2. The facility location is certified by CMS under the operating hospital's Medicare certification.

8.320.3 Services

8.320.3.A The following services provided by a CC are eligible for reimbursement:

1. Outpatient services, as defined in the Department's rule at 10 CCR 2505-10, section 8.300.3.B, section 8.300.B.2, 8.300.B.3; and

2. Observation stays, as defined in the Department's rule at 10 CCR 2505-10, section 8.300.3.B.1.

8.320.4 Reimbursement

8.320.4.A CC services are reimbursed as:

1. Outpatient services, in accordance with the Department's rule at 10 CCR 2505-10, section 8.300.6, using the hospital base rate for the hospital that is identified in the CMS certification of the CC.

8.390 LONG TERM CARE SINGLE ENTRY POINT SYSTEM

The long-term care Single Entry Point system consists of Single Entry Point Agencies, representing geographic districts throughout the state, for the purpose of enabling persons in need of long-term services and supports to access appropriate services and supports.

8.390.1 DEFINITIONS

A. Agency Applicant means a legal entity seeking designation as the provider of Single Entry Point Agency functions within a Single Entry Point district.

B. Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers), chosen by the individual, conducted by the case manager, with supporting diagnostic information from the individual's medical provider to determine the individual's level of functioning, service needs, available resources, and potential funding resources.

C. Case Management means the assessment of an individual seeking or receiving long-term services and supports' needs, the development and implementation of a Support Plan for such individual, referral and related activities, the coordination and monitoring of long-term service delivery, the evaluation of service effectiveness, and the periodic reassessment of such individual's needs.

D. Corrective Action Plan means a written plan by the CMA, which includes a detailed description of actions to be taken to correct non-compliance with waiver requirements, regulations, and direction from the Department, and which sets forth the date by which each action shall be completed and the persons responsible for implementing the action.

E. Critical Incident means an actual or alleged event that creates the risk of serious harm to the health or welfare of an individual receiving services; and it may endanger or negatively impact the mental and/or physical well-being of an individual. Critical Incidents include, but are not limited to, injury/illness; abuse/neglect/exploitation; damage/theft of property; medication mismanagement; lost or missing person; criminal activity; unsafe housing/displacement; or death.

F. Department means the Colorado Department of Health Care Policy and Financing, the Single State Medicaid Agency.

G. Failure to Satisfy the Scope of Work means acts or failures to act by the Single Entry Point Agency that constitute nonperformance or breach of the terms of its contract with the Department.

H. Financial Eligibility means an individual meets the eligibility criteria for a publicly funded program, based on the individual's financial circumstances, including income and resources.

I. Functional Eligibility means an individual meets the level of care criteria for a Long-Term Services and Supports (LTSS) Program as determined by the Department.

J. Functional Needs Assessment means a comprehensive evaluation with the individual seeking services and appropriate collaterals (such as family members, friends and/or caregivers) chosen by the individual and a written evaluation by the case manager utilizing the ULTC 100.2, with supporting diagnostic information from the individual's medical provider, to determine the individuals level of care and medical necessity for admission or continued stay in certain Long-Term Services and Supports (LTSS) Programs.

K. Home and Community Based Services (HCBS) waivers means services and supports authorized through a waiver under Section 1915(c) of the Social Security Act and provided in home- and community-based settings to individuals who require an institutional level of care that would otherwise be provided in a hospital, nursing facility, or Intermediate Care Facility for individuals with Intellectual Disabilities (ICF-IID).

L. Information Management System (IMS) means an automated data management system approved by the Department to enter case management information for each individual seeking or receiving long-term services as well as to compile and generate standardized or custom summary reports.

M. Intake, Screening and Referral means the initial contact with individuals by the Single Entry Point Agency and shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long-term services and supports; an individual's need for referral to other programs or services; an individual's eligibility for financial and program assistance; and the need for a comprehensive functional assessment of the individual seeking services.

N. Long-Term Services and Supports (LTSS) means the services and supports used by individuals of all ages with functional limitations and chronic illnesses who need assistance to perform routine daily activities such as bathing, dressing, preparing meals, and administering medications.

O. LTSS Program means any of the following: publicly funded programs, Home and Community-Based Services for the Elderly, Blind and Disabled (HCBS-EBD), Home and Community-Based Services for Persons with a Spinal Cord Injury (HCBS-SCI) (where applicable), Home and Community-Based Services for Persons with a Brain Injury (HCBS-BI), Home and Community-Based Services Community Mental Health Supports (HCBS-CMHS), Home and Community-Based Services for Children with a Life Limiting Illness (HCBS-CLLI), Medicaid Nursing Facility Care, Program for All-Inclusive Care for the Elderly (PACE) (where applicable), Hospital Back-up (HBU) and Adult Long-Term Home Health (LTHH).

P. Pre-Admission Screening and Resident Review (PASRR) means the pre-screening of individuals seeking nursing facility admission to identify individuals with mental illness (MI) and/or intellectual disability (ID), to ensure that individuals are placed appropriately, whether in the community or in a NF, and to ensure that individuals receive the services they require for their MI or ID.

Q. Professional Medical Information Page (PMIP) means the medical information form signed by a licensed medical professional used to certify level of care.

R. Reassessment means a periodic comprehensive reevaluation with the individual receiving services, appropriate collaterals, chosen by the individual, and case manager, to re-determine the individual's level of functioning, service needs, available resources and potential funding resources.

S. Resource Development means the study, establishment and implementation of additional resources or services which will extend the capabilities of community LTSS systems to better serve individuals receiving long-term services and individuals likely to need long-term services in the future.

T. Single Entry Point (SEP) means the availability of a single access or entry point within a local area where an individual seeking or currently receiving LTSS can obtain LTSS information, screening, assessment of need and referral to appropriate LTSS programs and case management services.

U. Single Entry Point Agency means the organization selected to provide intake, screening, referral, eligibility determination, and case management functions for persons in need of LTSS within a Single Entry Point District.

V. Single Entry Point District means one or more counties that have been designated as a geographic region in which one agency serves as the Single Entry Point for persons in need of LTSS.

W. Support Planning means the process of working with the individual receiving services and people chosen by the individual to identify goals, needed services, individual choices and preferences, and appropriate service providers based on the individual seeking or receiving services' assessment and knowledge of the individual and of community resources. Support Planning informs the individual seeking or receiving services of his or her rights and responsibilities.

X. Target Group Criteria means the factors that define a specific population to be served through an HCBS waiver. Target Group Criteria can include physical or behavioral disabilities, chronic conditions, age, or diagnosis, and May include other criteria such as demonstrating an exceptional need.

8.390.2 LEGAL AUTHORITY

Pursuant to Section 25.5.6.105, C.R.S., the State Department is authorized to provide for a statewide Single Entry Point system.

