DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Durable Medical Equipment Start of Service, Section 8.590
Rule Number: MSB 18-12-20-A
Division / Contact / Phone: Client and Clinical Care Office / Kristina Gould / 303-866-6715

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 18-12-20-A, Revision to the Medical Assistance Rule concerning Durable Medical Equipment Start of Service, Section 8.590

3. This action is an adoption of: an amendment

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

   Sections(s) 8.590.1, 8.590.7.N.1 and 8.590.7.N.2, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Replace the current text at 8.590 with the proposed text beginning at 8.590.1 through the end of 8.590.1. Replace the current text at 8.590.7 with the proposed text beginning at 8.590.7.N through the end of 8.590.7.N. This rule is effective April 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Durable Medical Equipment Start of Service, Section 8.590
Rule Number: MSB 18-12-20-A
Division / Contact / Phone: Client and Clinical Care Office / Kristina Gould / 303-866-6715

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).

   Section 8.590.1 is the definitions section of rule and the Department will add in "Start of Service" as a new definition. Section 8.590.7.N.1 and 8.590.7.N.2 describes that a face-to-face encounter must occur no more than six months before the DME is first provided to a member; however there is no defined term for "start of service" which has caused confusion amongst providers. Therefore, the language will read "the face-to-face encounter must occur no more than six months before the start of service". The "start of service" will be defined as when the written order is signed by the ordering practitioner.

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:

   42 CFR 410.38 (g)(3) and 42 CFR sec. 440.70(g)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);

Initial Review	**2/08/19**	Final Adoption	**3/8/19**
Proposed Effective Date	**4/30/19**	Emergency Adoption	

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning Durable Medical Equipment Start of Service, Section 8.590
Rule Number: MSB 18-12-20-A
Division / Contact / Phone: Client and Clinical Care Office / Kristina Gould / 303-866-6715

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.

   Providers and members will benefit from the proposed rule because there will be a clearly defined term for "start of service" on durable medical equipment products which require a face-to-face encounter. There are no apparent adverse costs associated with this proposed rule.

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

   There are no quantitative impacts associated with the proposed rule. Qualitatively, defining "start of service" will mitigate confusion amongst providers and members regarding what "start of service" means.

3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

   There are no probable costs to the Department or any other agency in the implementation and enforcement of this proposed rule.

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

   Inaction would result in continued confusion among providers and members regarding what the "start of service" means. There are no probable costs associated with this proposed rule. Therefore, defining this term is a necessity and will be appreciated among the stakeholder community.

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

   None.

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.

   None.

8.590 DURABLE MEDICAL EQUIPMENT AND DISPOSABLE MEDICAL SUPPLIES

8.590.1 DEFINITIONS

A. Abuse, for the purposes of ~~rule~~ Section 8.590, means the intentional destruction of or damage to Durable Medical Equipment, Prosthetics, Orthotics, and Supplies that results in the need for repair or replacement.

B. Billing Manual, for the purposes of ~~rule~~ Section 8.590, means a reference document that assists providers with appropriately billing claims for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies.

C. Cochlear Implant or cochlear prosthesis means an electrode or electrodes surgically implanted in the cochlea which are attached to an induction coil buried under the skin near the ear, and the associated unit which is worn on the body.

D. Complex Rehabilitation Technology means individually configured manual Wheelchair systems, power Wheelchair systems, adaptive seating systems, alternative positioning systems, standing frames, gait trainers, and specifically designated options and accessories, which qualify as Durable Medical Equipment that:

1. Are individually configured for individuals to meet their specific and unique medical, physical, and functional needs and capacities for basic activities of daily living and instrumental activities of daily living, including employment, identified as medically necessary to promote mobility in the home and community or prevent hospitalization or institutionalization of the member;

2. Are primarily used to serve a medical purpose and generally not useful in the absence of disability, illness or injury; and

3. Require certain services provided by a qualified Complex Rehabilitation Technology Supplier to ensure appropriate design, configuration, and use of such items, including patient evaluation or assessment of the client by a Qualified Health Care Professional, and that are consistent with the member's medical condition, physical and functional needs and capacities, body size, period of need, and intended use.

E. Complex Rehabilitation Technology Professional means an individual who is certified by the Rehabilitation Engineering and Assistive Technology Society of North America or other nationally recognized accrediting organizations as an assistive technology professional.

F. Complex Rehabilitation Technology Supplier means a provider who meets all the requirements of Section 8.590.5.D.

G. Disposable Medical Supplies (Supplies) means health care related items that are consumable, disposable, or cannot withstand repeated use by more than one individual. Supplies are required to address an individual medical disability, illness or injury.

H. Durable Medical Equipment (DME) means items, including Prosthetics and Orthotics, that are primarily and customarily used to serve a medical purpose, generally are not useful to an individual in the absence of a disability, illness or injury, can withstand repeated use, and can be reusable or removable.

I. Facilitative Device means DME with a retail price equal to or greater than one hundred dollars that is exclusively designed and manufactured for a member with disabilities to improve, maintain or restore self-sufficiency or quality of life through facilitative technology. Facilitative Devices do not include Wheelchairs.

J. Financial Relationship means any ownership interest, investment interest or compensation arrangement between a provider, or their officers, directors, employees or Immediate Family Members of the provider, and the entity. An ownership or investment interest may be reflected in equity, debt, or other instruments and includes, but is not limited to, mortgages, deeds of trust, notes or other obligations secured by either entity.

K. Hearing Aid means a wearable instrument or device designed or offered for the purpose of aiding or compensating for impaired human hearing and any parts, attachments, or accessories thereto, including ear molds but excluding batteries and cords.

L. Immediate Family Member means any spouse, natural or adoptive parent, natural or adoptive child, stepparent, stepchild, sibling or stepsibling, in-laws, grandparents and grandchildren.

M. Medical Necessity, for the purposes of Section 8.590, means the definition as described at 10 CCR 2505-10, Section 8.076.1.8.

N. Misuse means failure to maintain or the intentional utilization of DME and Supplies in a manner not prescribed, recommended or appropriate that results in the need for repairs or replacement. Misuse also means DME and Supplies used by someone other than the member for whom it was prescribed.

O. Prosthetic or Orthotic Device means replacement, corrective or supportive devices that artificially replace a missing portion of the body, prevent or correct physical deformity or malfunction, or support a weak or deformed portion of the body.

P. Qualified Health Care Professional means a licensed physical therapist, a licensed occupational therapist, or other licensed health care professional who performs specialty evaluations within his/her scope of practice and who has no Financial Relationship with a Complex Rehabilitation Technology Supplier.

Q. Related Owner means an individual with 5% or more ownership interest in a business and one entitled to a legal or equitable interest in any property of the business whether the interest is in the form of capital, stock, or profits of the business.

R. Related Party means a provider who is associated or affiliated with, or has control of, or is controlled by the organization furnishing the DME and Supplies. An owner related individual shall be considered an individual who is a member of an owner's Immediate Family.

S. Speech Generating Device (SGD) means a device that provides multiple methods of message formulation and is used to establish, develop or maintain the ability to communicate functional needs. These devices are electronic and computer based and can generate synthesized (computer-generated) or digitized (natural human) speech output for expressive communication.

