CCR 1011-1 Chapter 24.

3. All medication, when stored and administered by the ADS provider, shall be stored in a locked cabinet when unattended by QMAP or LMP staff.

4. Non-prescription medications, when stored by the ADS provider, shall be labeled with the recipient's name, and shall not be taken by any other participants.

5. A QMAP shall not conduct feeding or administer medication through a gastrostomy tube or administer intravenous, intramuscular or subcutaneous injections.

D. Records and Information

1. All ADS providers shall keep records and information necessary to document the services provided to participants receiving Adult Day Services. Records shall include but not be limited to:

a. Name, address, gender, and date of birth of each participant;

b. Name, address and telephone number of designated representative and/or emergency contact;

c. Name, address and telephone number of primary physician;

d. Documentation of the supervision and monitoring of services provided;

e. Documentation that all participants and their designated representatives (if any) were oriented to the ADS Center, their policies and procedures, to the services provided by the ADS provider, and delivery methods offered.;

f. A service agreement signed by the participant and/or the designated representative and appropriate ~~center~~ staff; and

g. For SADS providers only, a ~~A~~ copy of the PMIP, or diagnosis documentation from the participant's LMP~~;~~.

h. Documentation specifically stating the types of services and monitoring that are provided when rendered via Telehealth, ensuring the integrity of the service provided and the benefit the service provides the participant.

E. Care Plan

1. The following information must be documented in the Care Plan and used to direct the participant's care and must be reviewed annually.

a. Medical Information:

i. All medications the participant is taking, including those while receiving Center-Based or Non-Center-Based ADS, and whether they are being self-administered;

ii. Special dietary considerations, instructions, or restrictions;

iii. Services that are administered to the participant while receiving Center-Based and/or Non-Center-Based ADS (may include nursing or medical interventions, speech therapy, physical therapy, or occupational therapy);

iv. Any restrictions on social and/or recreational activities identified by participant's LMP; and

v. Any other special health or behavioral management services or supports recommended to assist the participant by the participant's LMP.

b. Care Planning Documentation:

i. Documentation that the provider was selected by the individual and/or designated representative or legal representative;

ii. Individual choices, including location and delivery method for ADS~~,~~, preferences, and needs shall be incorporated into the goals and services outlined in the Care Plan;

iii. All participant information and the Care Plan are considered protected health information and shall be kept confidential; and

iv. Participant and/or designated representative or legal representative must review and sign the Care Plan.

c. Modifications to the Care Plan must be supported by a specific and assessed need. Informed consent and proper documentation in the Care Plan are~~is~~ required for any changes including but not limited to:

i. Identification of the specific and individualized assessed need; and

ii. Documentation of any intervention and/or additional supports offered to support the participant appropriately.

d. Documentation that the participant and/or designated representative was provided with written information about the participant's right to establish an advance directive.

e. Documentation as to whether the participant has executed an advance directive or other declaration regarding medical decisions. Such documentation shall be maintained in the participant's record.

f. All entries into the record shall be legible, written in ink, dated, and signed with name and title designation, or records shall be maintained electronically with electronic signatures in accordance with standards for electronic medical record keeping practices.

F. Critical Incident Reporting

1. A Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of a participant. A Critical Incident may endanger or negatively impact the mental and/or physical well-being of a participant. Critical Incidents include, but are not limited to:

a. Death;

b. Abuse/neglect/exploitation;

c. Serious injury to participant or illness of participant;

c. Damage or theft of participant's property;

d. Medication mismanagement;

e. Lost or missing person; and

f. Criminal activity.

2. A provider must submit a verbal or written report of a Critical Incident to the HCBS participant's Case Management Agency (CMA) case manager within 24 hours of discovery of the actual or alleged incident. The report must include:

a. Participant name;

b. Participant Medicaid identification number;

c. Waiver;

d. Incident type;

e. Date and time of incident;

f. Location of incident;

g. Persons involved;

h. Description of incident; and

i. Resolution, if applicable.

3. If any of the above information is not available within 24 hours of incident and not reported to the CMA case manager, a follow-up to the initial report must be completed.