8.390.3 CHARACTERISTICS OF INDIVIDUALS RECEIVING SERVICES IN LTSS PROGRAMS

A. An individual served by the SEP Agency shall meet the following criteria:

1. The individual requires skilled, maintenance and/or supportive services long term;

2. The individual has functional impairment in activities of daily living (ADL) and/or a need for supervision, necessitating LTSS provided in a nursing facility, an alternative residential setting, the individual's home or other services and supports in the community;

3. The individual receives or is eligible to receive medical assistance (Medicaid) and/or financial assistance under one or more of the following programs: Old Age Pension, Aid to Blind, Aid to Needy Disabled, Supplemental Security Income, or Colorado Supplemental, or as a 300% eligible, as defined at 8.485.50.T, receiving LTSS in a nursing facility or through one of the HCBS Programs.

8.391 SINGLE ENTRY POINT DISTRICT DESIGNATION

8.391.1.A. District Designation Requirements

Single Entry Point (SEP) districts shall meet the following requirements:

1. Counties composing a multi-county district shall be contiguous.

2. A single county may be designated a district provided the county serves a monthly average of 200 or more individuals for LTSS programs.

3. Multi-county districts shall not be required to serve a minimum number of individuals receiving services.

4. Each district shall assure adequate staffing and infrastructure by the district's SEP agency, including at least one full-time case manager employed by the SEP agency, to provide coverage for all case management functions and administrative support, in accordance with rules at Section 8.393.

8.391.1.B. Changes in Single Entry Point District Designation

1. In order to change SEP district designation, a county or district shall submit an application to the Department, six (6) months prior to commencement date of the proposed change. The application shall include the following information:

   a. The geographic boundaries of the proposed SEP district;

   b. Assurances that the proposed district meets all criteria set forth in Department rules for SEP district designation;

   c. The designation of a contact person for the proposed district; and

   d. A resolution supporting the application passed by the county commissioners of each county or parts of counties in the proposed district.

2. The application shall be approved provided the proposed district meets the SEP district designation requirements.

8.391.2 Single Entry Point Agency Selection

A. Except as otherwise provided herein, upon a change in SEP district designation or upon expiration of the district's existing SEP agency contract, a SEP district may select a county agency, including a county department of social/human services, a county nursing service, an area agency on aging or a multicounty agency to serve as the SEP agency for the district. Once the SEP functions in a district are provided through a contract between the Department and an entity other than as listed above, the SEP agency for that district shall thereafter be selected by the Department pursuant to applicable state statutes and regulations.

B. The agency selected by the SEP district shall serve as the SEP agency for the district unless the agency selected by the district has previously had its SEP agency contract terminated by the Department.

C. The SEP district's selection shall be delivered to the Department no less than six (6) months prior to the effective date of the change in district designation or expiration of the contract with the district's existing SEP agency.

D. If the SEP district has not delivered to the Department its selection within the timeframe specified in subsection (C) of this rule, the SEP agency for the district shall be selected by the Department pursuant to applicable state statutes and regulations.

8.391.3 Single Entry Point Contract

A. A SEP agency shall be bound to the terms of the contract between the agency and the Department including quality assurance standards and compliance with the Department's rules for SEP agencies and for LTSS Programs.

8391.4 Certification of Single Entry Point Agencies

1. A SEP agency shall be certified annually in accordance with quality assurance standards and requirements set forth in the Department's rules and in the contract between the agency and the Department.

    a. Certification as a SEP agency shall be based on an evaluation of the agency's performance in the following areas:

        i. The quality of the services provided by the agency;

        ii. The agency's compliance with program requirements, including compliance with case management standards adopted by the Department;

        iii. The agency's performance of administrative functions, including reasonable costs per individual receiving services, timely reporting, managing programs in one consolidated unit, on-site visits to individuals, community coordination and outreach and individual monitoring;

        iv. Whether targeted populations are being identified and served;

        v. Financial accountability; and

        vi. The maintenance of qualified personnel to perform the contracted duties.

    b. The Department or its designee shall conduct reviews of the SEP agency.

    c. At least sixty (60) days prior to expiration of the previous year's certification, the Department shall notify the SEP agency of the outcome of the review, which may be approval, provisional approval, or denial of certification.

8.391.4.A. Provisional Approval of Certification

1. In the event a SEP agency does not meet all of the quality assurance standards established by the Department, the agency may receive provisional approval of certification for a period not to exceed sixty (60) days, provided the deficiencies do not constitute a threat to the health and safety of individuals receiving services.

2. The agency will receive notification of the deficiencies, a request to submit a corrective action plan to be approved by the Department and upon receipt and review of the corrective action plan, at the Department's option, a second sixty-day (60) provisional certification may be approved.

3. The Department or its designee shall provide technical assistance to facilitate corrective action.

8.391.4.B. Denial of Certification

In the event certification as a SEP agency is denied, the procedure for SEP agency termination or non-renewal of contract shall apply.

8.392 FINANCING OF THE SINGLE ENTRY POINT SYSTEM - Single Entry Point agencies are paid for deliverables completed and accepted by the Department and a Per Member Per Month (PMPM) payment for ongoing case management activities performed as identified in contract.

8.393 FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

8.393.1.A Administration of a Single Entry Point

1. The SEP Agency shall be required by federal or state statute, mission statement, by-laws, articles of incorporation, contracts, or rules and regulations which govern the Agency, to comply with the following standards:

   a. The SEP Agency shall serve persons in need of LTSS programs as defined in Section 8.390.3;

   b. The SEP Agency shall have the capacity to accept funding from multiple sources;

   c. The SEP Agency may contract with individuals, for-profit entities and not-for-profit entities to provide some or all SEP functions;

   d. The SEP Agency may receive funds from public or private foundations and corporations; and

   e. The SEP Agency shall be required to publicly disclose all sources and amounts of revenue.

2. For individuals with intellectual or developmental disabilities seeking or receiving services, the SEP will refer to the appropriate Community Centered Board (CCB) for programs that serve this population. In the event that the individual is eligible for programs administered by both the SEP and the CCB, the individual will have the right to choose the program in which he or she will participate.

8.393.1.B. Community Advisory Committee

1. The SEP Agency shall, within thirty (30) days of designation, establish a community advisory committee for the purpose of providing public input and guidance for SEP Agency operation.

    a. The membership of the Community Advisory Committee shall include, but not be limited to, regional representation from the district's county commissioners, area agencies on aging, medical professionals, LTSS providers, LTSS ombudsmen, human service agencies, county government officials and individuals receiving LTSS.

    b. The Community Advisory Committee shall provide public input and guidance to the SEP Agency in the review of service delivery policies and procedures, marketing strategies, resource development, overall SEP Agency operations, service quality, individual satisfaction and other related professional problems or issues.

8.393.1.C. Personnel System

1. The SEP Agency shall have a system for recruiting, hiring, evaluating and terminating employees.

    a. SEP Agency employment policies and practices shall comply with all federal and state affirmative action and civil rights requirements.

    b. The SEP Agency shall maintain current written job descriptions for all positions.