T. Start Of Service means the date that the ordering practitioner signs the written order for durable medical equipment following the face-to-face encounter with the member.

U.~~T.~~ Wheelchair means any wheelchair or scooter that is motor driven or manually operated for the purposes of mobility assistance, purchased by the Department or donated to the member.

V.~~U.~~ Wrongful Disposition means the mismanagement of DME and Supplies by a member by selling or giving away the item reimbursed by the Department.

8.590.7 REIMBURSEMENT

8.590.7.N. Face-to-Face Encounters

1. For DME specified in the Billing Manual, the ordering practitioner must perform a face-to-face encounter with the member related to the health condition that provides medical necessity for the DME~~ must be performed related to the primary reason a member requires the DME~~.

2. The face-to-face encounter must occur no more than six months before the Start Of Service. ~~DME is first provided to a member.~~

3. The face-to-face encounter must be conducted by one of the following practitioners:

   a. The physician responsible for prescribing the DME;

   b. A nurse practitioner or clinical nurse specialist, working in collaboration with the prescribing physician; or

   c. A physician assistant under the supervision of the prescribing physician.

4. A practitioner may conduct a face-to-face encounter via telehealth or telemedicine if those services are covered by the Medical Assistance Program.

5. If a non-physician practitioner performs a face-to-face encounter they must communicate the clinical findings of the face-to-face encounter to the physician responsible for prescribing the related DME. Those clinical findings must be incorporated into a written or electronic document included in the member's medical record.

6. A physician who prescribes DME requiring face-to-face encounters must document the following:

   a. The face-to-face encounter was related to the primary reason the member required the prescribed DME;

   b. The practitioner who performed the face-to-face encounter;

   c. The date of the face-to-face encounter; and

   d. The face-to-face encounter occurred within the required timeframe.

7. Compliance with this section is required as a condition of payment for DME requiring face-to-face encounters.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance rule concerning Targeted Case Management - Transition Services, Sections 8.519 and 8.760
Rule Number: MSB 18-08-16-A
Division / Contact / Phone: OCL / Sarah Grazier / 5331

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name: Health Care Policy and Financing / Medical Services Board

2. Title of Rule: MSB 18-08-16-A, Revision to the Medical Assistance rule concerning Targeted Case Management - Transition Services, Sections 8.519 and 8.760

3. This action is an adoption of: new rules

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

   Sections(s) 8.519 and 8.763, Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10).

5. Does this action involve any temporary or emergency rule(s)? No
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing). Yes

PUBLICATION INSTRUCTIONS*

Insert the proposed text at 8.519.27 beginning at 8.519.27 through the end of 8.519.27.G. Replace the current text at 8.760 with the proposed text beginning at 8.763 through the end of 8.763.C. This rule is effective April 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance rule concerning Targeted Case Management - Transition Services, Sections 8.519 and 8.760
Rule Number: MSB 18-08-16-A
Division / Contact / Phone: OCL / Sarah Grazier / 5331

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The statute authorizing HB18-1326 - Support For Transition From Institutional Settings was signed into law on April 30, 2018. Therefore, the rules implementing the program, 10 CCR 2505-10, section 8.519 and 10 CCR 2505-10, section 8.763, are being revised to include new sections specific to this program. The State Authority for the Rule that grants MSB rulemaking authority is C.R.S. 25.5-6-1501(6).

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:

   42 CFR § 441.18

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   C.R.S. 25.5-6-1501(6)
   CRS 25.5.-10-209.5 and CRS 25.5-6-106

Initial Review — Final Adoption **03/08/19**
Proposed Effective Date **04/30/19** — Emergency Adoption

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance rule concerning Targeted Case Management - Transition Services, Sections 8.519 and 8.760
Rule Number: MSB 18-08-16-A
Division / Contact / Phone: OCL / Sarah Grazier / 5331

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.

   Medicaid recipients who are eligible for Home and Community Based Services, reside in a nursing home or Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-IDD) and are willing to participate and have expressed interest in moving to a home and community-based setting. Medicaid recipients receiving Home and Community Based Services provided by the State operated Regional Centers who want to transition to a private Home and Community Based Services Provider. Services are expected to begin while an individual is living in a facility and continue through transition and integration into community living, based on the community risk assessment. Excluded are children under the age of 18.

   HB18-1326 is a cost savings initiative with no additional costs to the State.

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

   The Department of Health Care Policy & Financing (the Department) has administered the Colorado Choice Transitions (CCT) demonstration program since April 2013, federally funded by Money Follows the Person (MFP). CCT is designed to help transition Medicaid members out of nursing homes, intermediate care facilities or regional centers into home and community-based settings. Members who have transitioned into community through CCT achieve a higher quality of life, better health outcomes, and a reduction in the total cost of care to the State. As of December 2017, 328 Health First Colorado members transitioned into the community at a savings of more than $2.8 million to the state of Colorado. Ninety-three percent of members who transitioned were still successfully living in the community one year after their transition.

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.

   HB18-1326 is a cost savings initiative with no additional costs to the State.

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

   Without action, members who want to and are capable of living in home and community-based settings will not be supported in transition from facilities. As a result, member will incur additional costs to the State for care and experience a lower quality of life.

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

   This rule implements the most cost effective and least intrusive method of care for Health First Colorado members.

6. Describe any alternative methods for achieving the purpose for the proposed rule that were seriously considered by the Department and the reasons why they were rejected in favor of the proposed rule.

   There are several reasons why the Department chose the Targeted Case Management (TCM) authority in the State Plan to operate transition services instead of operating the service as a waiver benefit:

   Flexibility: The TCM State Plan authority allows the Department to access the broadest base of providers for the transition service across Colorado to ensure anyone who wants to transition to a less restrictive setting can do so.

   Timely payments for transition coordination time: Lessons learned from the CCT demonstration indicate that operating the transition services as an HCBS waiver benefit limited providers and created financial challenges inherent in the benefit structure. Reimbursement as a waiver service is only allowed as a flat rate for the transition itself, payable after the transition occurs. Work completed before and after transition, or for members who ultimately do not successfully transition, is not reimbursable through the waiver benefit. TCM allows for payment of services before, during and after a transition based on a unit rate for actual time spent, whether or not the transition occurs. If the transition services were to be provided as a waiver benefit, transition case managers could only coordinate Medicaid services. Under TCM, transition case managers can coordinate other services like housing.

   In addition, creating a waiver service would require an administrative claiming reimbursement methodology to reimburse for pre-transition work, subject to approval by CMS. Post-transition work would not be reimbursable. This model would require all transition providers to have both Provider Agreements and an administrative contract with the Department, creating additional administrative burden for both parties to manage multiple agreements.

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Ability for providers to authorize TCM-TS: The proposed TCM-TS (state plan benefit) would not require authorization from another case management agency, eliminating an administrative barrier. Under the waiver structure used in the demonstration project, an HCBS case manager at a Single Entry Point (SEP) or Community Centered Board (CCB) was required to be involved in the transition and submit PARs on behalf of transition coordination agencies.

