

Title of Rule: Revision to the Medical Assistance Community Living Rule Concerning Colorado Choice Transitions (CCT), a Money Follows the Person Demonstration, Section 8.555
Rule Number: MSB 14-09-09-A
Division / Contact / Phone: LTSS / Nicole Storm / 2858

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).

As a demonstration program, we are continually working to improve and make more efficient our operating processes and procedures. When the rule was first written and adopted, the program had not yet been operationalized. Therefore, changes to the rule are required to better reflect how the program actually operates.

Based on underutilization and the availability of other similar services which can be used in their place, we are removing two demonstration services from the benefits and services available to clients: transitional substance abuse and transitional specialized rehabilitation services. The substance abuse benefit is now available through the State Plan and cannot be duplicated through the CCT program. Activities offered through the transitional specialized day rehabilitation service can be offered through the adult day programs and day habilitation services instead. Funds allocated for these services will be redirected to other demonstration services used by clients to support successful transitions and community living.

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:

"Deficit Reduction Act of 2005, Pub. L. No. 109-171, § 6071, 120 Stat. 4, 102-110 (2006)" and "Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2403, 124 Stat. 119, 304-305 (2010)".

4. State Authority for the Rule:

25.5-1-301 through 25.5-1-303, C.R.S. (2013);
10 C.C.R. 2505 § 10.8.555

Initial Review **02/13/2015**

Final Adoption **03/13/2015**

Proposed Effective Date **05/01/2015**

Emergency Adoption

DOCUMENT #03

Title of Rule: Revision to the Medical Assistance Community Living Rule Concerning Colorado Choice Transitions (CCT), a Money Follows the Person Demonstration, Section 8.555

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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.

CCT members will no longer have access to the transitional substance abuse and transitional specialized day rehabilitation demonstration services, however, clients will have access to similar services through the Medicaid State Plan and adult day waiver programs.

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

To date, only one client has accessed transitional behavioral health supports; there has been zero utilization of the transitional specialized day rehabilitation service since the inception of the program. The program has spent \$145.88 per capita on transitional substance abuse and \$0 per capita on transitional specialized day rehabilitation services under CCT.

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.

To date, only one client has accessed transitional behavioral health supports; there has been zero utilization of the transitional specialized day rehabilitation service since the inception of the program. The program has spent \$145.88 per capita on transitional substance abuse and \$0 per capita on transitional specialized day rehabilitation services under CCT.

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

N/A

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

N/A

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.

N/A

8.555 COLORADO CHOICE TRANSITIONS (CCT), A MONEY FOLLOWS THE PERSON DEMONSTRATION

8.555.1 DEFINITIONS OF DEMONSTRATION SERVICES PROVIDED

Assistive Technology, Extended means devices, items, pieces of equipment, or product systems used to increase, maintain, or improve functional capabilities of clients and training in the use of the technology when the cost is not otherwise covered through the State Plan durable medical equipment benefit or home modification waiver benefit or available through other means.

~~Behavioral Health Support means services by a paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.~~

Caregiver Education Support Service means educational and coaching services that assist clients and family members with managing the stress of caregiving and to recruit other family members and friends to form an informal caregiver network to share caregiving responsibilities.

Community Transition Services means services as defined at 10 CCR 2505-10, Section 8.553.

Dental Services means dental services that are inclusive of diagnostic, preventive, periodontal and prosthodontic services, as well as basic restorative and oral surgery procedures to restore the client to functional dental health and not available through the Medicaid State Plan.

Enhanced Nursing Services means medical care coordination provided by a nurse for medically complex clients who are at risk for negative health outcomes associated with fragmented medical care and poor communication between primary care physicians, nursing staff, case managers, community-based providers and specialty care providers.

Home Delivered Meals means nutritious meals delivered to homebound clients who are unable to prepare their own meals and have no outside assistance.

Extended Home Modifications, Extended means physical adaptations to the home, required by the client's plan of care, necessary to ensure the health, welfare, safety and independence of the client above and beyond the cost of caps that exist in applicable Home and Community-Based (HCBS) waivers.

Independent Living Skills Training means services designed to improve or maintain a client's physical, emotional, and economic independence in the community with or without supports.

Intensive Case Management means case management services to assist clients' access to needed home and community-based services, Medicaid State Plan services and non-Medicaid supports and services to support the clients' return to the community from placement in a qualified institution and to aid the client in attaining their transition goals.