8.393.1.D. Information Management

1. The SEP Agency shall, in a format specified by the Department, be responsible for the collection and reporting of summary and individual-specific data including but not limited to information and referral services provided by the Agency, program eligibility determination, financial eligibility determination, Support Planning, service authorization, critical incident reporting, monitoring of health and welfare, monitoring of services, resource development and fiscal accountability.

    a. The SEP Agency shall have adequate phone and computer hardware and software, compatible with - IMS with such capacity and capabilities as prescribed by the Department to manage the administrative requirements necessary to fulfill the SEP Agency responsibilities.

    b. The SEP Agency shall have adequate staff support to maintain a computerized information system in accordance with the Department's requirements.

8.393.1.E. Recordkeeping

1. The SEP Agency shall maintain individual records in accordance with program requirements.

    a. The case manager shall use the Department-prescribed IMS for purposes of documentation of all case activities, monitoring of service delivery, and service effectiveness. If applicable, the individual's designated representative (such as guardian, conservator, or person given power of attorney) shall be identified in the case record, with a copy of appropriate documentation.

2. If the individual is unable to sign a form requiring his/her signature because of a medical condition, a digital signature or any mark the individual is capable of making will be accepted in lieu of a signature. If the individual is not capable of making a mark or performing a digital signature, the physical or digital signature of a guardian or authorized representative will be accepted.

8.393.1.F. Confidentiality of Information

The SEP Agency shall protect the confidentiality of all records of individuals seeking and receiving services in accordance with State statute (Section 26-1-114). Release of information forms obtained from the individual must be signed, dated, and kept in the client's record. Release of information forms shall be renewed at least annually, or sooner if there is a change of provider. Fiscal data, budgets, financial statements and reports which do not identify individuals by name or Medicaid ID number, and which do not otherwise include protected health information, are open records.

8.393.1.G. Individual Rights

1. The SEP Agency shall assure the protection of the rights of individuals receiving services as defined by the Department under applicable programs.

    a. The SEP Agency shall assure that the following rights are preserved for all individuals served by the SEP Agency, whether the individual is a recipient of a state-administered program or a private pay individual:

        i. The individual and/or the individual's authorized representative is fully informed of the individual's rights and responsibilities;

        ii. The individual and/or the individual's authorized representative participates in the development and approval of, and is provided a copy of, the individual's Support Plan;

        iii. The individual and/or the individual's authorized representative selects service providers from among available qualified and willing providers;

        iv. The individual and/or the individual's authorized representative has access to a uniform complaint system provided for all individuals served by the SEP Agency; and

        v. The individual who applies for or receives publicly funded benefits and/or the individual's authorized representative has access to a uniform appeal process, which meets the requirements of Section 8.057, when benefits or services are denied or reduced and the issue is appealable.

2. At least annually, the SEP Agency shall survey a random sample of individuals receiving services to determine their level of satisfaction with services provided by the agency.

    a. The random sample of individuals shall constitute ten (10) individuals or ten percent (10%) of the SEP Agency's average monthly caseload, whichever is higher.

    b. If the SEP Agency's average monthly caseload is less than ten (10) individuals, all individuals shall be included in the survey.

    c. The individual satisfaction survey shall conform to guidelines provided by the Department.

d. The results of the individual satisfaction survey shall be made available to the Department and shall be utilized for the SEP Agency's quality assurance and resource development efforts.

e. The SEP Agency shall assure that consumer information regarding LTSS is available for all individuals at the local level.

8.393.1.H. Access

1. There shall be no physical barriers which prohibit individual participation, in accordance with the Americans with Disabilities Act (ADA), 42 U.S.C. 12101 et seq.

a. The SEP Agency shall not require individuals receiving services to come to the Agency's office in order to receive SEP services.

b. The SEP Agency shall comply with nondiscrimination requirements, as defined by federal and Department rules and outlined in contract.

c. The functions to be performed by a SEP Agency shall be based on a case management model of service delivery.

8.393.1.I. Staffing Patterns

1. The SEP Agency shall provide staff for the following functions: receptionist/clerical, administrative/supervisory, case management, and medical consulting services.

a. The receptionist/clerical function shall include, but not be limited to, answering incoming telephone calls, providing information and referral, and assisting SEP Agency staff with clerical duties.

b. The administrative/supervisory function of the SEP Agency shall include, but not be limited to, supervision of staff, training and development of Agency staff, fiscal management, operational management, quality assurance, case record reviews on at least a sample basis, resource development, marketing, liaison with the Department, and, as needed, providing case management services in lieu of the case manager.

c. The case management function shall include, but not be limited to, all of the case management functions defined in Section 8.393.1.M. for SEP case management services, as well as resource development and attendance at staff development and training sessions.

d. Medical consultant services functions shall include, but not be limited to, employing or otherwise contracting with a physician and/or registered nurse who shall provide consultation to SEP Agency staff regarding medical and diagnostic concerns and Adult Long-Term Home Health prior authorizations.

8.393.1.J. Qualifications of Staff

1. The SEP case manager(s) hired on or after October 8, 2021 shall meet minimum standards for HCBS case managers required in Section 8.519.5.B and shall be able to demonstrate competency in pertinent case management knowledge and skills.

2.. The case manager must demonstrate competency in each of the following areas:

a. Application of a person-centered approach to planning and practice;

b. Knowledge of and experience working with populations served by the SEP Agency;

c. Interviewing and assessment skills;

d. Knowledge of the policies and procedures regarding public assistance programs;

e. Ability to develop Support Plans and service agreements;

f. Knowledge of LTSS and other community resources; and

g. Negotiation, intervention and interpersonal communication skills.

3. The SEP Agency supervisor(s) shall meet all qualifications for case managers and have a minimum of two years of experience in the field of LTSS.

8.393.1.M. Functions of the Case Manager.

1. The SEP Agency's case manager(s) shall be responsible for: intake, screening and referral, assessment/reassessment, development of Support Plans, ongoing case management, monitoring of individuals' health and welfare, documentation of contacts and case management activities in the Department-prescribed IMS, resource development, and case closure.

a. The case manager shall contact the individual at least once within each quarterly period, or more frequently if warranted by the individual's condition or as determined by the rules of the LTSS Program in which the individual is enrolled.

b. The case manager shall have in-person monitoring at least one (1) time during the Support Plan year. The case manager shall ensure one required monitoring is conducted in-person with the Member, in the Member's place of residence.. Upon Department approval, contact may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

c. The case manager shall complete a new ULTC-100.2 during a face-to-face reassessment annually, or more frequently if warranted by the individual's condition or if required by the rules of the LTSS Program in which the individual is enrolled. Upon Department approval, reassessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

d. The case manager shall monitor the delivery of services and supports identified within the Support Plan and the Prior Authorization Request (PAR). This includes monitoring:

i. The quality of services and supports provided;

ii. The health and safety of the individual; and

iii. The utilization of services.

e. The following criteria may be used by the case manager to determine the individual's level of need for case management services:

i. Availability of family, volunteer, or other support;

ii. Overall level of functioning;

iii. Mental status or cognitive functioning;

iv. Duration of disabilities;

v. Whether the individual is in a crisis or acute situation;

vi. The individual's perception of need and dependency on services;

vii. The individual's move to a new housing alternative; and

viii. Whether the individual was discharged from a hospital or Nursing Facility.