Alignment with overall Department structure and goals: Colorado is working to standardize how case management is delivered and reimbursed across all populations in Colorado, based on stakeholder feedback asking for consistency and clarity. The TCM State Plan authority aligns with how we currently reimburse for some case management. Creating a waiver service would require us to add a new benefit to existing waivers and set up an administrative claiming reimbursement methodology to reimburse for pre-transition work in the event that a transition does not occur, subject to approval by CMS. Post-transition work would not be reimbursable. This model would require all transition providers to have both Provider Agreements and an administrative contract with the Department, creating additional administrative burden for both parties to manage multiple agreements.

The Targeted Case Management approach best achieves the Department and Stakeholder goals of flexibility; timeliness; direct billing; person-centeredness; payment for work completed before, during and after a transition; and alignment with case management redesign.

8.519.27 Transition Coordination Services

8.519.27.A Definitions

1. Case Management Agency (CMA) means a public or private not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to sections 25.5.-10-209.5 and CRS 25.5-6-106, and pursuant to a provider participation agreement with the state department.

2. Community risk level means the potential for a client living in a community-based arrangement to require emergency services, to be admitted to a hospital, skilled nursing facility, or intermediate care facility for individuals with intellectual disabilities, be evicted from their home or be involved with law enforcement due to identified risk factors.

3. 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.

~~3.~~4. Post-transition monitoring means the activities that occur after a client has successfully transitioned into the community and is a recipient of home-and community-based services.

~~4.~~5. Pre-transition coordination means activities that occur before a client has transitioned into the community to prepare the client for success in community living and integration.

~~5.~~6. Risk factors means factors that include but are not limited to health, safety, environmental, community integration, service interruption, inadequate support systems and substance abuse that may contribute to an individual's community risk level and potential for readmission to an institution.

~~6.~~7. Risk mitigation plan means the document that records the risk mitigation planning process. Risk mitigation plans are used to conduct post-discharge monitoring of effectiveness of risk prevention strategies; to document identification of additional risk factors, and to revise risk incident response plans.

~~7.~~8. Risk mitigation planning means the process of identifying risk factors, developing options and actions to enhance opportunities and prevent adverse consequences that would result if risk is not managed and identifying planned actions to take in response to an adverse consequence should a risk be realized.

~~8.~~9. Service plan means the written document that specifies identified and needed services, to include Medicaid and non-Medicaid services regardless of funding source, to assist a client to remain safely in the community and developed in accordance with the Department regulations.

10. Transition assessment means the process of capturing a comprehensive understanding of the client's health conditions, functional needs, transition needs, behavioral concerns,

social and cultural considerations, educational interests, risks and other areas important to community integration and transition to a home and community-based setting.

~~9.~~11. Transition coordination means support provided to a client who is transitioning from a skilled nursing facility, intermediate care facility for individuals with intellectual disabilities, or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities as they relate to the transition.

~~10. Transition assessment means the process of capturing a comprehensive understanding of the client's health conditions, functional needs, transition needs, behavioral concerns, social and cultural considerations, educational interests, risks and other areas important to community integration and transition to a home and community-based setting.~~

~~11.~~12. Transition coordination agency (TCA) means a public or private not-for-profit or for-profit agency that ~~meets all applicable state and federal requirements~~is enrolled as a provider and is certified by the Department to provide transition coordination pursuant to a provider participation agreement with the state department.

~~12.~~13. Transition coordinator (TC) means a person who provides transition coordination services and meets all regulatory requirements for a transition coordinator.

~~13.~~14. Transition options team (TOT) means the group of people involved in supporting and implementing the transition, to include the person receiving services, the transition coordinator, the family, guardian or authorized representative, the home- and community-based services case manager, and others chosen by the individual receiving services as being valuable to participate in the transition process.

~~14.~~15. Transition period means the period of time in which the client receives Transition Coordination for the purpose of successful integration into community living. A transition period is complete when the client has successfully established community residence and is no longer in need of Transition Coordination based on the risk mitigation plan.

~~15.~~16. Transition plan means the written document that identifies person-centered goals, assessed needs, and the choices and preference of services and supports to address the identified goals and needs; appropriate services and additional community supports; outlines the process and identifies responsibilities of transition options team members; details a risk mitigation plan; and establishes a timeline that will support an individual in transitioning to a community setting of their choosing.

~~16.~~17. Transition planning means development of a transition plan, risk mitigation plan and transition plan in coordination with the transition options team.

8.519.27.B Qualifications of ~~agencies offering transition coordination~~Transition Coordination Agencies

~~Pending federal approval, in~~In order to be approved as a transition coordination agency, the agency shall meet all of the following qualifications:

Have a physical location in Colorado.

Be a public or private not for profit or for profit agency.

Demonstrate proof the agency has employed staff that meet transition coordinator qualifications.

Have a minimum of two years of agency experience in assisting high-risk, low income individuals to obtain medical, social, education and/or other services. Transition coordination agencies providing transition coordination in Colorado prior to December 31, 2018 are exempt from this requirement.

Provide transition coordination to clients who select the agency and also reside in the county/counties for which the agency has elected to provide services.

Possess the administrative capacity to deliver transition coordination ~~in accordance with state and federal requirements~~.

Have established community referral systems and demonstrate linkages and referral ability to make community referrals for services with other agencies.

Demonstrate ability to meet all ~~state and federal~~applicable requirements ~~governing~~contained within Sections 8.125, 8.130, 8.519.27, 8.763, the Medicaid State Plan and the provider participation ~~of transition coordination agencies in the state Medicaid program, including but not limited to the ability to meet state and federal requirements for documentation, billing, and auditing~~agreement.

Have one month reserved financial capacity or access to at least one month of average monthly expenses.

Financial reserves shall match one month of expenditures associated to the number of clients expected through that catchment area and provide stability for transition coordinators, clients and service providers.

All agencies are required to submit an audited financial statement or equivalent to the Department for review annually.

Possess and maintain adequate liability insurance (including automobile insurance, professional liability insurance and general liability insurance) to meet the Department's minimum requirements.

8.519.27.C Functions of all Transition Coordination Agencies

~~Pending federal approval, in~~In order to be approved as a Transition Coordination Agency, the agency shall perform all of the following functions:

Transition coordination agencies shall be responsible to maintain sufficient documentation of all transition coordination activities performed and to support claims within the Department-designated data system and internal agency records.

Transition coordination agencies may not provide guardianship services for any client for whom they provide transition coordination services.

Transition coordination agencies shall be responsible to maintain, or have access to, information about public and private, state and local services, supports and resources and shall make information available to the client and/or persons inquiring upon their behalf.

Transition coordination agencies shall respond to referrals for transition coordination support within 2 business days and specify whether the referral is accepted or not by completing the Transition Services Referral Form.

Transition coordination agencies shall assign and schedule the first visit with the client within 10 state business days after accepting a referral.

Transition coordination agencies shall assign one (1) primary person who ensures transition coordination is provided on behalf of the client.

Transition coordination agencies shall provide coordination in accordance with state business days as defined in 24-11-101(1) C.R.S.

Transition coordination agencies shall ~~include~~maintain all documents, records, communications, notes, and other materials ~~maintained by transition coordination agencies~~ that relate to any work performed.

Transition coordination agencies shall possess appropriate financial management capacity and systems to document and track services and costs in accordance with state and federal regulation.