Peer Mentorship Services means services provided by peers to promote self-advocacy and encourage community living among clients by instructing and advising on issues and topics related to community living, describing real-world experiences as example and modeling successful community living and problem-solving.

~~Specialized Day Rehabilitation means services offered in a group setting designed and directed at the development and maintenance of the client's ability to independently, or with support, sustain himself/herself physically, emotionally and economically in the community.~~

~~Substance Abuse (Transitional) means enhanced individual or group substance abuse counseling, behavioral interventions, or consultations to address issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's sobriety. Services can be provided in the home or office setting.~~

~~Transitional Behavioral Health Supports means services by a paraprofessional to support a client during the transition period to mitigate issues, symptoms, and/or behaviors that are exacerbated during the transition period and negatively affect the client's stability in the community.~~

Vision Services means services that include eye exams and diagnosis, glasses, contacts, and other medically necessary methods to improve specific vision system problems when not available through the Medicaid State Plan.

8.555.2 GENERAL DEFINITIONS

Demonstration services means services unique to the CCT program and provided during a client's enrollment in the demonstration program.

Medically complex means one or more medical conditions that are persistent and substantially disabling or life threatening and meets the following conditions:

1. Requires treatment and services across a variety of domains of care;
2. Is associated with conditions that have severe medical or health-related consequences;
3. Affects multiple organ systems;
4. Requires coordination and management by multiple specialties; and
5. Treatments carry a risk of serious complications.

~~Operational Protocol means the Centers for Medicare and Medicaid Services (CMS) approved policy and procedures manual for the CCT Program. The Operational Protocol (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. The Operational Protocol is available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. The Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the Operational Protocol from the Department.~~

Paraprofessional means a person with a Bachelor's Degree in psychology, social work or other human service related field who is employed by a mental health provider; is supervised by a Licensed Professional Counselor, Licensed Clinical Social Worker or Licensed Psychologist; and has experience with facilitating the implementation of a behavioral management plan among families, a client, providers and other members of a support system for the client.

Qualified institution means a nursing facility; intermediate care facilities for people with intellectual disabilities (ICF/ID); or institutions for mental diseases (IMDs), which include Psychiatric Hospitals only to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

Qualified residence means a home owned or leased by the client or the client's family member; a residence, in a community-based residential setting, in which no more than 4 unrelated

individuals reside; or an apartment with an individual lease, eating, sleeping, cooking and bathing areas, lockable access and egress, and not associated with the provision or delivery of services.

Qualified services mean services that are provided through an existing HCBS waiver and may continue if needed by the client and if the client continues to meet eligibility for HCBS at the end of his or her enrollment in CCT.

Transition Assessment/Plan means an assessment of client needs completed by a transition coordinator prior to a transition and the corresponding plan developed by the coordinator to meet the needs of the client in a community-setting post-transition.

Transition Options Team means a group of individuals who have a personal or professional relationship with the client who is exploring their options for community living. This group is responsible wholly or in part for the transition assessment, transition plan, determining whether the transition is feasible, completing the service plan and brokering services.

8.555.3 LEGAL BASIS

The Colorado Choice Transitions (CCT) program is created through a Money Follows the Person (MFP) grant award authorized by section 6071 of the Deficit Reduction Act of 2005. Section 2403 of Patient Protection and Affordable Care Act extended the program through September 30, 2016. The United States Department of Health and Human Services awarded the MFP demonstration grant to Colorado. This demonstration program is administered by the Centers for Medicare and Medicaid Services (CMS). The MFP statute provides waiver authority for four provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of the demonstration. These provisions are:

1. Statewideness (Section 1902(a)(1) ~~of the Social Security Act~~) - in order to permit implementation of a State initiative in a selected area or areas of the State.
2. Comparability (Section 1902(a)(10)(B) - in order to permit a State initiative to assist a selected category or categories of individuals enrolled in the demonstration.
3. Income and Resource Eligibility (Section 1902(a)(10)(C)(i)(III) – in order to permit a State to apply institutional eligibility rules to individuals transitioning to community-based care.
4. Provider agreement (Section 1902(a)(27)) - in order to permit a State to implement self-direction services in a cost-effective manner for purposes of this demonstration program.

