Department of Health Care Policy and Financing

Appendix A.IV.C

Department Managed Care Regulations

8.212 COMMUNITY MENTAL HEALTH SERVICES

8.212.1 ENROLLMENT

8.212.1.A. The following individuals are not eligible for enrollment in the Community Mental Health Services program:

1. Qualified Medicare Beneficiary only (QMB-only).

2. Qualified Working Disabled Individuals (QWDI).

3. Qualified Individuals 1 (QI 1).

4. Special Low Income Medicare Beneficiaries (SLMB).

5. Undocumented aliens.

6. Program of All-Inclusive Care for the Elderly (PACE).

7. Individuals who are inpatient at the Colorado Mental Health Institute at Pueblo who are:

   a. Found by a criminal court to be Not Guilty by Reason of Insanity (NGRI)

   b. Found by a criminal court to be Incompetent to Proceed (ITP)

   c. Ordered by a criminal court to the Institute for evaluation (eg. Competency to proceed, sanity, conditional release revocation, pre-sentencing).

8. Individuals between ages 21 and 64 who receive inpatient treatment who are inpatient at the Colorado Mental Health Institute at Pueblo or the Colorado Mental Health Institute at Fort Logan.

9. Individuals who are NGRI and who are in the community on Temporary Physical Removal (TPR) from the Colorado Mental Health Institute at Pueblo and who are eligible for Medicaid are exempted from the Community Mental Health Services program while they are on TPR. TPR individuals remain under the control and care of the Institute.

10. Classes of individuals determined by the Department to require exclusion from the Community Mental Health Services program.

11. Individuals who receive an individual exemption as set forth at 8.212.2.

8.212.1.B. All other Medicaid clients shall be enrolled in the Community Mental Health Services program.

8.212.2 INDIVIDUAL EXEMPTIONS

1. A client may request to be exempt from enrollment in the Community Mental Health Services program if:

   a. The client has a clinical relationship with a provider of mental health services that the client wishes to maintain and that provider is not part of the provider network of the behavioral health organization in the client's geographic area; or

   b. The client and the behavioral health organization have been unable to develop a healthy working relationship and continued enrollment would not be in the best clinical interest of the client.

2. If the client requests an exemption based on Section 8.212.2.1.a:

   a. The client shall notify the behavioral health organization of his/her request to receive necessary mental health services from the provider with whom the client has established a clinical relationship.

   b. Within fourteen (14) calendar days of receiving notice from the client, the behavioral health organization shall determine whether it can contract with the client's chosen provider to provide necessary mental health services to the client and provide written notice to the client and the client's provider of that determination.

   c. If the behavioral health organization is unable to approve the client's request, the notice shall:

      i) Identify one or more providers within the behavioral health organization's network who can appropriately meet the client's mental health needs;

      ii) Include information on the client's right to request an exemption, the process for requesting an exemption and assistance available to the client.

   d. The client may request an exemption with the Department within fourteen (14) calendar days of the date of the notice from the behavioral health organization disapproving the client's request.

   e. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its

determination to the client, the client's provider and the behavioral health organization.

3. If the client requests an exemption based on Section 8.212.2.1.b:

   a. The client shall request an exemption from the Department.

   b. Within thirty (30) calendar days after receipt of the client's request for exemption, the Department shall provide written notice of its determination to the client, the client's provider and the behavioral health organization.

4. A client whose request for exemption has been denied by the Department has the right to appeal the determination pursuant to Section 8.057.

5. A newly Medicaid eligible client who requests an exemption shall be enrolled in the Community Mental Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.

6. A client who is enrolled in the Community Mental Health Services program and is requesting an exemption shall continue to be enrolled in the Community Mental Health Services program pending the outcome of the request for exemption and any appeal pursuant to Section 8.057.

7. A client who wants to reenroll in the Community Mental Health Services program shall notify the Department. The client will be reenrolled within thirty (30) calendar days of receipt of the client's request. The Department shall notify the client and the behavioral health organization of the reenrollment prior to the effective date of reenrollment.

8.212.3 CLIENT RIGHTS AND PROTECTIONS

8.212.3.A. A client enrolled in the Community Mental Health Services program shall have the following rights and protections:

1. To be treated with respect and with due consideration for his/her dignity and privacy.

2. To receive information on available treatment options and alternatives, presented in a manner appropriate to the enrollee's condition and ability to understand.

3. To participate in decisions regarding his/her health care, including the right to refuse treatment and the right to a second opinion.

4. To be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.

5. To request and receive a copy of his/her medical records and to request that they be amended or corrected, as specified in 45 CFR Part 164.

6. To exercise his/her rights without any adverse effect on the way he/she is treated.

7. To enforce, pursuant to Section 8.209, the provisions of the community mental health services contracting regarding rights or duties owed to the client under the contract.

8.212.4 MENTAL HEALTH SERVICES

8.212.4.A. The following are required services of the Community Mental Health Services program:

1. Inpatient Hospital -- A program of psychiatric care in which the consumer remains 24 hours a day in a facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.

2. Under 21 Psychiatric -- A program of care for consumers under age 21 in which the consumer remains 24 hours a day in a psychiatric hospital, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.