In accordance with reporting requirements of the Department's data system, maintain and update records of persons receiving transition coordination.

Transition coordination agencies shall establish and maintain working relationships with community-based resources, supports, and organizations, hospitals, service providers, and other organizations that assist in meeting the needs of clients.

Transition coordination agencies shall have a system for recruiting, hiring, evaluating, and terminating employees. Transition coordination agencies' employment policies and practices shall comply with all federal and state laws.

Transition coordination agencies shall ensure staff have access to statutes and regulations relevant to the provision of authorized services and shall ensure that appropriate employees are oriented to the content of statues and regulations.

Transition coordination agencies shall provide transition coordination ~~.~~ for clients without discrimination on the basis of race, religion, political affiliation, gender, national origin, age, sexual orientation, gender expression, or disability.

Transition coordination agencies shall provide information and reports as required by the Department including, but not limited to, data and records necessary for the Department to conduct operations.

Transition coordination agencies shall allow access by authorized personnel of the Department, or its contractors, for the purpose of reviewing services and supports funded by the Department and shall cooperate with the Department in evaluation of such services and supports.

Transition coordination agencies shall establish agency procedures sufficient to execute Transition Coordination according to the provisions of these regulations. Such procedures shall include, but are not limited to:

1. Referral Management.

2. Transition Assessment of community needs ~~and~~.

3. Transition Plan.

~~1.~~4. Risk Mitigation Plan that identifies potential risk factors.

~~2.~~5. Service and support coordination for non-Medicaid transition-related services and supports.

~~3.~~6. Monitoring of the transition and transition plan review~~:~~.

~~a. The transition coordinator shall ensure that clients receive services in accordance with their transition plan, transition plan and risk mitigation plan and monitor the quality of the services and supports provided to clients.~~

~~b. Monitoring shall occur no less than weekly in the first three months post-transition and at least twice monthly the remainder of the transition period unless indicated otherwise by the community risk level and documented in the risk mitigation plan, including the reason why the frequency was changed.~~

~~c. The level of monitoring shall meet the need based on the client's community risk level as documented in the risk mitigation plan. Monitoring may include and be determined by the community risk level:~~

~~i. Face-to-face in the client's residence.~~

~~ii. Face-to face in community.~~

~~iii. By telephone or electronic communication.~~

~~4.~~7. Denial and discontinuation of Transition Coordination.

~~5.~~8. In the case of an interstate transfer to another provider area, transition coordination may be transferred to the provider in the new geographic region with any remaining billable units.

9. Complaint Procedure that includes the requirement to share information, such as points of contact within the agency, to clients, families and referring agencies who may wish to file a complaint.

8.519.27.D Qualifications of Transition Coordinators

~~Pending federal approval, transition~~Transition coordinators must be employed by an approved transition coordination agency.

Transition Coordinator minimum experience:

1. Bachelor's degree in a human behavioral science or related field of study~~-~~.

    a. Copy of degree or official transcript must be kept in the transition coordinator's personnel file.

2. If an individual does not meet the minimum requirement, the transition coordination agency shall request a waiver from the Department and demonstrate that the individual meets one of the following:

    a. Experience working with LTSS population, in a private or public agency or lived experience, may substitute for the required education on a year for year basis; or

    b. A combination of LTSS experience and education, demonstrating a strong emphasis in a human behavioral science field.

3. For clients for whom the transition coordinator is providing transition coordination, transition coordinators may not:

    a. Be related by blood or marriage to the client.

    b. Be related by blood or marriage to any paid caregiver of the client.

    c. Be financially responsible for the client.

    d. Be the client's legal guardian, authorized representative, or be empowered to make decisions on the client's behalf through a power of attorney.

    ~~**e.** Be a provider for the client, have an interest in, or be employed by a provider for the same client.~~

8.519.27.E Training

~~Pending federal approval, transition~~Transition coordinators must complete and document the following trainings within 90 days from the date of hire and prior to providing transition coordination services independently:

1. ~~Community~~Transition Assessment of community needs and risk factor ~~assessment~~.

2. Transition Planning.

~~2.~~3. Risk mitigation plan development, monitoring and revision.

~~3.~~4. Referral for non-Medicaid services.

~~4.~~5. Monitoring services.

~~5.~~6. Case documentation.

~~6.~~7. Person-centered approaches to planning and practice.

~~7.~~8. Housing voucher application and housing navigation services.

8.519.27.F Functions of transition coordinators

~~Pending federal approval, transition~~ Transition coordinators must also perform all the following activities. These activities are the only activities billable under transition coordination:

1. Coordination of the transition options team (TOT): members of the TOT are convened to work in a cooperative and supportive manner to develop and implement the transition plan, and to serve in an advocacy role to the individual. Responsibilities of team members are to:

    a. Facilitate completion of an assessment which identifies preferences, needs and any risk factors the resident may have in a home or community-based setting within six weeks of accepting a referral.

    b. Participate in the development of a risk mitigation plan to address identified risk factors within six weeks of accepting a referral.

    c. Assist in the identification of supports and services that will be required to address the individual's needs, preferences and risk factors.

    d. Conduct service brokering for non-Medicaid services to determine if the identified necessary supports and services are available at the frequency needed.

    ~~e. Participate in a team decision regarding whether a transition is recommended~~

    e. Solidify a transition recommendation from the TOT within 10 weeks from the first TOT meeting but not before the first TOT meeting, unless the member chooses to opt out of transition services.

    f. Facilitate completion of a transition plan if the client chooses to proceed with the transition.

2. Pre-transition coordination includes:

    a. Facilitate completion of transition assessment, risk mitigation and transition plans.

    b. Complete, as needed, housing voucher application, including assistance to obtain necessary documents.

    c. Collaborate, as needed, with housing navigation services to obtain a voucher and locate housing.

    d. Assist client to create a transition budget.

    e. Facilitate a community-based living arrangement.

    f. Coordinate any medication, home modification and/or durable medical equipment needs with the nursing facility or HCBS case manager as needed prior to discharge to ensure that all components of transition plan are in place prior to a discharge.

    g. Assist client in preparing for discharge, including being present on day of discharge.

    h. Meet with client at new home on the day of discharge to ensure that services are in place and the household set-up is complete.

3. Post-transition monitoring shall meet the need based on the client's community risk level as documented in the risk mitigation plan. Occur at the frequency and type to meet the client's community risk level documented in the:

a. The transition coordinator shall ensure that clients receive services in accordance with their transition plan and risk mitigation plan and monitor the quality and adequacy of the services and supports provided to clients.

b. Monitoring and follow-up activities include making necessary changes to the transition plan and risk mitigation plan.

~~d.~~c. The level of monitoring shall occur at the frequency and type to meet the client's community risk level~~, but no less than the following:~~.

d. Monitoring may include as determined by the community risk level:

i. Face-to-face in the client's residence.

ii. Face-to face in community.

iii. By telephone or electronic communication.