8.393.1.N. Functions of the Single Entry Point Agency Supervisor

1. SEP Agencies shall provide adequate supervisory staff who shall be responsible for:

a. Supervisory case conferences with case managers on a regular basis;

b. Approval of indefinite lengths of stay, pursuant to 8.402.15;

c. Regular, systematic review and remediation of case records and other case management documentation, on at least a sample basis;

d. Communication with the Department when technical assistance is required by case managers and the supervisor is unable to provide answers after reviewing the regulations and other departmental publications;

e. Allocation and monitoring of staff to assure that all standards and time frames are met; and

f. Assumption of case management duties when necessary.

8.393.1.L. Training of Single Entry Point Agency Staff

1. SEP Agency staff, including supervisors, shall attend training sessions as directed and/or provided by the Department for SEP agencies.

a. Prior to start-up, the SEP Agency staff shall receive training provided by the Department or its designee, which will include, but not be limited to, the following content areas:

i. Background information on the development and implementation of the SEP system;

ii. Mission, goals, and objectives of the SEP system;

iii. Regulatory requirements and changes or modifications in federal and state programs;

iv. Contracting guidelines, quality assurance mechanisms, and certification requirements; and

v. Federal and state requirements for the SEP Agency.

b. During the first year of Agency operation, in addition to an Agency's own training, the Department or its designee will provide in-service and skill development training for SEP Agency staff. Thereafter, the SEP Agency will be responsible for in-service and staff development training.

8.393.1.M. Provision of Direct Services

1. The SEP Agency may be granted a waiver by the Department to provide direct services provided the Agency complies with the following:

a. The SEP Agency shall document at least one of the following in a formal letter of application for the waiver:

i. The service is not otherwise available within the SEP district or within a sub-region of the district; and/or

ii. The service can be provided more cost effectively by the SEP Agency, as documented in a detailed cost comparison of its proposed service with all other service providers in the district or sub-region of the district.

b. The SEP Agency that is granted a waiver to provide direct services due to its ability to provide the service cost effectively shall provide an annual report, at such time and on a form as prescribed by the Department, which includes a cost comparison of the service with other service providers in the area in order to document continuing cost effectiveness.

c. The SEP Agency shall assure the Department that efforts have been made, and will continue to be made, to develop the needed service within the SEP district or within the sub-region of the district, as a service external to the SEP Agency. The SEP Agency shall submit an annual progress report, at such time as prescribed by the Department, on the development of the needed service within the district.

d. The direct service provider functions and the SEP Agency functions shall be administratively separate.

e. In the event other service providers are available within the district or sub-region of the district, the SEP Agency case manager shall document in the individual's case record that the individual has been offered a choice of providers.

8.393.2 SERVICE FUNCTIONS OF A SINGLE ENTRY POINT AGENCY

The SEP Agency shall provide intake and screening for LTSS Programs, information and referral assistance to other services and supports, eligibility determination, case management and, if applicable, Utilization Management services in compliance with standards established by the Department. The SEP Agency shall provide sufficient staff to meet all performance standards. In the event a SEP Agency sub-contracts with an individual or entity to provide some or all service functions of the SEP Agency, the sub-contractor shall serve the full range of LTSS programs served by the SEP Agency. Subcontractors must abide by the terms of the SEP Agency's contract with the Department and are obligated to follow all applicable federal and state rules and regulations. The SEP Agency is responsible for subcontractor performance.

8.393.2.A. Protective Services

1. In the event, at any time throughout the case management process, the case manager suspects an individual to be a victim of mistreatment, abuse, neglect, exploitation or a harmful act, the case manager shall immediately refer the individual to the protective services section of the county department of social services of the individual's county of residence and/or the local law enforcement agency. The agency shall ensure that employees and contractors obligated by statute, including but not limited to, Section 19-13-304, C.R.S., (Colorado Children's Code), Section 18-6.5-108, C.R.S., (Colorado Criminal Code - Duty To Report A Crime), and Section 26-3.1-102, C.R.S., (Human Services Code - Protective Services), to report suspected abuse, mistreatment, neglect, or exploitation, are aware of the obligation and reporting procedures.

8.393.2.B. Intake, Screening and Referral

1. The intake, screening and referral function of a SEP Agency shall include, but not be limited to, the following activities:

    a. The completion of the intake, screening and referral functions using the Department's IMS;

        SEPs may ask referring agencies to complete and submit an intake and screening form to initiate the process;

    b. The provision of information and referral to other agencies as needed;

    c. A screening to determine whether a functional eligibility assessment is needed;

    d. The identification of potential payment source(s), including the availability of private funding resources; and

    e. The implementation of a SEP Agency procedure for prioritizing urgent inquiries.

2. When LTSS are to be reimbursed through one or more of the publicly funded LTSS programs served by the SEP system:

    a. The SEP Agency shall verify the individual's demographic information collected during the intake;

    b. The SEP Agency shall coordinate the completion of the financial eligibility determination by:

        i. Verifying the individual's current financial eligibility status; or

ii. Referring the individual to the county department of social services of the individual's county of residence for application; or

iii. Providing the individual with financial eligibility application form(s) for submission, with required attachments, to the county department of social services for the county in which the individual resides; and

iv. Conducting and documenting follow-up activities to complete the functional eligibility determination and coordinate the completion of the financial eligibility determination.

c. The determination of the individual's financial eligibility shall be completed by the county department of social services for the county in which the individual resides, pursuant to Section 8.100.7 A-U.

d. Individuals shall be notified by the SEP Agency at the time of their application for publicly funded long term services and supports that they have the right to appeal actions of the SEP Agency, the Department, and contractors acting on behalf of the Department. The notification shall include the right to request a fair hearing before an Administrative Law Judge.

e. The county department shall notify the SEP Agency of the Medicaid application date for the individual seeking services upon receipt of the Medicaid application.

f. The county shall not notify the SEP Agency for individuals being discharged from a hospital or nursing facility or Adult Long-Term Home Health.

8.393.2.C. Initial Assessment

1. For additional guidance on the ULTC-100.2, as well as the actual tool itself, see Section 8.401.1. GUIDELINES FOR LONG TERM CARE SERVICES

a. The SEP Agency shall complete the ULTC 100.2 within the following time frames:

i. For an individual who is not being discharged from a hospital or a nursing facility, the individual assessment shall be completed within ten (10) working days after receiving confirmation that the Medicaid application has been received by the county department of social services, unless a different time frame specified below applies.

ii. For a resident who is changing pay source (Medicare/private pay to Medicaid) in the nursing facility, the SEP Agency shall complete the assessment within five (5) working days after notification by the nursing facility.

iii. For a resident who is being admitted to the nursing facility from the hospital, the SEP Agency shall complete the assessment, including a PASRR Level 1 Screen within two (2) working days after notification.