G. Staff Requirements

1. In determining appropriate staffing levels, the ADS ~~Center~~ provider shall adjust staffing ratios based on the individual acuity and needs of the participants ~~in the Center~~being served. At a minimum, staffing must be sufficient in number to provide the services outlined in the Care Plans, considering the individual needs, level of assistance, and risks of accidents. A staff person can have multiple functions, as long as they meet the definition of Direct Care Staff defined at 10 CCR 2505-10, Sections 8.491.1. Staff counted in the staff-participant ratio are those who are trained and able to provide direct services to participants.

a. Staffing ~~at an~~for Center-Based and in person Non-Center-Based ADS ~~Center~~ shall be no less than the following standard:

i. A minimum of 1 staff to 8 participants with continuous supervision of participants during program operation.

b. Staffing for Telehealth ADS shall be no less than the following standard:

i. A minimum of 1 staff to 15 virtual participants with continuous virtual supervision of participants during Telehealth program operation.

c~~b~~. Staff shall provide the following:

i. Immediate response to emergency situations to assure the safety, health and welfare of participants;

ii. Activities that are planned to support the plans of care for the participants; and

iii. Administrative, recreational, social, and supportive functions and duties.

d~~c~~. Nursing services for regular monitoring of the on-going medical needs of participants and the supervision of medications. These services must be available a minimum of two hours daily during Center-Based ADS, and as needed for Non-Center-Based ADS, and must be provided by a~~n~~ Registered Nurse (RN) or Licensed Practical Nurse (LPN). Certified Nursing Assistant's (CNA) may provide nursing services under the direction of a RN or an LPN, in conformance with nurse delegation provisions outlined in CRS 12-38-132. Supervision of CNAs must include documented consultation and oversight on a weekly basis or more according to the participant's needs. If the supervising RN or LPN is an ADS provider~~Center~~ staff member, with consultation and oversight of CNAs included in the member's job description, the supervising nurse's documented attendance shall be sufficient to document consultation and oversight.

2. In addition to the above services, Specialized Adult Day Services (SADS) Centers shall have sufficient staff to provide nursing services during all hours of operation.

   a. Nursing services must be provided by a licensed RN or LPN or by a CNA under the supervision of an RN or LPN, as per 10 CCR 2505-10 section 8.491.4.G.1.e above and employed or contracted by the SADS Center.

3. The ADS ~~Center~~ provider shall require any individual seeking employment with that~~eir~~ agency~~the~~ ~~Center~~ to submit to a criminal history record check to ascertain whether the individual seeking employment has been convicted of a felony or misdemeanor that involves conduct that the provider~~Center~~ determines could pose a risk to the health, safety or welfare of participants.

4. The criminal history record check shall, at a minimum, include a search of criminal history in the State of Colorado and be conducted not more than 90 days prior to employment of the individual.

5. In assessing whether to employ an applicant with a felony or misdemeanor conviction, the ADS ~~Center~~ provider shall consider the following factors:

   a. The history of convictions, pleas of guilty or no contest,

   b. The nature and seriousness of the crimes;

   c. The time that has elapsed since the conviction(s);

   d. Whether there are any mitigating circumstances; and

   e. The nature of the position for which the applicant would be employed.

6. The ADS ~~Center~~provider shall develop and implement policies and procedures regarding the employment of any individual who is convicted of a felony or misdemeanor to ensure that the individual does not pose a risk to the health, safety and welfare of the consumer.

H. Director Qualifications

1. All Directors hired or designated after January 1, 2019, shall meet one of the following qualifications:

   a. At least a bachelor's degree from an accredited college or university and a minimum of two years of social services or health services experience and shall have demonstrated ability to perform all aspects of the position; or

   b. A licensure by the state of Colorado as a Licensed Practical Nurse or Registered Nurse and completion of two years of paid or volunteer experience in planning or delivering health or social services including experience in supervision and administration; or

   c. A high school diploma or GED equivalent, a minimum of four years of experience in a social services or health services setting, skills to work with aging adults or adults with functional impairment, and skills to supervise ADS Center staff persons.