~~a. Weekly, face-to-face, for the first thirty (30) days upon discharge.~~

~~b. Every other week in a method preferred by the client, after the first thirty (30) days and until the transition is complete.~~

~~3.~~4. Post-transition monitoring includes:

a. Provide support services to aid in sustaining community-based living.

b. Respond to risk incidents and notify case manager.

c. Revise risk mitigation plan as needed.

d. Assess need for independent living skills training.

e. Problem-solve community integration issues.

f. Support community integration activities.

g. Monitor service provision, to include contacting guardians, providers, and case management agencies.

h. Complete client satisfaction survey prior to discharge and at the end of the transition period to evaluate the client's experience of the following:

i. Service planning.

ii. Transition plan implementation.

iii. Transition coordination process.

iv. Level and adequacy of services provided.

v. Overall client satisfaction.

~~4.~~5. Post-transition monitoring may not duplicate services for Life Skills Training (LST), defined in 10 CCR 2505-10, § 8.553.3; Transition Setup defined in 10 CCR 2505-10, § 8.553.4; Home Delivered Meals, defined in 10 CCR 2505-10, § 8.553.5; and Peer Mentorship, defined in 10 CCR 2505-10, § 8.553.6.

8.519.27.G Conflict of Interest for Transition Coordination Agencies

~~Pending federal approval, if~~If an agency provides both HCBS case management and transition ~~services~~coordination, the same employee must provide both services to a client who is transitioning to an HCBS setting.

If a transition coordination agency also provides services under HCBS waivers, a policy must be in place to avoid conflict of interest and provide a free choice of providers to clients. The HCBS case management agency shall be responsible for all service brokering for Medicaid services.

8.760 TARGETED CASE MANAGEMENT SERVICES

8.763 TARGETED CASE MANAGEMENT - TRANSITION COORDINATION

~~Pending federal approval, transition~~Transition coordination means support provided to a client who is transitioning from a skilled nursing facility, intermediate care facility for individuals with intellectual disabilities, or regional center and includes the following activities: comprehensive assessment for transition, community risk assessment, development of a transition plan, referral and related activities, and monitoring and follow up activities~~.~~ as they relate to the transition.

8.763.A ~~———~~Eligibility

~~Pending federal approval, to~~ To be eligible for Transition Coordination, clients must be Medicaid recipients who are eligible for Home and Community Based Services, reside in a nursing home or, Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-IDD), or Regional Center, and are willing to participate and have expressed interest in moving to a home and community-based setting. Clients may also be Medicaid recipients receiving Home and Community Based Services provided by the State operated Regional Centers who want to transition to a private Home and Community Based Services Provider. Services are expected to begin while an individual is living in a facility and continue through transition and integration into community living, based on the community risk assessment. Excluded are children under the age of 18.

8.763.B ~~———~~ Services

~~Pending federal approval,~~ Transition Coordination is provided pursuant to 10 CCR 2505-10, section 8.519.27.

8.763.C ~~———~~ Limitations on Service

~~Pending federal approval, transition~~ Transition coordination is limited to 240 units per client per transition. A unit of service is defined as each completed 15-minute increment that meets the description of a Transition Coordination activity. When an individual has a documented need for additional units, the 240 unit cap may be exceeded to ensure the health and welfare of the client. The Transition Coordinator shall submit documentation to the Department including:

1. ~~a~~A copy of the community risk assessment describing the client's current needs.
2. ~~the~~The number of additional units requested.
3. ~~a~~A history of transition coordination units provided to date and outcomes of those services

4. ~~an~~An explanation of the additional transition coordination supports to be provided by the transition coordinator using any additional approved units.

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Title of Rule: Revision to the Medical Assistance Rule concerning Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Setup, Section 8.553
Rule Number: MSB 18-08-21-A
Division / Contact / Phone: Policy Innovation and Engagement / Matthew Baker / ext. 6381

SECRETARY OF STATE

RULES ACTION SUMMARY AND FILING INSTRUCTIONS

SUMMARY OF ACTION ON RULE(S)

1. Department / Agency Name:	Health Care Policy and Financing / Medical Services Board
2. Title of Rule:	MSB 18-08-21-A, Revision to the Medical Assistance Rule concerning Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Setup, Section 8.553
3. This action is an adoption of:	New rules

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

Sections(s) Sections(s)
Colo. Code of Regulations, 8.553. Transition Services (new rule)
Colo. Code of Regulations, 8.485. Elderly Blind and Disabled Waiver
Colo. Code of Regulations, 8.500.5. Developmental Disabilities Waiver
Colo. Code of Regulations, 8.500.90. Supported Living Services Waiver
Colo. Code of Regulations, 8.509. Community Mental Health Services Waiver
Colo. Code of Regulations, 8.515. Brain Injury Waiver
Colo. Code of Regulations, 8.516. Independent Living Skills Training
Colo. Code of Regulations, 8.517. Spinal Cord Injury Waiver
Colorado Department of Health Care Policy and Financing, Staff Manual Volume 8, Medical Assistance (10 CCR 2505-10)

5. Does this action involve any temporary or emergency rule(s)?
   If yes, state effective date:
   Is rule to be made permanent? (If yes, please attach notice of hearing).

*to be completed by MSB Board Coordinator

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PUBLICATION INSTRUCTIONS*

Replace the current text at 8.485.30 with the proposed text beginning at 8.485.30 through the end of 8.485.61.F. Replace the current text at 8.500.5 with the proposed text beginning at 8.500.5.A through the end of 8.500.6.C. Replace the current text at 8.500.94 with the proposed text beginning at 8.500.94.A through the end of 8.500.94.C.3. Replace the current text at 8.509 with the proposed text beginning at 8.509.11 through the end of 8.509.14.S.3. Replace the current text at 8.515 with the proposed text beginning at 8.515.1 through the end of 8.515.4. Replace the current text at 8.516.10 with the proposed text beginning at 8.516.10 through the end of 8.516.70.E.5. Replace the current text at 8.517 with the proposed text beginning at 8.517.1.A through the end of 8.517.4.C. Insert new text at 8.553 with the proposed text beginning 8.553 through the end of 8.553.6.F.5. This rule is effective April 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Rule concerning Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Setup, Section 8.553
Rule Number: MSB 18-08-21-A
Division / Contact / Phone: Policy Innovation and Engagement / Matthew Baker / ext. 6381

STATEMENT OF BASIS AND PURPOSE

1. Summary of the basis and purpose for the rule or rule change. (State what the rule says or does and explain why the rule or rule change is necessary).

   The purpose of the proposed rule-- Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Setup, 10 C.C.R. 2505-10, 8.553, as consistent with its state authority § 6-1501, 25.5 C.R.S.--is to implement, through six adult HCBS waivers, services to support eligible persons in their transition from an institutional or setting to a Home- or Community-Based setting, as well as supporting all eligible persons on the respective waivers to develop or sustain independence through change of circumstance. These services uphold Colorado's commitment to the federal precedent established through the United States Supreme Court ruling in Olmstead v. L.C., 527 U.S. 581 (1999), that, under appropriate conditions, individuals with disabilities have a qualified right to receive state funded supports and services in the least restrictive environment, including in the community setting rather than institutions or institution-like settings. The need for the new rule is further justified by Federally required assessments indicate that more persons living in institutional settings expressed an interest in transitioning to home- or community-based settings than currently have transitions available to them. In order to ensure a successful transition, such persons will need ongoing services and supports after the transition.