1) For PASRR Level 1 Screen regulations, refer to 8.401.18, PRE-ADMISSION SCREENING AND ANNUAL RESIDENT REVIEW (PASRR) AND SPECIALIZED SERVICES FOR INDIVIDUALS WITH MENTAL ILLNESS OR INDIVIDUALS WITH AN INTELLECTUAL OR DEVELOPMENTAL DISABILITY

b. For an individual who is being transferred from a nursing facility to an HCBS program or between nursing facilities, the SEP Agency shall complete the assessment within five (5) working days after notification by the nursing facility.

c. For an individual who is being transferred from a hospital to an HCBS program, the SEP Agency shall complete the assessment within two (2) working days after notification from the hospital.

2. Under no circumstances shall the start date for functional eligibility based on the See Section 8.486.30, ASSESSMENT.

3. The SEP Agency shall complete the ULTC 100.2 for LTSS Programs, in accordance with Section 8.401.1.

a. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may complete the ULTC 100.2 for CHCBS.

4. The SEP Agency shall assess the individual's functional status face-to-face in the location where the person currently resides.. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.). .

5. The SEP Agency shall conduct the following activities for a comprehensive assessment of an individual seeking services:

a. Obtain diagnostic information through the Professional Medical Information Page (PMIP) form from the individual's medical provider for individuals in nursing facilities, HCBS Programs for Community Mental Health Supports (HCBS-CMHS), Persons with a Brain Injury (HCBS-BI), Elderly, Blind and Disabled (HCBS-EBD), Persons with a Spinal Cord Injury (HCBS-SCI) and Children with a Life Limiting Illness (HCBS-CLLI).

i. If enrolled as a provider of case management services for Children's Home and Community Based Services (CHCBS), SEP agencies may obtain diagnosis(es) information from the individual's medical provider.

b. Determine the individual's functional capacity during an evaluation, with observation of the individual and family, if appropriate, in his or her residential setting and determine the functional capacity score in each of the areas identified in Section 8.401.1.

c. Determine the length of stay for individuals seeking/receiving nursing facility care using the Nursing Facility Length of Stay Assignment Form in accordance with Section 8.402.15.

d. Determine the need for long-term services and supports on the ULTC 100.2 during the evaluation.

e. For HCBS Programs and admissions to nursing facilities from the community, the original ULTC-100.2 copy shall be sent to the provider agencies, and a copy shall be placed in the individual's case record. If there are changes in the individual's condition which significantly change the payment or services amount, a copy of the ULTC-100.2 must be sent to the provider agency, and a copy is to be maintained.

f. When the SEP Agency assesses the individual's functional capacity on the ULTC-100.2, the assessment is not an adverse action that is directly appealable. The individual's right to appeal arises only when an individual is denied enrollment into an LTSS Program by the SEP based on the ULTC-100.2 thresholds for functional eligibility. The appeal process is governed by the provisions of Section 8.057.

6. The case manager and the nursing facility shall complete the following activities for discharges from nursing facilities:

a. The nursing facility shall contact the SEP Agency in the district where the nursing facility is located to inform the SEP Agency of the discharge if placement into home- or community-based services is being considered.

b. The nursing facility and the SEP case manager shall coordinate the discharge date.

c. When placement into HCBS Programs is being considered, the SEP Agency shall determine the remaining length of stay.

i. If the end date for the nursing facility is indefinite, the SEP Agency shall assign an end date not past one (1) year from the date of the most recent assessment.

ii. If the ULTC 100.2 is less than six (6) months, the SEP Agency shall generate a new certification page that reflects the end date that was assigned to the nursing facility.

iii. The SEP Agency shall complete a new ULTC 100.2 if the current completion date is six (6) months old or older. The assessment results shall be used to determine level of care and the new length of stay.

iv. The SEP Agency shall send a copy of the ULTC-100.2 certification page to the eligibility enrollment specialist at the county department of social services.

v. The SEP Agency shall submit the HCBS prior authorization request to the Department or its fiscal agent.

7. For individuals receiving services in HCBS Programs who are already determined to be at the nursing facility level of care and seeking admission into a nursing facility, the SEP Agency shall:

a. Coordinate the admission date with the facility;

b. Complete the PASRR Level 1 Screen, and if there is an indication of a mental illness or developmental disability, submit to the Department or its agent to determine whether a PASRR Level 2 evaluation is required;

c. Maintain the Level 1 Screen in the individual's case file regardless of the outcome of the Level 1 Screen; and

d. If appropriate, assign the remaining HCBS length of stay towards the nursing facility admission if the completion date of the ULTC 100.2 is not six (6) months old or older.

8.393.2.D. Reassessment

1. The case manager shall commence a regularly scheduled reassessment at least one (1) but no more than three (3) months before the required completion date. The case manager shall complete a reassessment of an individual receiving services within twelve (12) months of the initial individual assessment or the most recent reassessment. A reassessment shall be completed sooner if the individual's condition changes or if required by program criteria.

2. The case manager shall update the information provided at the previous assessment or reassessment, utilizing the ULTC 100.2.

3. Reassessment shall include, but not be limited to, the following activities:

   a. Assess the individual's functional status face-to-face, in the location where the person currently resides.. Upon Department approval, assessment may be completed by the case manager at an alternate location, via the telephone or using virtual technology methods. Such approval may be granted for situations in which face-to-face meetings would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

   b. Review Support Plan, service agreements and provider contracts or agreements;

   c. Evaluate effectiveness, appropriateness and quality of services and supports;

   d. Verify continuing Medicaid eligibility, other financial and program eligibility;

   e. Annually, or more often if indicated, complete a new Support Plan and service agreements;

   f. Inform the individual's medical provider of any changes in the individual's needs;

   g. Maintain appropriate documentation, including type and frequency of LTSS the individual is receiving for certification of continued program eligibility, if required by the program;

   h. Refer the individual to community resources as needed and develop resources for the individual if the resource is not available within the individual's community; and

   j. Submit appropriate documentation for authorization of services, in accordance with program requirements.

4. The SEP Agency shall be responsible for completing reassessments of individuals receiving care in a nursing facility. A reassessment shall be completed if the nursing facility determines there has been a significant change in the resident's physical/medical status, if the individual requests a reassessment or if the case manager assigns a definite end date. The nursing facility shall be responsible to send the SEP Agency a referral for a new assessment as needed.

5. In order to assure quality of services and supports and the health and welfare of the individual, the case manager shall ask for permission from the individual to observe the individual's residence as part of the reassessment process, but this shall not be compulsory of the individual. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.). .

8.393.2.E. Support Plan

1. The nursing facility shall be responsible for developing a Support Plan for individuals residing in nursing facilities.

2. The SEP Agency shall develop the Support Plan (SP) for individuals not residing in nursing facilities within fifteen (15) working days after determination of program eligibility.