CCT is designed to complement the Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD); Home and Community Based Services for People with Brain Injury (HCBS-BI); Home and Community Based Services for Community Mental Health Supports (HCBS-CMH~~SC~~); Home and Community Based Services for the Developmentally Disabled (HCBS-DD); and Home and Community Based Services for Supported Living Services (HCBS-SLS) programs. These waivers are authorized through Section 1915(c) of the Social Security Act (42 U.S.C. § 1396n). ~~Title 42 of the United States Code, Section 1396n (2012) is hereby incorporated by reference into this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These regulations are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant Street, Denver, CO 80203. Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing~~

~~maintains either electronic or written copies of the incorporated texts for public inspection. The Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.~~

8.555.4 SCOPE AND PURPOSE

8.555.4.A. The CCT program assists clients ~~currently~~ residing in qualified institutions with exploring their community-based options for long term supports and services; ~~facilitates the -and transition of clients~~ing to a community setting ~~with enhanced services and supports if they choose to transition; if the so long as the~~ right services and supports can be arranged in the community to ensure the health, welfare and safety of the client; ~~and provides enhanced services and supports through willing and qualified providers, and if willing and qualified providers are available to deliver services.~~

8.555.4.B. The CCT program strengthens the transition process for residents of qualified institutions and provides additional supports and services for a successful transition. These additional supports and services are ~~called~~ demonstration services.

8.555.4.C. Clients may be enrolled in the CCT program for 365 days. Days in a hospital or ~~other~~ qualified institution for a period of less than 30 days during the enrollment period will not count towards the 365 days.

8.555.4.D. CCT clients will be concurrently enrolled in the CCT program and one of the following waivers:

1. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) (10. C.C.R. 2505-10, Section 8.485);
2. Home and Community Based Services for People with Brain Injury (HCBS-BI) (10 CCR 2505-10, Section 8.515.00);
3. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) (10 CCR 2505-10, Section 8.509);
4. Home and Community Based Services for the Developmentally Disabled (HCBS-DD) (10 CCR 2505-10, Section 8.500); and
5. Home and Community Based Services for Supported Living Services (HCBS-SLS) (10 CCR 2505-10, Section 8.500.90).

8.555.4.E. At the end of the ~~365 day~~ enrollment period for ~~the CCT program~~, case managers will dis-enroll clients from the ~~CCT~~ program.

1. Demonstration services will ~~discontinue~~terminate at the end of the ~~365 days of CCT enrollment period.~~
2. ~~After CCT concludes, if~~ clients continue to meet eligibility requirements for one of the waivers listed in 8.555.4.D., case managers will arrange for the continuation of qualified HCBS services ~~through the appropriate waiver, after the CCT period ends through the appropriate HCBS waiver.~~

8.555.5 CLIENT ELIGIBILITY

8.555.5.A. ELIGIBLE PERSONS

CCT services shall be offered only to persons who meet all of the following eligibility requirements:

1. Clients shall be aged 18 years or older.
2. Clients shall have resided in a qualified institution for a period of 90 days. Days in a nursing facility for a rehab stay will not count towards the 90 days.
3. Clients shall be enrolled in Medicaid for at least one day prior to transition from a qualified institution.
4. Clients shall reside in a qualified residence post-transition.
5. Clients shall meet criteria of a targeted population which includes persons with mental illness, brain injury, physical disabilities or intellectual disabilities and the elderly.
6. Clients shall meet the eligibility requirements for the appropriate HCBS waiver programs listed in Section 8.555.4.D. in which they will be enrolled post-transition.
7. Clients concurrently enrolled in the HCBS-BI program and CCT shall be in the age range of 18-64 rather than 16-64 as specified in the HCBS-BI eligibility requirements.

8.555.5.B. FINANCIAL ELIGIBILITY

Clients must meet the financial eligibility requirements specified at 10 CCR 2505-10, Section 8.100.7 LONG TERM CARE MEDICAL ASSISTANCE ELIGIBILITY.

8.555.5.C. LEVEL OF CARE CRITERIA

Clients shall require long term support services at a level comparable to services typically provided in a nursing facility or ICF/ID in accordance with the waiver to which they will enroll upon transition.