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:

   Federal authority for the Rule, if any:

   42 U.S.C. §1396n(c) and The Social Security Act, §1915(c).

   Olmstead v. L.C., 527 U.S. 581 (1999),

3. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018) and Section 25.5-6-1501, C.R.S.

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Title of Rule: Revision to the Medical Assistance Rule concerning Life Skills Training, Home Delivered Meals, Peer Mentorship, and Transition Setup, Section 8.553
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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.

Medicaid recipients who are eligible for Home and Community Based Services, reside in a nursing home, Intermediate Care Facility for Individuals with Intellectual and Developmental Disabilities (ICF-IDD), or Regional Center, and are willing to participate and have expressed interest in moving to a home and community-based setting, or any eligible persons on the respective waivers to develop or sustain independence through change of circumstance. Excluded are children under the age of 18. Eligible individuals do not include individuals between ages 22 and 64 who are served in Institutes for Mental Disease or individuals who are inmates of public institutions.

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

The Department of Health Care Policy & Financing (the Department) has administered the Colorado Choice Transitions (CCT) demonstration program since April 2013, federally funded by Money Follows the Person (MFP). CCT is designed to help transition Medicaid members out of nursing homes, intermediate care facilities or regional centers into home and community-based settings. The CCT program has been demonstrating each of the four services, which Section 8.553 proposes to sustain through six adult HCBS waivers. The CCT program has demonstrated essential qualitative and quantitative outcomes.

- Qualitatively, MFP and CCT evaluations have demonstrated that eligible clients who have transitioned into community achieve a higher quality of life, better health outcomes, and a reduction in the total cost of care to the State.

- Quantitatively, as of December 2017, 328 Health First Colorado members transitioned into the community at a savings of more than $2.8 million to the state of Colorado. Further, ninety-three percent of members who transitioned were still successfully living in the community one year after their transition.

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3. Discuss the probable costs to the Department and to any other agency of the implementation and enforcement of the proposed rule and any anticipated effect on state revenues.

The Department of Health Care Policy & Financing (the Department) has administered the Colorado Choice Transitions (CCT) demonstration program since April 2013, federally funded by Money Follows the Person (MFP). CCT is designed to help transition Medicaid members out of nursing homes, intermediate care facilities or regional centers into home and community-based settings. The CCT program has been piloting transition-related services through a time limited demonstrating grant--Section 8.553 proposes to sustain four of these services through six adult HCBS waivers.

The CCT program has demonstrated that, as of, December 2017, 328 Health First Colorado members transitioned into the community at a savings of more than $2.8 million to the state of Colorado. The Department has been conscientious in its development and redesign of the respective CCT transition services. The Department has been committed to ensuring the proposed waiver services optimally address service needs and maximize quality, while remaining conscientious and dually reverent to budget impact. The Department has carefully analyzed current utilization data and forecasted impact of the proposed service design and other changes in diligence to prevent any significant unforeseen cost increases.

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

Without action, members who want to and are capable of living in home and community-based settings will remain in facilities, incurring additional costs to the State for care, and experience a more restrictive life. The Centers for Medicare and Medicaid Services (CMS) has determined that services provided in institutional settings have proven costlier than those provided in the community; as mentioned, this determination has been corroborated by the CCT program's findings. Accordingly, foregoing sustaining transition services would maintain the higher costs of serving a larger number of individuals in institutional settings.

Per Federal Assessment, without the proposed waiver services, the remaining infrastructure of supports would not have capacity to meet the demand and needs of individuals who wish to and qualify for a transition to the community as well as those who need supports to remain in the community due to a change of circumstance. By increasing capacity for transitions, the proposed waiver services will, at a greater rate, support the transition of a greater number of individuals to the community, as well as sustain individuals in the community who have encountered a change of circumstance, and thus shift utilization within state funded services toward the more cost effective alternative.

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

The CCT program has demonstrated that, as of, December 2017, 328 Health First Colorado members transitioned into the community at a savings of more than $2.8 million to the state of Colorado. CMS has determined that services provided in institutional settings have proven costlier than those provided in the community; as mentioned, this determination has been corroborated by the CCT program's findings.

The proposed waiver services advance the Olmstead percent of a least restrictive environment. Individuals who wish to transition or adapt to a change in circumstance may explore other alternatives to services. The proposed waiver services will, as a matter of both state policy intention and federal compliance, must uphold policies of least restrictive environment and those requirements of the CMS Final Rule, including maximizing individual choice, autonomy, rights, community integration, among other principles. These policies and the services' person-centered commitment, will be balanced with each individual's determined health and safety needs.

The option of waiver transition services may be enhanced, substituted, or supplemented with other Department initiatives including No Wrong Door initiative's helping an individual explore and coordinate other effective, low cost alternatives or supplements to state funded resources. Further, the concurrently proposed Transitions Coordination state plan benefit includes the availability of exploration and coordination of additional and/or alternative resources and supports for those needs the proposed waiver services are designed to serve.

Through supporting any mix or alternatives of supports, state-funded and/or not state-funded, the Department is committed to working toward supporting individuals access to quality, effective, individualized services in a way that best services individuals' needs and upholds fiscal responsibility and a commitment to reducing cost impact on the state.

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.

Alternative methods that were considered for achieving purpose of offering the services through the waivers included: continuing the services through a Medicaid administrative claiming or inaction or delay.

The Department has not yet established Medicaid administrative claiming. CMS allows for services such as those proposed in 8.553 to be reimbursed through a Medicaid administrative claiming prior to the transition occurring. Administrative claiming may be

a vehicle, on its own, to fund and house services or the administrative claiming may work in conjunction with transition services otherwise housed in waivers. In the latter case, the administrative claiming could provide reimbursement for the proposed Transition Setup services furnished prior to a client's enrolling in a waiver through the services would thereafter be reimbursed. Without the administrative fund, the State is limited to reimbursing providers for transition setup services furnished only upon a client's enrollment in the respective waiver.

If the Department were to establish an administrative claiming, it foresees the necessary development as a longer-term process, possibly requiring multiple years. The Transition Coordination (TC) State Plan benefit, proposed for rule 519, has significant scope for administrating and coordinating services and resources an individual needs to have in place prior or directly upon transition. The TC benefit is available prior to transition, and accordingly can initiate such coordination proactively and with greater ability than the HCBS Waivers alone. The Department’s position is that HCBS Waivers, working in conjunction with the TC benefit, are a viable, effective alternative to the use of administrative claiming. Further the Department has the ability to develop the wavier and TC systems and models to be ready in time for January 2019 implement, whereas dependency on administrative claiming would delay the availability of Transition Setup services.

The other alternative available has been inaction or delay, which would be more costly and detrimental to individuals receiving services for the aforementioned reasons provided above.