I. Training Requirements

1. All ADS ~~Center~~ staff and volunteers must be trained in the ADS ~~Centers'~~ provider's~~'~~ programmatic policies and procedures.

2. ADS ~~Centers~~ providers providing medication administration as a service must have QMAP staff qualified in accordance with C.R.S. 6 CCR 1011-1 Chapter 24, unless medications are administered only by LMPs.

3. All staff and volunteers must be trained in the use of universal precautions and infection control, as defined at 10 CCR 2505-10 section 8.491.1.

4. The ADS ~~Center~~ Director and staff must receive training specific to the needs and diagnoses of the participants served.~~,~~ Training may include, but is not limited to: behavioral expression and management techniques, effective communication techniques, redirection, cardiopulmonary resuscitation, validation theory and communication, seizure response, and brain injuries.

    a. Documentation of staff member and Director trainings must include, but is not limited to: training provided, who completed trainings, who conducted trainings, and completion date.

5. All ADS ~~Center~~ staff must be trained in the handling of emergency services including written procedures to meet medical crises, and natural and manmade disasters.

6. All required training must be documented, and documentation must be maintained in individual staff's personnel files. Each staff person's training must be up-to-date.

J. Written Policies

1. The ADS provider ~~Center~~ shall have written policies and procedures relevant to its operation. Such policies shall include, but not be limited to, statements describing:

    a. Admission criteria for participants who can be appropriately served ~~in~~ by the ADS ~~Center~~ provider;

    b. Intake procedures conducted for participants and/or designated representatives prior to admission with ~~to~~ the ADS provider~~Center~~;

    c. The meals and nourishments including special diets that are provided;

    d. The hours and days that Center-Based ADS are open and available, and the days and times that Non-Center-Based ~~the~~ ADS ~~Center is~~ are available~~are open and services available~~ to participants, including the availability of nursing services;

    e. Medication administration and storage;

    f. The personal items that the participants may bring with them to the ADS Center; ~~and~~

    g. Emergency services including written procedures to meet medical crises, and natural and manmade disasters; and

    h. The administration of Telehealth Adult Day Services, if provided. This includes telehealth options, provision of services, and examples of virtually offered services.

2. There shall be a written, signed agreement between the participant and/or designated representative and the ADS ~~Center~~ provider outlining the rules and responsibilities of the ADS ~~Center~~provider and the participant. Each party in the agreement shall be provided a copy.

K. Exclusions

1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS~~s~~ and therefore are not~~-~~ reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.

8.491.5 REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

A. Reimbursement for ADS for participants in the HCBS Elderly, Blind and Disabled (EBD) waiver, Community Mental Health Supports waiver (CMHS), and the Spinal Cord Injury (SCI) waiver~~:~~, ~~shall be based upon a single all-inclusive payment rate per unit of service for each participating provider which shall be prospectively determined. Units are to~~ is to ~~be~~ billed in accordance ~~to~~with the current rate schedule:

1. Providers may bill in 15-minute units or for 1-2 units of 3-5-hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 12 units or three (3) hours per day of Basic Adult Day Services. A provider may bill the maximum of 15-minute units for ADS in combination with no more than 1 unit of 3-5 hour ADS on the same day, as long as services were rendered at separate times.

~~cannot bill for 15-minute units of ADS if 2 units of 3-5 hour ADS were provided on the same day. A provider can bill for up to 12 15-minute units or 3 hours of Center-Based ADS or Non-Centered-Based ADS on the same day as 1 unit of 3-5 hour ADS, as long as services were rendered at separate times. nit = a partial day = three (3) to five (5) hours of service~~

~~nits = a full day = more than five (5) hours of service~~

B. For persons in the HCBS waiver for Persons with a Brain Injury (BI), reimbursement for BI-ADS is to be billed in accordance with the current rate schedule. ~~shall be based upon a single all-inclusive payment rate per unit of service for each participating provider.~~

1. A unit is defined as the following:

a. Providers may bill in units of 15 minutes or a unit of 2 or more hours depending on the participant's needs and how the service is delivered. When billing 15-minute units, which can be delivered either in-person or via Telehealth, the total number of units may not exceed 8 units or two (2) hours per day of services. Units of 2 hours or more can only be delivered in-person. A provider cannot bill for 15-minute units of ADS if a unit of 2-hour BI ADS was provided on the same day.~~one (1) unit = two or more hours per day.~~

C. ADS Centers are permitted to utilize funding from other Federal sources, such as the Child and Adult Care Food Program (CACFP), in addition to the Medicaid per diem. If such funding is utilized, a Center must acknowledge the use of multiple funding sources and demonstrate that Federal funds are not used in a duplicative manner to Medicaid-funded services.