8.555.5.D. NEED FOR CCT SERVICES

1. Only clients who have agreed to accept demonstration and qualified services as soon as all other eligibility criteria have been met are eligible for the CCT program.
 - a. Case management ~~shall not be used to satisfy the requirement that a HCBS service must be received within 30 days. is a CCT service but case management shall not be used to satisfy this requirement.~~
 - b. The desire or need for any Medicaid services other than CCT demonstration services, as listed at Section 8.555.1, or qualified services offered through one of the waiver programs listed in Section 8.555.4.D. shall not satisfy this eligibility requirement.

2. Once enrolled, clients who have not received demonstration or qualified services for a period greater than 30 consecutive days shall be discontinued from the program.

8.555.5.E. EXCLUSIONS

1. Clients who are residents of nursing facilities, other qualified institutions or hospitals are not eligible to receive CCT or waiver services in preparation for discharge except for but not limited to transition coordination, ~~or~~ case management, peer mentorship, independent living skills training, and/or enhanced nursing services. ~~services in preparation of discharge.~~
2. CCT clients readmitted to a qualified institution or hospital may not receive CCT services while admitted except for transition coordination or case management services in preparation for discharge.
 - a. CCT clients admitted to a nursing facility or hospital for 30 consecutive days or longer shall be discontinued from the CCT program but may have the option to re-enroll upon discharge provided they continue to meet all eligibility requirements. The state has the right to exempt the 30 day exclusion on a case-by-case basis.
 - b. CCT clients entering a nursing facility for Respite Care as a qualified HCBS waiver service shall not be discontinued from the CCT program.
3. Clients who reside in a residence that is not a qualified residence as defined in Section 8.555.2 are not eligible for CCT services.
4. ~~Certain d~~ Demonstration services may not be available to clients for certain waivers if those demonstration services are similar to or are the same as services already offered through the state plan or HCBS waiver in which the client will enroll. ~~upon discharge.~~

8.555.5.F. COST CONTAINMENT AND SERVICE ADEQUACY

1. The client shall not be eligible for the CCT program if:
 - a. The Department or its agent determines that the client's needs cannot be met within the specific cCost cContainment requirements set for the HCBS waiver in which they will enroll. ~~upon discharge.~~
 - b. The transition assessment reveals that the client's needs are more extensive than CCT demonstration services and/or HCBS qualified or state plan services are able to support and/or that the client's health and safety cannot be reasonably assured in a community setting.
2. In the event that the Department or its agent denies or reduces the request for services prior to transition, the case manager shall provide the client with the client's appeal rights pursuant to Section 8.555.12.
3. The client may be eligible for continuation with an HCBS waiver program following the CCT enrollment period if the case manager at reassessment determines that qualified services are able to support the client's needs and the

client's health and safety can be assured in a community setting with HCBS services.

- a. If the case manager expects that the services required to support the client's needs will exceed the cCost cContainment requirements for the waiver in which the client is enrolled, the Department or its agent will review the service plan to determine if the client's request for services is appropriate and justifiable based on the client's condition.
 - i) The client may request of the case manager that existing qualified services remain intact during this review process. CCT demonstration services will still end on the 365th day of the client's enrollment in the CCT program.
 - ii) In the event that the request for services is denied by the Department or its agent, the case manager shall provide the client with:
 - 1) The client's appeal rights pursuant to Section 8.555.12; and
 - 2) Alternative options to meet the client's needs that may include, but are not limited to, nursing facility or ICF/ID placement.

8.555.6 CCT ENROLLMENT

- 8.555.6.A. Clients shall demonstrate by signature that he or she provides consent to participate in the CCT demonstration program; understands the roles and responsibilities of the client, case manager and transition coordinator; and agrees to participate in the program evaluation activities.
- 8.555.6.B. Guardians shall demonstrate by signature that he or she provides consent for the client to participate in the CCT demonstration program; understands the roles and responsibilities of the client, case manager and transition coordinator; and agrees to participate in the program evaluation activities.
- 8.555.6.C. Transition coordinators and case managers will ensure that clients meet all eligibility requirements identified in Section 8.555.5 prior to enrollment.
- 8.555.6.D. Transition coordinators shall facilitate the completion of the Department approved Transition Assessment/Plan for each client with the support of the transitions options team members. complete the Department approved Transition Assessment and Plan for each client within 10 days of the initial meeting with the client.
- 8.555.6.E. Transition coordinators and case managers will follow all policies and procedures defined by the state and made available through trainings and other guidance. steps and processes stated in Section B.1, Enrollment and Eligibility, and Section B.2, Informed Consent and Guardianship, of the CCT Operational Protocol to complete the transition process and enrollment of the CCT client.
- 8.555.6.F. Transition coordinators shall act in accordance with Department guidance and the requirements established in 10 C.C.R. 2505-10, Section 8.553.