8.485 HOME AND COMMUNITY BASED SERVICES FOR THE ELDERLY, BLIND AND DISABLED (HCBS-EBD) GENERAL PROVISIONS

8.485.30 SERVICES PROVIDED [Eff. 12/30/2007]

.31 HCBS-EBD services provided as an alternative to nursing facility or hospital care include:

A. ~~A.~~ Adult day services; ~~and~~

B. ~~B.~~ Alternative care facility services, including homemaker and personal care services in a residential setting; and

C. Consumer Directed Attendant Support Services;

~~C.~~D. ~~C.~~ Electronic monitoring~~;~~; ~~and~~

E. Home Delivered Meals; ~~and~~

~~D.~~F. ~~D.~~ Home modification; ~~and~~

~~E.~~G. ~~E.~~ Homemaker services; ~~and~~

H. In-Home Support Services; ~~and~~

I. Life Skills Training; ~~and~~

~~F.~~J. ~~F.~~ Non-medical transportation; ~~and~~

K. Peer Mentorship; ~~and~~

~~G.~~L. ~~G.~~ Personal care; ~~and~~

~~H.~~M. ~~H.~~ Respite care; and

~~I. In-Home Support Services; and~~

~~I.~~N. ~~J. Community Transition Services; and~~Transition Setup.

~~K. Consumer Directed Attendant Support Services.~~

.32 Case management is not a service of the HCBS-EBD waiver program, but shall be provided as an administrative activity through Single Entry Point Agencies.

.33 HCBS-EBD clients are eligible for all other Medicaid state plan benefits, including the Home Health program.

8.485.40 DEFINITIONS OF SERVICES [Eff. 12/30/2007]

A. ~~A.~~ Adult day services shall be as defined at ~~10 CCR 2505-10 section~~Section 8.491.

B. ~~B.~~ Alternative Care Facility services shall be as defined at ~~10 CCR 2505-10 section~~Section 8.495.

C. Consumer Directed Attendant Support Services (CDASS) shall be defined at ~~10 CCR 2505-10 section~~Section 8.510.

D. ~~C.~~ Electronic monitoring services shall be as defined at ~~10 CCR 2505-10 section~~Section 8.488.

~~C.~~E. Home Delivered Meals services shall be defined at ~~10 CCR 2505-10, §~~Section 8.553.

~~D.~~F. ~~D.~~ Home modification shall be as defined at ~~10 CCR 2505-10 section~~Section 8.493.

G. ~~E.~~ Homemaker services shall be as defined at ~~10 CCR 2505-10 section~~Section 8.490.

H. In-Home Support Services shall be as defined at ~~10 CCR 2505-10, §~~Section 8.552.

~~E.~~I. Life Skills Training (LST) services shall be as defined at ~~10 CCR 2505-10, §~~Section 8.553.

~~F.~~J. ~~F.~~ Non-medical transportation services shall be as defined at 10 CCR 2505-10 ~~s~~Section 8.494.

K. Peer Mentorship services shall be defined at ~~10 CCR 2505-10, §~~Section 8.553.

~~G.~~L. ~~G.~~ Personal care services shall be as defined at ~~10 CCR 2505-10 section~~Section 8.489.

~~H.~~M. ~~H.~~ Respite care shall be as defined at ~~10 CCR 2505-10 section~~Section 8.492.

~~I.~~N. ~~I.~~ In-Home Support Services shall be as defined at ~~10 CCR 2505-10 section~~Section 8.552.

O. Transition Setup services shall be as defined at ~~10 CCR 2505-10, §~~Section 8.553.

~~J. Community Transition Services (CTS) shall be as defined at 10 CCR 2505-10 section 8.553.~~

~~K. Consumer Directed Attendant Support Services (CDASS) shall be defined at 10 CCR 2505-10 section 8.510.~~

8.485.50 GENERAL DEFINITIONS

A. Agency shall be defined as any public or private entity operating in a for-profit or nonprofit capacity, with a defined administrative and organizational structure. Any sub-unit of the agency that is not geographically close enough to share administration and supervision on a frequent and adequate basis shall be considered a separate agency for purposes of certification and contracts.

B. Assessment shall be as defined at ~~10 CCR 2505-10 s~~Section 8.390.1.B.

C. Case management shall be as defined at ~~10 CCR 2505-10 section~~Section 8.390.1.~~D~~C~~.~~, including the calculation of client payment and the determination of individual cost-effectiveness.

D. Categorically eligible shall be defined in the HCBS-EBD program as any client eligible for medical assistance (Medicaid), or for a combination of financial and medical assistance; and who retains eligibility for medical assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible shall not include persons who are eligible for financial assistance, but not for medical assistance, or persons who are eligible for HCBS-EBD as three hundred percent eligible persons, as defined at ~~10 CCR 2505-10 section~~Section 8.485.50.T~~U~~.~~.~~

E. Congregate facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

F. Uncertified Congregate Facility shall be a facility as defined at ~~10 CCR 2505-10 section~~Section 8.485.50.E~~F~~. that is not certified as an Alternative Care Facility. See ~~10 CCR 2505-10 s~~Section 8.495.1.

G. Continued stay review shall be a re-assessment as defined at ~~10 CCR 2505-10 section~~Sections 8.402.60 and 8.390.1.S~~C~~.

H. Corrective action plan shall be as defined at ~~10 CCR 2505-10 section~~Section 8.390.1.D~~E~~.

I. Cost containment shall be defined as the determination that, on an individual client basis, the cost of providing care in the community is less than the cost of providing care in an institutional setting. The cost of providing care in the community shall include the cost of providing HCBS-EBD services and long term home health services.

J. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility type services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-EBD. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected HCBS-EBD.

K. Diverted shall be defined as HCBS-EBD waiver recipients who were not deinstitutionalized.~~, as defined at 10 CCR 2505-10 section 8.485.50.K~~.

L. Home and Community Based Services for the Elderly, Blind and Disabled (HCBS-EBD) shall be defined as services provided in a home or community setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing facility or hospital care without the provision of HCBS-EBD, and for whom HCBS-EBD services can be provided at no more than the cost of nursing facility or hospital care.

M. Intake/screening/referral shall be as defined ~~10 CCR 2505-10 section~~Section 8.390.1.M~~J~~.

N. Level of care screen shall be as defined as an assessment conducted in accordance with ~~at 10 CCR 2505-10 section~~Section 8.401.

O. Provider agency shall be defined as an agency~~,~~ certified by the Department and which has a contract with the Department to provide one or more of the services listed at ~~10 CCR 2505-10 section~~Section 8.485.40. A single entry point agency is not a provider agency, as case management is an administrative activity, not a service. Single Entry Point Agencies may become service providers if the criteria ~~at~~ in ~~10 CCR 2505-10 section~~Sections 8.390-8.3933.61 are met.

P. Reassessment shall be as defined at ~~10 CCR 2505-10 section~~Section 8.390.1.S~~N~~.

Q. Service Plan means the written document that identifies approved services, including Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a client to remain safely in the community and developed in accordance with the Department rules, ~~. Service plan shall be as defined 10 CCR 2505-10 section 8.390.1.C.,~~ including the funding source, frequency, amount and provider of each service, and ~~. This case plan shall be~~ written on a State-prescribed Long Term Care Plan form.

R. Single entry point agency shall be defined as an organization ~~as~~ described at ~~10 CCR 2505-10 section~~Section 8.390.1.V~~R.~~.

S. The Department shall be defined as the state agency designated as the single state Medicaid agency for Colorado~~, or any divisions or sub-units within that agency~~.

T. Three hundred percent (300%) eligible shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level; and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty consecutive days.

