





the CMA shall conduct another SIS assessment for the client only when approved by the Department through the following process:

1. Prior to a subsequent SIS assessment being conducted, the CMA shall submit a request to the Department for approval in the format prescribed by the Department.
2. The Department shall provide the CMA with a written decision regarding the request to conduct another SIS assessment within fifteen (15) business days after the date the request was received.
3. If the client, his or her legal guardian, authorized representative or family member, as appropriate, disagrees with the decision, then a request for review of the decision may be submitted within fifteen (15) business days after the date the decision was received by the Executive Director of the Department or his or her designee.
4. The Executive Director or his or her designee shall review the request for conducting another SIS assessment and provide a written decision within fifteen (15) business days.
5. The decision of the Executive Director or his or her designee shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.

H. A subsequent SIS assessment shall be conducted only when approved by the Department and when:

1. There has been a change in the client's life circumstances or condition resulting in the significant change to the amount of services and supports needed to keep the client safe;
2. The client or his or her legal guardian, authorized representative, family member or case manager as appropriate, has reason to believe that the results of the most recent SIS assessment do not accurately reflect his or her current support needs; or,
3. The Department deems it necessary to complete a new assessment in order to ensure its accuracy.

I. Administration of the SIS assessments shall be reviewed by the Department for the purpose of quality assurance.

J. When the Department identifies SIS Interviewer practices that result in inaccurate SIS assessments:

1. Remediation efforts may occur to ensure that the SIS Interviewer performs assessments according to Department standards. The SIS Interviewer(s) who conducted the inaccurate SIS assessment(s) may be deemed no longer qualified to conduct SIS assessments.
2. Payments made for the administration of the inaccurate SIS assessments may be recovered through a repayment agreement; by offsetting the amount owed against current and future SIS determination payments; or, by any other appropriate action within its legal authority.
3. The client shall receive another SIS assessment conducted by a SIS Interviewer designated by the

Department.

4. The client's Support Level and Service Plan Authorization Limit will be adjusted as necessary and effective on the date determined by the Department.

**16.652 SIS Complaint Process [Eff. 2/1/12]**

- A. The client, his or her legal guardian, authorized representative, or family member as appropriate, may file a complaint regarding the administration of the SIS assessment up to thirty (30) calendar days after the SIS assessment is conducted.
- B. The complaint shall be filed verbally or in writing with the client's CMA. Additional information to support the complaint may be submitted at that time. If the complaint has been filed verbally the CMA shall document in the client's record on the Department required data system the time, date and details surrounding the complaint.
- C. When the complaint requests that another SIS assessment be completed, the CMA shall submit a request for approval to conduct another SIS assessment, pursuant to the process identified in Section 16.651, G.
- D. The CMA shall make efforts to resolve the complaint and provide the complainant with a written response within ten (10) business days after receipt of the complaint.
- E. When a resolution cannot be reached, the CMA shall inform the complainant that he or she may submit the complaint to the Department within fifteen (15) business days after receipt of the CMA response.
- F. The Department shall provide a written response to the complainant within fifteen (15) business days after receipt of the complaint.

**16.653 Support Levels [Eff. 2/1/12]**

- A. A client is assigned into one of six Support Levels according to his or her overall support needs and based upon the standardized algorithm for the HCBS-DD or HCBS-SLS waivers.
- B. The structure of the algorithm includes the following:
  1. ALGORITHM FACTORS:
    - a. Standard scores from Section 1: Parts A, B, and E (ABE) from the SIS assessment;
    - b. Scores from Section 3A: Exceptional medial support needs score from the SIS assessment;
    - c. Scores from Section 3B: exceptional behavioral support needs score from the SIS assessment; and,
    - d. Whether the client presents as a safety risk, as follows:
      - 1) In the HCBS-SLS waiver, Public Safety Risk-Convicted.
      - 2) In the HCBS-DD waiver, Public Safety Risk-Convicted/Not Convicted or Extreme Safety Risk to Self.
  2. The subgroups under each support level reflect

variations of the intensity of the client's basic support, medical support and behavioral support needs.