8.555.7 START DATE FOR SERVICES

8.555.7.A. The start date of eligibility for CCT services shall not precede the date that all of the requirements at Section 8.555.5 have been met.

8.555.7.B. The first date for which CCT services may be reimbursed shall be the date of discharge from a qualified institution.

8.555.7.C. Transition coordination services and case management services may be offered prior to the client's transition in preparation of the transition to a community setting. Other services may be provided pre-transition with Departmental approval if the service is necessary for transition. Services shall be billed retroactively upon the date of discharge or up to 120 days after discharge.

8.555.8 CASE MANAGEMENT FUNCTIONS

8.555.8.A. The requirements at 10 CCR 2505-10, Section 8.486 shall apply to the Case Management Agencies performing the case management functions of the CCT program and the HCBS-EBD, HCBS-CMHS or HCBS-BI waiver programs. Case managers for these waivers shall comply with these requirements and the CCT-specific requirements in the rest of this section.

8.555.8.B. The requirements at 10 CCR 2505-10, Section 8.760 shall apply to the Case Management Agencies performing the case management functions of the CCT program and the HCBS-SLS or HCBS-DD programs. Case managers for these waivers shall comply with these requirements and the CCT-specific requirements in the rest of this section.

8.555.8.C. The case manager is responsible for:

1. Assessing needs;
2. Determining CCT and waiver program eligibility;
3. Service planning and authorization;
4. Arranging services;
5. Identifying potential risks for reinstitutionalization;
6. Implementing strategies with the client and family to mitigate risks;
7. Monitoring services;
8. Monitoring the health, welfare and safety of the client; and
9. Promotion of client's self-advocacy.

8.555.8.D. [The case manager shall administer the first Quality of Life \(QoL\) Survey \(baseline survey\) within 14 days prior to the participant's transition to community living. For surveys conducted at 11 and 24 months following transition, the Department will send a survey request to the case management agencies \(CMA\) in the area where the survey needs to be completed. Once assigned, the](#)

interviewer from a CMA will schedule a time with the client and/or his or her proxy in the month that the survey is due and submit results to the Department.

8.555.8.E The case manager shall conduct a home visit with the transition coordinator on the date of discharge to:~~on the date of discharge to:~~

1. Confirm the start of services;
2. Ensure clients are safe; and
3. Identify and address any unanticipated concerns, issues and problems clients may have with the transition.

8.555.8.~~FE~~. The case manager shall conduct a check-in with the client by phone 48 hours after discharge and conduct any necessary follow-up activities needed.

8.555.8.~~GF~~. The case manager shall conduct three additional home visits in the first month that clients are enrolled in the program to provide support for success with community living.

8.555.8.~~HG~~. The case manager shall ~~tailor~~have weekly ~~the frequency of~~ contacts to the individual needs of the clients. ~~Regular contacts, based on functional status,~~ with clients, family members, guardians or other designated representatives for the duration of their enrollment in the CCT program to monitor services and the health, welfare and safety of the clients; ~~to review functional status;~~ and to conduct any necessary follow-up activities necessary to ensure independent living in the community is expected. ~~The Department strongly recommends~~prefers that within the first few months post-transition that the case manager shall have a minimum of weekly contacts.

Contacts may either be phone contacts or home visits based on necessity.

8.555.8.~~IH~~. The case manager shall revise the service plan, risk mitigation plan, and emergency back-up plan as needed based on the weekly contacts or as otherwise needed due to change in the client's condition.

8.555.8.~~IJ~~. The case manager shall review the client's most recent ULTC 100.2 and update the ULTC 100.2 assessment if a change in functional status or a significant change impacting eligibility has occurred, in accordance with 10 CCR 2505-10, Section 8.401.1.