3. 65 and Over Psychiatric -- A program of care for consumers age 65 and over in which the consumer remains 24 hours a day in an institution for mental diseases, or other facility licensed as a hospital by the State. This service is limited to forty-five (45) days per State fiscal year.

4. Outpatient -- A program of care in which the consumer receives services in a hospital or other health care facility, but does not remain in the facility 24 hours a day.

5. Psychiatrist -- Services provided within the scope of practice of medicine as defined by State law.

6. Rehabilitation -- Services provided under the Rehabilitation Option of the Medicaid Program, including:

   a. Partial Long Day -- Therapeutic contact with a consumer lasting more than four hours but less than 24 hours. Activities are programmatically linked.

b. Partial Short Day -- Therapeutic contact with a consumer lasting more than two hours, but no more than four hours. Activities are programmatically linked.

c. Group – Therapeutic contact with more than one consumer, of up to and including two hours.

d. Individual -- Therapeutic contact with one consumer of more than 30 minutes, but no more than two hours. This service, in conjunction with Individual Brief services, is limited to thirty-five (35) visits per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.

e. Individual Brief -- Therapeutic contact with one consumer of up to and including 30 minutes. This service, in conjunction with Individual services, is limited to thirty-five (35) visits per State fiscal year, except as otherwise required by EPSDT as described in 10 C.C.R. 2505-10, Section 8.282.

7. Psychosocial Rehabilitation -- Rehabilitative services include any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his/her practice under state law, for maximum reduction of physical or mental disability and restoration of a recipient to his/her best possible functional level.

8. Case Management -- Medically necessary case management services provided in a licensed community mental health center or clinic by a licensed/qualified non-physician practitioner or physician.

9. Medication Management -- Monitoring of medications prescribed and consultation provided to consumers by a physician.

10. Emergency -- Services provided during a mental health emergency which involve unscheduled, immediate, or special interventions in response to crisis situation with a consumer.

11. Residential -- Any type of 24 hour care provided in a non-hospital, non-nursing home setting, where the contractor provides supervision in a therapeutic environment. Residential services are appropriate for children, youth, adults and older adults who need 24 hour supervised care in a therapeutic environment.

12. School-Based Services -- Mental health services provided to school aged children and adolescents on site in their schools, with the cooperation of the schools.

8.212.4.B. Alternative services of the Community Mental Health Services program include, but are not limited to:

1. Vocational -- Services designed to help adult and adolescent consumers to gain employment skills and employment.

2. Home-Based Services for Children and Adolescents -- Therapeutic services for children/adolescents and their families provided in their homes.

3. Intensive Case Management -- Community-based services averaging more than one hour per week, provided to children with serious emotional disturbances and adults with serious mental illness who are at risk of a more intensive 24 hour placement and who need extra support to live in the community. Services may include but are not limited to mentoring.

8.212.5 EMERGENCY SERVICES

8.212.5.A. A client enrolled in the Community Mental Health Services program shall seek all mental health services from the behavioral health organization with which he/she is enrolled except as specified in 8.212.5.B.

8.212.5.B. Clients with an emergency medical condition may seek emergency services outside of the network of the behavioral health organization in which they are enrolled.

8.212.5.C. Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention or mental health services to result in the following:

1. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) or the health of another in serious jeopardy.

2. Serious impairment to bodily functions.

3. Serious dysfunction of any bodily organ or part.

8.212.5.D. Emergency services means covered inpatient and outpatient services that are as follows:

1. Furnished by a provider that is qualified to furnish these services.

2. Needed to evaluate or stabilize an emergency medical condition.

8.212.6 ESSENTIAL COMMUNITY PROVIDERS

8.212.6.A. In order to be eligible for designation as an Essential Community Provider, the following health care providers shall be determined to have historically served medically needy or medically indigent patients and demonstrated a commitment to serve low-income and medically indigent populations who make up a significant portion of their patient population or, in the case of a sole community provider, serve the medically indigent patients within their medical capability:

1. Disproportionate share hospitals.

2. Local county and district health departments, county nursing services and regional health department operating pursuant to Title 25, C.R.S., as amended.

3. Federally Qualified Health Centers (FQHCs).

4. School based health centers that can verify that 25% of students enrolled in the school are at or below 185% of the Federal Poverty Level and that services are offered to the entire student population enrolled in the school without regard to the patient's ability to pay.

5. Family Medicine Residency Training Programs that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

6. Rural Health Clinics that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

7. State certified Title X Family Planning Agencies that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

8. Sole community providers that are not located within a metropolitan statistical area, as designated by the U.S. Office of Management and Budget, and in whose community there is no other similar type of health care and the provider can verify that it provides health care services to patients below 185% of the Federal Poverty Level within its medical capability.

9. New health care providers operating under a sponsoring or participating entity that qualifies as an Essential Community Provider.

10. Health care providers that can verify that 25% of the patients served are at or below 185% of the Federal Poverty Level.

8.212.6.B. In order to be eligible for designation as an Essential Community Provider, the provider shall waive charges or charge for services on a sliding scale for patients/families at or below 185% of the Federal Poverty Level.

8.212.6.C. Health care providers, except those set forth a 8.212.6.A(1) through (3), who seek to be designated as an Essential Community Provider, shall submit their application, including a copy of their sliding fee scale to the Department.