3. Following an assessment of the factors defined above, scores for each factor are applied to the algorithm.

The Support Level is Determined when the scores for each factor meet all of the criteria of a support level subgroup

C. The formula for the algorithm is:

**SUPPORT LEVEL 1**

SUBGROUP 1A:  $A+B+E \leq 25$ ; AND  $3A \leq 1$ ; AND  $3B \leq 2$

SUBGROUP 1B:  $A+B+E \leq 25$ ; AND  $3A \leq 2$ ; AND  $3B < 5$

SUBGROUP 1C:  $A+B+E \leq 25$ ; AND  $3A \leq 4$ ; AND  $3B \leq 5$

**SUPPORT LEVEL 2**

SUBGROUP 2A:  $A+B+E = 26-30$ ; AND  $3A \leq 1$ ; AND  $3B \leq 2$

SUBGROUP 2B:  $A+B+E = 26-30$ ; AND  $3A \leq 2$ ; AND  $3B \leq 5$

SUBGROUP 2C:  $A+B+E = 26-30$ ; AND  $3A \leq 4$ ; AND  $3B \leq 5$

SUBGROUP 1D:  $A+B+E \leq 25$ ; AND  $3A < 6$

SUBGROUP 1G:  $A+B+E \leq 25$ ; AND  $3B \leq 9$

SUBGROUP 2D:  $A+B+E = 26-30$ ; AND  $3A \leq 6$

SUBGROUP 2G:  $A+B+E = 26-30$ ; AND  $3B \leq 9$

SUBGROUP 3A:  $A+B+E = 31-33$ ; AND  $3A \leq 1$ ; AND  $3B \leq 2$

SUBGROUP 3B:  $A+B+E = 31-33$ ; AND  $3A \leq 2$ ; AND  $3B \leq$

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**SUPPORT LEVEL 3**

SUBGROUP 1H:  $A+B+E \leq 25$ ; AND  $3B \leq 13$

SUBGROUP 2H:  $A+B+E = 26-30$ ; AND  $3B \leq 13$

SUBGROUP 3C:  $A+B+E = 31-33$ ; AND  $3A \leq 4$ ; AND  $3B \leq 5$

SUBGROUP 3D:  $A+B+E = 31-33$ ; AND  $3A \leq 6$

SUBGROUP 3G:  $A+B+E = 31-33$ ; AND  $3B \leq 9$

SUBGROUP 4A:  $A+B+E \geq 34$ ; AND  $3A \leq 1$ ; AND  $3B \leq 2$

SUBGROUP 4B:  $A+B+E \geq 34$ ; AND  $3A \leq 2$ ; AND  $3B \leq 5$

**SUPPORT LEVEL 4**

SUBGROUP 1E:  $A+B+E \leq 25$ ; AND  $3A \leq 8$

SUBGROUP 1F:  $A+B+E \leq 25$ ; AND  $3A \geq 9$

SUBGROUP 1I:  $A+B+E \leq 25$ ; AND  $3B \leq 15$

SUBGROUP 1J:  $A+B+E \leq 25$ ; AND  $3B \geq 16$

SUBGROUP 2E:  $A+B+E 26-30$ ; AND  $3A \leq 8$

SUBGROUP 2I:  $A+B+E 26-30$ ; AND  $3B \leq 15$

SUBGROUP 2J:  $A+B+E 26-30$ ; AND  $3B \geq 16$

SUBGROUP 3E:  $A+B+E = 31-33$ ; AND  $3A \leq 8$

SUBGROUP 3H:  $A+B+E = 31-33$ ; AND  $3B \leq 13$

SUBGROUP 4C:  $A+B+E \geq 34$ ; AND  $3A \leq 4$ ; AND  $3B \leq 5$

SUBGROUP 4G:  $A+B+E \geq 34$ ; AND  $3B \leq 9$

**SUPPORT LEVEL 5**

SUBGROUP 2F:  $A+B+E = 26-30$ ; AND  $3A \geq 9$

SUBGROUP 3I:  $A+B+E = 31-33$ ; AND  $3B \leq 15$

SUBGROUP 3J:  $A+B+E = 31-33$ ; AND  $3B \geq 16$

SUBGROUP 4D:  $A+B+E \geq 34$ ; AND  $3A \leq 6$

SUBGROUP 4E:  $A+B+E \geq 34$ ; AND  $3A \leq 8$

SUBGROUP 4H:  $A+B+E \geq 34$ ; AND  $3B \leq 13$

SUBGROUP 4I:  $A+B+E \geq 34$ ; AND  $3B \leq 15$

GROUP 5A: PUBLIC SAFETY RISK; AND  $3B \leq 11$

**SUPPORT LEVEL 6**

SUBGROUP 4J:  $A+B+E \geq 34$ ;  $3B \geq 16$

GROUP 6A: PUBLIC SAFETY RISK; AND  $3B \geq 12$

SUBGROUP 3F:  $A+B+E = 31-33$ ; AND  $3A \geq 9$

SUBGROUP 4F: A+B+E ≥ 34; AND 3A ≥ 9

EXTREME SAFETY RISK TO SELF - THIS FACTOR ACTS TO INCREASE THE LEVEL OTHERWISE DETERMINED BY THE ABOVE CRITERIA. LEVEL 1 INCREASES TO LEVEL 3, LEVEL 2 INCREASES TO LEVEL 4, LEVEL 3 INCREASES TO LEVEL 4, LEVEL 4 INCREASES TO LEVEL 5. NO CHANGE TO LEVEL 5 OR LEVEL 6.