3. The SEP Agency shall:

   a. Address the functional needs identified through the individual assessment;

   b. Offer informed choices to the individual regarding the services and supports they receive and from whom, as well as the documentation of services needed, including type of service, specific functions to be performed, duration and frequency of service, type of provider and services needed but that may not be available;

   c. Include strategies for solving conflict or disagreement within the process, including clear conflict-of-interest guidelines for all planning participants;

   d. Reflect cultural considerations of the individual and be conducted by providing information in plain language and in a manner that is accessible to individuals with disabilities and individuals who have limited English proficiency;

   e. Formalize the Support Plan agreement, including appropriate physical or digital signatures, in accordance with program requirements;

   f. Contain prior authorization for services, in accordance with program directives, including cost containment requirements;

   g. Contain prior authorization of Adult Long-Term Home Health Services, pursuant to Sections 8.520-8.527;

   h. Include a method for the individual to request updates to the plan as needed;

   i. Include an explanation to the individual of complaint procedures;

   j. Include an explanation to the individual of critical incident procedures; and

k. Explain the appeals process to the individual.

4. The case manager shall provide necessary information and support to ensure that the individual directs the process to the maximum extent possible and is enabled to make informed choices and decisions and shall ensure that the development of the Support Plan:

   a. Occurs at a time and location convenient to the individual receiving services;

   b. Is led by the individual, the individual's parent's (if the individual is a minor), and/or the individual's authorized representative;

   c. Includes people chosen by the individual;

   d. Addresses the goals, needs and preferences identified by the individual throughout the planning process;

   e. Includes the arrangement for services by contacting service providers, coordinating service delivery, negotiating with the provider and the individual regarding service provision and formalizing provider agreements in accordance with program rules; and

   f. Includes referral to community resources as needed and development of resources for the individual if a resource is not available within the individual's community.

5. Prudent purchase of services:

   a. The case manager shall arrange services and supports using the most cost-effective methods available in light of the individual's needs and preferences.

   b. When family, friends, volunteers or others are available, willing and able to support the individual at no cost, these supports shall be utilized before the purchase of services, providing these services adequately meet the individual's needs.

   c. When public dollars must be used to purchase services, the case manager shall encourage the individual to select the lowest-cost provider of service when quality of service is comparable.

   d. The case manager shall assure there is no duplication in services provided by LTSS programs and any other publicly or privately funded services.

6. In order to assure quality of services and supports and health and welfare of the individual, the case manager shall observe the individual's residence prior to completing and submitting the individual's Support Plan. Upon Department approval, observation may be completed using virtual technology methods may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.).

8.393.2.F. Cost Containment

1. If the case manager expects that the cost of services required to support the individual will exceed the Department-determined Cost Containment Review Amount, the Department or its agent will review the Support Plan to determine whether the individual's request for services is appropriate and justifiable based on the individual's condition and quality of life and, if it is, will sign the Prior Authorization Request.

    a. The individual may request of the case manager that existing services remain intact during this review process.

    b. In the event that the request for services is denied by the Department or its agent, the case manager shall provide the individual with:

        i. The individual's appeal rights pursuant to Section 8.057; and

        ii. Alternative options to meet the individual's needs that may include, but are not limited to, nursing facility placement.

8.393.2.G. Ongoing Case Management

1. The functions of the ongoing case manager shall be:

    a. Assessment/Reassessment: The case manager shall continually identify individuals' strengths, needs, and preferences for services and supports as they change or as indicated by the occurrence of critical incidents;

    b. Support Plan Development: The case manager shall work with individuals to design and update Support Plans that address individuals' goals and assessed needs and preferences;

    c. Referral: The case manager shall provide information to help individuals choose qualified providers and make arrangements to assure providers follow the Support Plan, including any subsequent revisions based on the changing needs of individuals;

    d. Monitoring: The case manager shall ensure that individuals obtain authorized services in accordance with their Support Plan and monitor the quality of the services and supports provided to individuals enrolled in LTSS Programs. Monitoring shall:

        1. Be performed when necessary to address health and safety and services in the care plan;

        2. Include activities to ensure:

            A. Services are being furnished in accordance with the individual's Support Plan;

            B. Services in the Support Plan are adequate; and

            C. Necessary adjustments in the Support Plan and service arrangements with providers are made if the needs of the individual have changed;

3. Include an in-person contact and observation with the individual in their place of residence, at least once per certification period. Additional in person monitoring shall be performed when required by the individual's condition or circumstance. Upon Department approval, observation may be completed using virtual technology methods or delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g. natural disaster, pandemic, etc.)

e. Remediation: The case manager shall identify, resolve, and to the extent possible, establish strategies to prevent Critical Incidents and problems with the delivery of services and supports.

2. The case manager shall assure quality of services and supports, the health and welfare of the individual, and individual safety, satisfaction and quality of life, by monitoring service providers to ensure the appropriateness, timeliness and amount of services provided. The case manager shall take corrective actions as needed.

3. The case manager may require the Contractor to revise the Support Plan and Prior Authorization if the results of the monitoring indicate that the plan is inappropriate, the services as described in the plan are untimely, or the amount of services need to be changed to meet the Client's needs.

4. Ongoing case management shall include, but not be limited to, the following tasks:

a. Review of the individual's Support Plan and service agreements;

b. Contact with the individual concerning their safety, quality of life and satisfaction with services provided;

c. Contact with service providers to coordinate, arrange or adjust services, to address quality issues or concerns and to resolve any complaints raised by individuals or others;

d. Conflict resolution and/or crisis intervention, as needed;

e. Informal assessment of changes in individual functioning, service effectiveness, service appropriateness and service cost-effectiveness;

f. Notification of appropriate enforcement agencies, as needed; and

g. Referral to community resources as needed.

5. The case manager shall immediately report, to the appropriate agency, any information which indicates an overpayment, incorrect payment or mis-utilization of any public assistance benefit, and shall cooperate with the appropriate agency in any subsequent recovery process, in accordance with Department of Human Services Income Maintenance Rules at 9 C.C.R. 2503-8, Section 3.810 and Section 8.076.

6. The case manager shall contact the individual at least quarterly, or more frequently as determined by the individual's needs or as required by the program.

7. The case manager shall review the Department prescribed assessment and the Support Plan with the individual every six (6) months. The review shall be conducted by telephone or at the individual's place of residence, place of service or other appropriate setting as determined by the individual's needs or preferences.

8. The case manager shall complete a new ULTC 100.2 when there is a significant change in the individual's condition and when the individual changes LTSS programs.

9. The case manager shall contact the service providers, as well as the individual, to monitor service delivery as determined by the individual's needs and as required by the authorities applicable to the service.