8.555.8.~~KJ~~. The case ~~manager~~ manager in accordance with Section B.10, Continuity of Care Post Demonstration, in the CCT Operational Protocol shall begin preparing clients for disenrollment from the CCT program 90 days prior to the end of the clients' CCT enrollment period and arrange for the continuation of HCBS services if the clients continue to meet the eligibility requirements for a waiver listed at 8.555.4.D.

8.555.9 SERVICE PLAN

8.555.9.A. The service plan will be developed with input from the transition coordinator, staff from the discharging facility, the resident wanting to transition and others at the invitation of the client or guardian.

8.555.9.B. The transition assessment/plan, the client's level of functioning, service needs, available resources and potential funding resources will inform the development of the service plan.

~~8.555.9.C. The Transition Administrator at the Department shall approve the service plan before the transition occurs.~~

8.555.9.~~C~~D. The service plan shall:

1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver qualified services, CCT demonstration services or through other means;
2. Identify risks to reinstitutionalization and outline a contingency plan identifying paid and unpaid supports and services necessary to mitigate the risk.
3. Be in accordance with the rules, policies and procedures related to service plans established by the Division for Developmental Disabilities if clients are enrolled in the HCBS-SLS (10 CCR 2505-10, Section 8.500.95) or -DD waivers (10 CCR 2505-10, Section 8.500.6);
4. Be in accordance with the rules, policies and procedures established related to service plans by the Department of Health Policy and Financing for clients enrolled in the HCBS-EBD (10 CCR 2505-10, Section 8.486.51), -CMHS (10 CCR 2505-10, Section 8.509.31.D.) or -BI waivers (10 CCR 2505-10, Section 8.5165.30.E-);

~~5. Be in accordance with the rules, policies and procedures of the CCT Operational Protocol; and~~

~~56.~~ Include updates and revisions when warranted by changes in the client's needs or conditions.

8.555.9.~~D~~E. The service plan shall document that the client has been offered a choice:

1. Between community-based services or institutional care;
2. Between the CCT Program or a traditional HCBS Waiver;
3. Among qualified and demonstration services; and
4. Among qualified providers.

8.555.9.~~E~~F. A new service plan will be developed each time a client is reinstitutionalized and plans to return to a community setting. The service plan shall address the reasons for the client's reinstitutionalization.

8.555.10 PROVIDER REIMBURSEMENT

8.555.10.A. All CCT demonstration and qualified services must be prior authorized by the Department or its agent.

8.555.10.B. The Department shall develop the Prior Authorization Request (PAR) form to be completed by case managers who shall comply with all applicable regulations when completing the form.

8.555.10.C. The Department or its agent shall determine if the services requested are:

1. Consistent with the client's documented medical condition and functional capacity;
 2. Reasonable in amount, scope, frequency, and duration;
 3. Not duplicative of the other services included in the client's service plan;
 4. Not for services for which the client is receiving funds to purchase; and
 5. Do not total more than 24 hours per day of care.
- 8.555.10.D. The services requested on the PAR must meet all criteria listed at 8.555.10.C for the Department or its agent to approve the request.
- 8.555.10.E. If the Department or its agent determines that the services requested on the PAR do not meet the criteria at 8.555.10.C., the Department or its agent shall deny the PAR and work with the case management agency to submit a revised request.
1. If services are reduced or denied through a revised PAR, the case manager shall provide the client with the client's appeal rights pursuant to Section 8.555.12.
- 8.555.10.F. The prior authorization of services does not constitute an entitlement to those services, and does not guarantee payment.
- 8.555.10.G. The PAR start date shall not precede the start date of CCT eligibility in accordance with Section 8.555.7.
- 8.555.10.H. The PAR end date shall not exceed the end date of the initial CCT enrollment period, which cannot exceed 365 calendar days.
- 8.555.10.I. Revisions to the PAR that are requested six months or more after the end date of CCT enrollment shall be disapproved.
- 8.555.10.J. Prior to the end date, case managers shall establish a new CCT enrollment period and create a new PAR to reflect any days during the initial enrollment period that a client entered a hospital, nursing home, ICF/ID or other long term care institution for a period less than 30 days to ensure the client has a full 365 days of CCT enrollment in the community.
1. The numbers of days for the new enrollment period and PAR shall be equal to the numbers of days that the client was placed in an institution and shall commence on the first day after the end date of the initial enrollment period.
- 8.555.10.K. Prior Authorization Requests for clients enrolled in the HCBS-DD waiver shall be completed in accordance with Section 8.500.12
- 8.555.10.L. Prior Authorization Requests for clients enrolled in the HCBS-SLS waiver shall be completed in accordance with Section 8.500.101.
- 8.555.10.M. The PAR for qualified and demonstration services shall be sent to the [Transition Administrator at the Department](#) [or its agent](#) for approval.
- 8.555.10.N. Approval of the PAR by the Department shall authorize providers of CCT services to submit claims to the fiscal agent and to receive payment for authorized

services provided during the period of time covered by the PAR. However, a PAR does not guarantee payment.