D. Only providers certified as a Specialized Adult Day Services Center are permitted to receive the SADS reimbursement rate, for participants needing SADS. The SADS reimbursement rate

applies to every participant at a SADS Center, even if the participant does not have a specialized diagnosis.

E. Certified SADS providers may provide Non-Center-Based Adult Day Services, including Telehealth ADS, billing only for Basic Adult Day Services using the 15-minute unit, up to 3 hours per day. The SADS provider may bill the maximum of 15-minute units for Basic ADS in combination with no more than 1 unit of 3-5 hour SADS on the same day, as long as services were rendered at separate times.

F~~E~~. Providers shall not bill for services on the same day of service for a participant in an HCBS residential program, unless the following criteria have been met:

1. ADS and residential services have been authorized by the Department and are included on the prior authorization request (PAR);

2. Participant's diagnoses must meet the criteria for a SADS Center;

3. Documentation from the participant's physician demonstrating the required specialized services in the SADS Center are necessary because of the qualifying diagnosis(es), are essential to the care of the participant, and are not included in the residential per diem;

4. Documentation that the extensive rehabilitative therapies and therapeutic needs of the participant are not being met by the residential program and are not included in the residential per diem; and

5. Documentation from the participant's physician recommending SADS and how it will meet the previously mentioned needs.

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

8.515.70 ADULT DAY SERVICES

A. DEFINITIONS

1. Adult Day Services means both health and social services furnished on a regularly scheduled basis in an A~~a~~dult D~~d~~ay S~~s~~ervices center two or more hours per day, one or more days per week to ensure the optimal functioning of the client Services are directed towards recreation and socialization as well as maintaining a safe and supportive environment. A participant can receive either Center-Based ADS, Non-Center-Based

ADS, or a combination of Center-Based ADS and Non-Center-Based ADS within the same week.

2.a. Adult Day Services ~~Center~~provider means a non-institutional entity that conforms to requirements for maintenance model.

b. Center-Based Adult Day Services are services provided in a certified ADS Center.

c. Non-Center-Based Adult Day Services are services that may be provided outside of the certified ADS Center, where participants can engage in activities and community life, either in-person or through virtual means.

~~b.~~ Telehealth Adult Day Services are provided through virtual means in a group or on an individual basis. Telehealth ADS are ways for participants to engage in activities, with their community, and connect to staff and other ADS participants virtually or over the phone, only if a participant does not have access or the ability to use video chat technology. Services provided through Telehealth are not required to provide nutrition services.

~~3~~. e. Maintenance Model means services in health monitoring and individual and group therapeutic and psychological activities which serve as an alternative to long-term nursing home care.

2~~5~~4. Adult D~~d~~ay S~~s~~ervices include:

a. Daily monitoring to assure that clients are maintaining personal hygiene and participating in age appropriate social activities as prescribed; and assisting with activities prescribed; and assisting with activities of daily living (e.g., eating, dressing).

b. Emergency services including whiten procedures to meet medical crises.

c. Assistance in the development of self-care capabilities personal hygiene, and social support services.

d. Provision of nutritional needs appropriate to the hours in which the client is served. Nutrition services are not required during the delivery of T~~t~~elehealth ADS.

e. Nursing services as necessary to supervise medication regimen of trained medication aides and carry out any of the services listed as SKILLED CARE in SECTION 8.489.30.

f. Social and recreational services as prescribed to meet the client's needs.