10. Case Managers shall report critical incidents within 24 hours of notification within the State Approved IMS.

    a. Critical Incident reporting is required when the following occurs

        i. Injury/Illness;

        ii. Missing Person;

        iii. Criminal Activity;

        iv. Unsafe Housing/Displacement;

        v. Death;

        vi. Medication Management Issues;

        vii. Other High-Risk Issues;

        viii. Allegations of Abuse, Mistreatment, Neglect, or Exploitation;

        ix. Damage to the Consumer's Property/Theft.

    b. Allegations of abuse, mistreatment, neglect and exploitation, and injuries which require emergency medical treatment or result in hospitalization or death shall be reported immediately to the Agency administrator or designee.

    c. Case Managers shall comply with mandatory reporting requirements set forth at Section 18-6.5-108, C.R.S, Section 19-3-304, C.R.S and Section 26-3.1-102, C.R.S.

    d. Each Critical Incident Report must include:

        i. incident type

            a. Mistreatment, Abuse, Neglect or Exploitation (MANE) as defined at Section 19-1-103, 26-3.1-101, 16-22-102 (9), and 25.5-10-202 C.R.S.

b. Non-Mane: A Critical Incident, including but not limited to, a category of criminal activity, damage to a consumer's property, theft, death, injury, illness, medication management issues, missing persons, unsafe housing or displacement, other high risk issues.

ii. Date and time of incident;

iii. Location of incident, including name of facility, if applicable;

iv. Individuals involved;

v. Description of incident, and

vi. Resolution of incident, if applicable.

e. The Case Manager shall complete required follow up activities and reporting in the State approved IMS within assigned timelines.

8.393.2.H. Case Recording/Documentation

1. The SEP Agency shall complete and maintain all required records included in the State approved IMS and shall maintain individual case records at the Agency level for any additional documents associated with the individual applying for or enrolled in a LTSS Program.

2. The case record and/or IMS shall include:

a. Identifying information, including the individual's state identification (Medicaid) number and Social Security number (SSN);

b. All State-required forms; and

c. Documentation of all case management activity required by these regulations.

3. Case management documentation shall meet all the following standards:

a. Documentation must be objective and understandable for review by case managers, supervisors, program monitors and auditors;

b. Entries must be written at the time of the activity or no later than five (5) business days from the time of the activity;

c. Entries must be dated according to the date of the activity, including the year;

d. Entries must be entered into Department's IMS;

e. The person making each entry must be identified;

f. Entries must be concise, but must include all pertinent information;

g. All information regarding an individual must be kept together, in a logical organized sequence, for easy access and review by case managers, supervisors, program monitors and auditors;

h. The source of all information shall be recorded, and the record shall clarify whether information is observable and objective fact or is a judgment or conclusion on the part of anyone;

i. All persons and agencies referenced in the documentation must be identified by name and by relationship to the individual;

j. All forms prescribed by the Department shall be completely and accurately filled out by the case manager; and

k. Whenever the case manager is unable to comply with any of the regulations specifying the time frames within which case management activities are to be completed, due to circumstances outside the SEP Agency's control, the circumstances shall be documented in the case record. These circumstances shall be taken into consideration upon monitoring of SEP Agency performance.

4. Summary recording to update a case record shall be entered into the IMS at least every six (6) months, whenever a case is transferred from one SEP Agency to another, and when a case is closed.

8.393.2.I. Resource Development Committee

1. The SEP Agency shall assume a leadership role in facilitating the development of local resources to meet the LTSS needs of individuals seeking or receiving services who reside within the SEP district served by the SEP Agency.

2. Within 90 days of the effective date of the initial contract, the SEP Agency's community advisory committee shall appoint a resource development committee.

3. The membership of the resource development committee shall include, but not be limited to, representation from the following local entities: Area Agency on Aging (AAA), county departments of social services, county health departments, home health agencies, nursing facilities, hospitals, physicians, community mental health centers, community centered boards, vocational rehabilitation agencies, and individuals receiving long-term services.

4. In coordination with the resource development efforts of the Area Agency on Aging (AAA) that serves the district, the resource development committee shall develop a local resource development plan during the first year of operation.

a. The resource development plan shall include:

i. An analysis of the LTSS resources available within the SEP district;

ii. Gaps in LTSS resources within the SEP district;

iii. Strategies for developing needed resources; and

iv. A plan for implementing these strategies, including the identification of potential funding sources, potential in-kind support and a time frame for accomplishing stated objectives.

b. The data generated by the SEP Agency's intake, screening and referral, individual assessment, documentation of unmet individual needs, resource development for individuals and data available through the Department shall be used to identify persons most at risk of nursing facility care and to document the need for resources locally.

5. At least annually, the resource development committee shall provide progress reports on the implementation of the resource development plan to the community advisory committee and to the Department.

8.393.3 DENIALS/DISCONTINUATIONS/ADVERSE ACTIONS

8.393.3.A. Denial Reasons and Notification Actions

1. Individuals seeking or receiving services shall be denied or discontinued from services under publicly funded programs served by the SEP system if they are determined ineligible for any of the reasons below. Individuals shall be notified of any of the adverse actions and appeal rights as follows:

a. Financial Eligibility

i. The eligibility enrollment specialist from the county department of social services shall notify the individual of denial or discontinuation for reasons of financial eligibility and shall inform the individual of appeal rights in accordance with Section 8.057.

ii If the individual is found to be financially ineligible for LTSS programs, the SEP Agency shall notify the individual of the adverse action and inform the individual of their appeal rights in accordance with Section 8.057. The case manager shall not attend the appeal hearing for a denial or discontinuation based on financial eligibility, unless subpoenaed, or unless requested by the Department.

b. Functional Eligibility and Target Group

i. The SEP Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual does not meet the functional eligibility threshold for LTSS Programs or nursing facility admissions; or

2) The individual does not meet the target group criteria as specified by the HCBS Program.

c. Receipt of Services

i. The SEP Agency shall notify the individual of the denial or discontinuation and appeal rights by sending the Notice of Services Status (LTC-803) and shall attend the appeal hearing to defend the denial or discontinuation, when:

1) The individual has not received long-term services or supports for thirty (30) days;

2) The individual has two (2) times in a thirty-day consecutive period refused to schedule an appointment for assessment, or monitoring required by these regulations;

3) The individual has failed to keep three scheduled assessment appointments within a thirty-day consecutive period; or

4) The SEP Agency does not receive the completed Professional Medical Information Page (PMIP) form, when required.

d. Institutional Status

i. The SEP Agency shall notify the individual of denial or discontinuation by sending the Notice of Services Status (LTC-803) when the case manager determines that the individual does not meet the following program eligibility requirements.

1) The individual is not eligible to receive HCBS services while a resident of a nursing facility, hospital, or other institution; or

2) The individual who is already a recipient of program services enters a hospital for treatment, and hospitalization continues for thirty (30) days or more.

e. Cost-Effectiveness/Service Limitations

i. During the Support Planning process in conjunction with the initial assessment or reassessment, the individual seeking or receiving services shall not be eligible for the HCBS program if the case manager determines the individual's needs are more extensive than the HCBS program services are able to support, the individual's health and safety cannot be assured in a community setting, and/or the cost containment review process is not met as outlined in Section 8.393.2.F.

1) If the case manager determines that the individual is ineligible for an HCBS Program, the case manager shall:

a) Obtain any other documentation necessary to support the determination; and

b) Inform the individual of their appeal rights pursuant to Section 8.057.