8.555.10.O. Reimbursement shall be claimed only by a qualified provider who delivers services in accordance with the service definition and policy guidance established by the Department.

8.555.10.P. Payment for CCT Services

1. Payment for CCT services shall reflect the lower of billed charges or the maximum rate of reimbursement set by the Department.
 - a. Rates for ~~Behavioral Health Support~~, Caregiver ~~Education Support Service~~, ~~Community Transition Services~~, Enhanced Nursing ~~Services~~, Home Delivered Meals, ~~Extended~~, Independent Living Skills Training, Intensive Case Management, ~~Peer Mentorship Service~~, ~~Specialized Day Rehabilitation~~, ~~Substance Abuse Counseling (Transitional)~~, and ~~Transitional Behavioral Health Supports~~ are reimbursed on a fee-for-service basis and payment is based on the rate for each service found on the Departments statewide fee schedule.
 - b. The statewide fee schedule for these services ~~is~~ reviewed annually and published in the provider billing manual.
 - c. Payment for ~~the following services is reimbursed at billed cost but cannot exceed the Department's established maximums:~~ Assistive Technology, ~~Extended~~, Dental ~~Services~~, ~~Extended~~ Home Modifications, ~~Extended~~, and Vision ~~services~~. ~~services are reimbursed the billed at cost but cannot exceed the Department established maximums.~~
2. Payment for CCT services is also conditional upon:
 - a. The client's eligibility for CCT services;
 - b. The provider's certification status; and
 - c. The submission of claims in accordance with proper billing procedures.

8.555.11 PROVIDER AGENCIES

8.555.11.A. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-EBD, -BI, or ~~-CMHSM~~ shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.487.

8.555.11.B. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-DD shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.500.9.

8.555.11.C. CCT providers providing demonstration services to clients enrolled in CCT and HCBS-SLS shall abide by all general certification standards, conditions, and processes established at 10 CCR 2505-10, Section 8.500.98.

8.555.11.D. CCT providers of specific demonstration services must:

1. ~~_____A._____~~ Conform to all state established standards for the specific services they provide under this program.
2. ~~_____B._____~~ Abide by all the terms of their provider agreement with the Department; and
3. ~~_____C._____~~ Comply with all applicable federal and state ~~statutes, regulations and guidance~~ ~~requirements~~ [QK1].
4. ~~A provider shall not discontinue or refuse services to a client unless documented efforts have been made to resolve the situation that triggers such discontinuation or refusal to provide services.~~ [QK2]

~~comply with any additional certification standards or conditions contained in Appendix L of the CCT Operational Protocol. Appendix L (2012) is hereby incorporated by reference in this rule. Such incorporation, however, excludes later amendments to or editions of the referenced material. These materials are available for public inspection at the Department of Health Care Policy and Financing, 1570 Grant St, Denver, CO 80203. The Department shall provide certified copies of the material incorporated at cost upon request or shall provide the requestor with information on how to obtain a certified copy of the material incorporated by reference from the agency of the United States, this state, another state, or the organization or association originally issuing the code, standard, guideline or rule.~~

8.555.12 APPEAL RIGHTS

- 8.555.12.A. Case management agencies shall follow the rules for notification and appeals established for the waiver in which the client will enroll upon discharge.
1. For clients enrolled on HCBS-EBD, -BI and -CMHS, the case management agencies or utilization review contractor shall provide notification of adverse actions and appeals rights in accordance with 8.393.28.A.
 2. For clients enrolled on HCBS-DD, the case management agencies shall provide notification of adverse actions and appeal rights in accordance with 8.500.16.
 3. For clients enrolled on HCBS-SLS, the case management agencies shall provide notification of adverse actions and appeal rights in accordance with 8.500.106.