~~g. Any additional services if such services are included in the budget submitted to the Department in accordance with the section on REIMBURSEMENT METHOD FOR ADULT DAY CARE below, and determined by the Department to be necessary for adult day care.~~

g~~h~~. Documentation specifically stating the types of services and monitoring that were provided when services are provided via Telehealth, ensuring the integrity of the service provided and the benefit that service provides the participant.

B. CERTIFICATION STANDARDS

All Aadult Ddday Ssservice providers ~~centers~~ shall conform to all of the following Departmental standards

1. All providers must conform to all established departmental standards in the general certification standards section.

2. All providers of Aadult Ddday Ssservices ~~care~~ shall operate in full compliance with all applicable federal, state and local fire, health, safety, sanitation and other standards prescribed in law or regulation.

3. The ~~agency~~ Aadult Ddday Ssservice Ccenter shall provide a clean environment, free of obstacle; that could pose a hazard to client health and safety.

4. ~~Agencies~~ Adult Ddday Ssservice Ccenters shall provide lockers or a safe place for clients' personal items.

5. Adult Ddday Ssservice Ccenters shall provide recreational areas and activities appropriate to the number and needs of the recipients.

6. Adult Ddday Ssservice Ccenters shall have ~~D~~drinking facilities ~~shall be~~ located within easy access to ~~residents~~clients.

7. Adult Ddday Ssservice Ccenters shall provide eating and resting areas consistent with the number and needs of the clients being served.

8. Adult Ddday Ssservice Ccenters shall provide easily accessible toilet facilities, hand washing facilities and paper towel dispensers.

9. The center shall be accessible to clients with supportive devices for ambulation or who an in wheelchairs.

C. RECORDS AND INFORMATION

Adult Ddday Ssservice providers shall keep such records and information necessary to document the services provided to clients receiving Aadult Ddday Ssservices. Medical Information Records shall include but not be limited to:

1. Medications the client is taking and whether they are being self-administered.

2. Special dietary needs, if any.

3. Restrictions on activities identified by physician in the case plan.

D. STAFFING

All Aadult Ddday Ssservice ~~centers~~ providers shall have staff who have been trained in current cardiopulmonary resuscitation, seizure prophylaxis and control and brain injury. Adequate staff shall ~~be on the premises~~ available at all times to ensure:

1. Supervision of clients at all times during the operating hours of the program.

2. Immediate response to emergency situations to assure the welfare of clients.

3. Provision of prescribed recreational and social activities.

4. Provision of administrative, recreational, social and supportive functions of the Aaadult Ddday Ssservices Cceenter.

E. POLICIES

The ~~center~~ Aaadult Ddday Ssservice provider shall have a written policy relevant to the operation of the Aaadult Ddday Ssservices ~~center~~. Such policy shall include but not be limited to statements describing:

1. Admission criteria that qualify clients to be appropriately served ~~in the center~~by the provider.

2. Interview procedures conducted for qualified clients and/or family members prior to admission ~~to the center~~to the provider.

3. The meals and nourishments that will be provided, including special diets, at Center-Based ADS.

4. The hours that the clients will be served ~~in the center~~by the provider and days of the week services will be available.

5. The personal items participants may bring with them to the center.

6. A written signed contract to be drawn up between the client or responsible party and the Cceenter outlining rules and responsibilities of the provider~~center~~ and of the client. Each par~~r~~ty of the contract will have a copy.

7. A statement of the center's policy for providing ~~drop in~~drop-in care or day respite.

F. REIMBURSEMENT METHOD FOR ADULT DAY SERVICES

1. Reimbursement information for BI ADS is outlined in Section 8.491.5.B. ~~Reimbursement for adult day services shall be based upon a single a single all-inclusive payment rate per unit of service for each participating provider.~~

~~2. Each provider will be paid on a per diem statewide uniform rate. The rate of payment shall be subject to available appropriations and may be the lower of the billed amount or the Medicaid allowable rate which is determined by multiplying the number of units times a rate established by the Department~~

F. EXCLUSIONS

1. The delivery of a meal, workbook, activity packet, etc. does not constitute rendered ADS and therefore are not reimbursable, unless in-person ADS service was provided in addition to the delivery of food or item.