- D. The CMA shall make a determination whether a client meets the definition of Public Safety Risk or Extreme Safety Risk to Self through the following process:
1. The decision shall be made by a case management supervisor meeting the qualifications of a Developmental Disabilities Professional as defined in Section 16.120. He or she shall:
    - a. Document the rationale to support the decision which shall be kept in the client's record;
    - b. Document that the client meets the definition in the Department required data system; and,
    - c. Review the client at least annually or when significant changes occur to assure that the client continues to meet the definition.
  2. At the point when a client no longer meets the definition, his or her status must be changed in the Department-required data system and his or her Support Level must be re-calculated.
- E. The CMA shall inform each client, his or her legal guardian, authorized representative, or family member, as appropriate, of his or her Support Level at the time of the Service Plan development or when the Support Level changes for any reason.
- F. Notification of a Support Level change shall occur within ten (10) business days of the date after the Service Plan development or Support Level change.
- G. Each Support Level corresponds with the standardized reimbursement rates for individual waiver services and the Service Plan Authorization Limits (SPAL) in HCBS-SLS.
- H. In HCBS-DD, the Department may assign a reimbursement rate for day habilitation services and residential habilitation services provided to a client with exceptional overall needs in accordance with the Support Level Review Process.

**16.654 Support Level Review Process [Eff. 2/1/12]**

A. The client, his or her legal guardian, authorized representative, family member, or CMA, as appropriate, may request a review regarding the Support Level assigned to meet the client's needs.

B. The CMA shall complete the information required by the Department to request that the client's assigned Support Level be reviewed. Prior to submitting the

request, the CMA shall provide an opportunity for the client, his or her legal guardian, authorized representative, or family member, as appropriate, to review and provide additional information that will be submitted the Department.

- C. The Department shall convene a review panel to examine Support Level review requests monthly or as needed.
  - 1. The review panel shall be comprised of the following:
    - a. A minimum of three (3) members designated by the Department.
    - b. Members shall include staff from the Department, staff from a CMA that does not provide services to the client, or an additional party with extensive knowledge and experience with the SIS assessment, the Support Levels, case management, and HCBS waiver services.
  - 2. The review panel:
    - a. Shall examine all of the information submitted by the CMA and seek to identify any significant factors not included in the Support Level calculation, which cause the client to have substantially higher support needs than those in the established Support Level.
    - b. In cases where the panel finds that the client does have substantially higher support needs than those in the initial Support Level, the panel may assign the client to a Support Level that is a closer representation of the client's overall support needs.
  - 3. A client who has been assigned to a higher Support Level shall have this assignment re-examined by the review panel annually or as determined by the Department, unless the panel determines that the client's condition necessitating a higher Support Level is unlikely to improve.
- D. The Department shall provide the CMA and the client, his or her legal guardian, authorized representative, or family member, as appropriate, with the written decision regarding the requested review of the client's Support Level within fifteen (15) business days after the panel meeting.
  - 1. The results of the panel review for a client enrolled in the HCBS-DD waiver are conclusive.
  - 2. If a client enrolled in the HCBS-SLS waiver, his or her legal guardian, authorized representative, or family member, as appropriate, disagrees with the decision provided by the panel, the client may request a review by the Executive Director or his or her designee, within fifteen (15) business days after the receipt of the decision.
    - a. The Executive Director or his or her designee shall review the request and provide a written decision within fifteen (15) business days.
    - b. The decision of the Executive Director or his or her designee shall constitute the final agency decision and will be subject to judicial review pursuant to Section 24-4-106, C.R.S.
- E. The client shall be notified, pursuant to the Department of



Health Care Policy and Financing rules in Section 8.057.2, A (10 CCR 2505-10) when a waiver service is terminated, reduced, or denied. At any time, the client may pursue a Medicaid Fair Hearing in accordance with Section 8.057.3, A (10 CCR 2505-10).