2. The Long-Term Care Waiver Program Notice Action (LTC-803) shall be completed in the IMS for all applicable programs at the time of initial eligibility, when there is a significant change in the individual's payment or services, an adverse action, and at the time of discontinuation.

3. In the event the individual appeals a denial or discontinuation action, except for reasons related to financial eligibility, the case manager shall attend the appeal hearing to defend the denial or discontinuation action.

8.393.3.B. Case Management Actions Following a Denial or Discontinuation

1. In the case of denial or discontinuation, the case manager shall provide appropriate referrals to other community resources, as needed, within one (1) working day of discontinuation.

2. The case manager shall notify all providers on the Support Plan within one (1) working day of discontinuation.

3. The case manager shall follow procedures to close the individual's case in the IMS within one (1) working day of discontinuation for all HCBS Programs.

4. If a case is discontinued before an approved HCBS Prior Authorization Request (PAR) has expired, the case manager shall submit to the Department or its fiscal agent, within five (5) working days of discontinuation, a copy of the current PAR form on which the end date is adjusted (and highlighted in some manner on the form); and the reason for discontinuation shall be written on the form.

8.393.3.C. Notification

1. The SEP Agency shall notify the county eligibility enrollment specialist of the appropriate county department of social services:

   a. At the same time it notifies the individual seeking or receiving services of the adverse action;

   b. When the individual has filed a written appeal with the SEP Agency; and

   c. When the individual has withdrawn the appeal or a final Agency decision has been entered.

2. The SEP Agency shall provide information to individuals seeking and receiving services regarding their appeal rights when individuals apply for publicly funded LTSS and whenever the individual requests such information, whether or not adverse action has been taken by the SEP Agency.

8.393.4. COMMUNICATION

A. In addition to any communication requirements specified elsewhere in these rules, the case manager shall be responsible for the following communications:

1. The case manager shall inform the eligibility enrollment specialist of any and all changes affecting the participation of an individual receiving services in SEP Agency-served programs, including changes in income, within one (1) working day after the case manager learns of the change. The case manager shall provide the eligibility enrollment specialist with copies of the certification page of the approved ULTC-100.2 form.

2. If the individual has an open adult protective services (APS) case at the county department of social services, the case manager shall keep the individual's APS worker informed of the individual's status and shall participate in mutual staffing of the individual's case.

3. The case manager shall inform the individual's physician of any significant changes in the individual's condition or needs.

4. The case manager shall report to the Colorado Department of Public Health and Environment (CDPHE) any congregate facility which is not licensed.

8.393.5 FUNCTIONAL ELIGIBILITY DETERMINATION

A. The SEP Agency shall be responsible for the following:

1. Ensuring that the ULTC 100.2 is completed in the IMS in accordance with Section 8.401.1 and justifies that the individual seeking or receiving services should be approved or disapproved for admission to or continued stay in an applicable LTSS program.

2. Once the assessment is complete in the IMS, the case manager shall generate a certification page in the IMS within three (3) business days for hospital discharge to a Nursing Facility, within six (6) business days for Nursing Facility discharge and within eleven (11) business days of receipt of referral.

3. If the assessment indicates approval, the SEP Agency shall notify the appropriate parties.

4. If the assessment indicates denial, the SEP Agency shall notify the appropriate parties in accordance with 8.393.3.A.2.

5. If the individual or individual's legally authorized representative appeals, the SEP Agency shall process the appeal request, according to Section 8.057.

8.393.6. INTERCOUNTY AND INTER-DISTRICT TRANSFER PROCEDURES

8.393.6.A. Intercounty Transfers

1. SEP agencies shall complete the following procedures to transfer individuals receiving case management services to another county within the same SEP district:

a. Notify the current county department of social services eligibility enrollment specialist of the individual's plans to relocate to another county and the date of transfer, with financial transfer details at Section 8.100.3.C.

b. If the individual's current service providers do not provide services in the area where the individual is relocating, make arrangements, in consultation with the individual, for new service providers.

c. In order to assure quality of services and supports and health and welfare of the individual, the case manager must observe and evaluate the condition of the individual's residence. Upon Department approval, observation may be completed using virtual technology methods. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.).

d. If the individual is moving from one county to another to enter an Alternative Care Facility (ACF), forward copies of the following individual records to the ACF prior to the individual's admission to the facility:

i. ULTC 100.2, certified by the SEP;

ii. The individual's updated draft Prior Authorization Request (PAR) and/or Post Eligibility Treatment of Income (PETI) form; and

iii. Verification of Medicaid eligibility status.

8.393.6.B. Inter-district Transfers

1. SEP Agencies shall complete the following procedures in the event an individual receiving services transfers from one SEP district to another SEP district:

   a. The transferring SEP Agency shall contact the receiving SEP Agency by telephone and give notification that the individual is planning to transfer, negotiate a transfer date and provide all necessary information.

   b. The transferring SEP Agency shall notify the original county department of social services eligibility enrollment specialist of the individual's plan to transfer and the transfer date, and eligibility enrollment specialist shall follow rules described in Section 8.100.3.C. The receiving SEP Agency shall coordinate the transfer with the eligibility enrollment specialist of the new county.

   c. The transferring SEP Agency shall make available in the IMS the individual's case records to the receiving SEP Agency prior to the relocation.

   d. If the individual is moving from one SEP District to another SEP District to enter an ACF, the transferring SEP Agency shall forward copies of the individual's records to the ACF prior to the individual's admission to the facility, in accordance with section 8.393.6.A.

   e. To ensure continuity of services and supports, the transferring SEP Agency and the receiving SEP Agency shall coordinate the arrangement of services prior to the individual's relocation to the receiving SEP Agency's district and within ten (10) working days after notification of the individual's relocation.

   f. The receiving SEP Agency shall complete a face-to-face meeting with the individual in the individual's residence and a case summary update within ten (10) working days after the individual's relocation, in accordance with assessment procedures for individuals served by SEP Agencies. Upon Department approval, meeting may be completed using virtual technology methods or may be delayed. Such approval may be granted for situations in which in-person observation would pose a documented safety risk to the case manager or client (e.g., natural disaster, pandemic, etc.)

   g. The receiving SEP Agency shall review the Support Plan and the ULTC 100.2 and change or coordinate services and providers as necessary.

   h. If indicated by changes in the Support Plan, the receiving SEP Agency shall revise the Support Plan and prior authorization forms as required by the publicly funded program.

   i. Within thirty (30) calendar days of the individual's relocation, the receiving SEP Agency shall forward to the Department, or its fiscal agent, revised forms as required by the publicly funded program.

Editor's Notes

10 CCR 2505-10 has been divided into smaller sections for ease of use. Versions prior to 3/4/07, Statements of Basis and Purpose, and rule history are located in the first section, 10 CCR 2505-10. Prior versions can be accessed from the All Versions list on the rule's current version page. To view versions effective on or after 3/4/07, select the desired section of the rule, for example 10 CCR 2505-10 8.100, or 10 CCR 2505-10 8.500.

History

[For history of this section, see Editor's Notes in the first section, 10 CCR 2505-10]