~~U. Transition Coordination Agency (TCA) shall be defined as an agency certified by the Department to provide CTS. To be a certified TCA, the agency shall provide at least two independent living core services. Independent living core services means information and referral services, independent living skills training, peer counseling, including cross-disability peer counseling and individual and systems advocacy.~~

8.485.60 ELIGIBLE PERSONS

.61 HCBS-EBD services shall be offered to persons who meet all of the eligibility requirements below provided the individual can be served within the capacity limits in the federal waiver:

A. Financial Eligibility

Clients shall meet the eligibility criteria as stated at Section 8.100. Clients must also meet criteria ~~as s~~specified in the Colorado Department of Human Services~~the~~ Income Maintenance Staff Manual, ~~of the Colorado Department of Human Services at~~ 9 CCR 2503-1 ~~and the Colorado Department of Health Care Policy and Financing regulations at 10 CCR 2505-10 Section 8.100, Medical Assistance Eligibility, (2018),~~, which ~~are~~ is hereby incorporated by reference. The incorporation of 9 CCR 2503-1 ~~and 10 CCR 2505-10 10 CCR 2505-10 section 8.100~~ excludes later amendments to, or editions of, the referenced material. Pursuant to ~~C.R.S. section~~Section 24-4-103(12.5), C.R.S., the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at: Colorado Department of Health Care Policy and Financing, 1570 Grant Street, Denver Colorado 80203. ~~Certified copies of incorporated materials are provided at cost upon request from the Colorado Department of Human Services.~~ The Colorado Department of Human Services will provide Certified copies of incorporated materials are provided at cost upon request

B. Level of Care and Target Group

Clients who have been determined to meet the level of care and target group criteria shall be certified by a Single Entry Point agency as eligible for HCBS-EBD. The Single Entry Point agency shall only certify HCBS-EBD eligibility for those clients:

1. Determined by the Single Entry Point agency to meet the target group definition for functionally impaired elderly, or the target group definition for physically disabled or blind adult, or persons living with AIDS as defined at ~~10 CCR 2505-10 section~~Section 8.400.16; and

2. Determined by a formal level of care assessment to require the level of care available in a nursing facility, according to ~~10 CCR 2505-10 section~~Section 8.401.11 through 8.401.15; or

3. Determined by a formal level of care assessment to require the level of care available in a hospital;

4. A length of stay shall be assigned by the Single Entry Point agency for approved admissions, according to guidelines at ~~10 CCR 2505-10 section~~Section 8.402.60.

C. Receiving HCBS-EBD Services

1. Only clients who receive HCBS-EBD services, or who have agreed to accept HCBS-EBD services as soon as all other eligibility criteria have been met, are eligible for the HCBS-EBD program.

2. Case management is not a service and shall not be used to satisfy this requirement

3. Desire or need for home health services or other Medicaid services that are not HCBS-EBD services, as listed at ~~10 CCR 2505-10 section~~Section 8.485.30, shall not satisfy this eligibility requirement

4. HCBS-EBD clients who have received no HCBS-EBD services for one month must be discontinued from the program.

D. Institutional Status

1. Clients who are residents of nursing facilities or hospitals are not eligible for HCBS-EBD services while residing in such institutions unless the single entry point agency determines the client is eligible for EBD as described in ~~10 CCR 2505-10 section~~Section 8.486.33.

2. A client who is already an HCBS-EBD recipient and who enters a hospital for treatment may not receive HCBS-EBD services while in the hospital. If the hospitalization continues for 30 days or longer, the case manager must terminate the client from the HCBS-EBD program.

3. A client who is already an HCBS-EBD recipient and who enters a nursing facility may not receive HCBS-EBD services while in the nursing facility.

   (a) The case manager must terminate the client from the HCBS-EBD program if Medicaid pays for all or part of the nursing facility care, or if there is a Utilization Review Contractor-certified ULTC-100.2 for the

nursing facility placement, as verified by telephoning the Utilization Review Contractor.

(b) A client receiving HCBS-EBD services who enters a nursing facility for respite care as a service under the HCBS-EBD program shall not be required to obtain a nursing facility ULTC-100.2, and shall be continued as an HCBS-EBD client in order to receive the HCBS-EBD service of respite care in a nursing facility.

E. Cost-effectiveness

Only clients who can be safely served within cost containment, as defined at ~~10 CCR 2505-10 section~~Section 8.485.50, are eligible for the HCBS-EBD program.

F. Waiting List

Persons who are determined eligible for services under the HCBS-EBD waiver, who cannot be served within the capacity limits of the federal waiver, shall be eligible for placement on a waiting list.

1. The waiting list shall be maintained by the Department.

2. The date used to establish the person's placement on the waiting list shall be the date on which eligibility for services under the HCBS-EBD waiver was initially determined.

3. As openings become available within the capacity limits of the federal waiver, persons shall be considered for services based on the following priorities:

a. Clients being deinstitutionalized from nursing facilities.

b. Clients being discharged from a hospital who, absent waiver services, would be discharged to a nursing facility at a greater cost to Medicaid.

c. Clients who receive long term home health benefits who could be served at a lesser cost to Medicaid.

d. Clients with high ULTC 100.2 scores who are at risk of imminent nursing facility placement.

8.500 HOME AND COMMUNITY BASED SERVICES FOR THE DEVELOPMENTALLY DISABLED (HCB-DD) WAIVER

8.500.5 HCBS-DD WAIVER SERVICES

8.500.5.A SERVICES PROVIDED

1. Behavioral Services

2. Day Habilitation Services and Supports

3. Dental Services

4. Home Delivered Meals

5. Non-Medical Transportation

6. Peer Mentorship

7. Residential Habilitation Services and Supports (RHSS)

8. Specialized Medical Equipment and Supplies

9. Supported Employment

10. Transition Setup

11. Vision Services

8.500.5.B~~A~~ DEFINITIONS OF SERVICES

The following~~-~~ services are available through the HCBS-DD Waiver within the specific limitations as set forth in the federally approved HCBS-DD Waiver.~~services are available through the HCBS-DD Waiver within the specific limitations as set forth in the federally approved HCBS-DD Waiver.~~

1. Behavioral Services are services related to a client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

   a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

   b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid State Plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

   c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

   d. Behavioral Services include:

      i) Behavioral Consultation Services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self management.

ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall be established.

iii) Behavioral consultation services are limited to eighty (80) units per service plan year. One unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

v) Behavioral Plan Assessment Services are limited to forty (40) units and one (1) assessment per service plan year. One unit is equal to fifteen (15) minutes of service.

vi). Individual and Group Counseling Services include psychotherapeutic or psycho educational intervention that:

1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

3) Counseling services are limited to two-hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral Line Services include direct one-to-one implementation of the Behavioral Support Plan and is:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a client at risk of institutional placement and to address an identified challenging behavior that places the client's health and safety or the safety of others at risk.

4) Behavioral Line Services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Requests for ~~an~~ Behavioral Line Services shall be prior authorized in accordance with the Operating Agency's procedures.

2. Day Habilitation Services and Supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-

residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence and personal choice.

b. Day Habilitation Services and Supports encompass three (3) types of habilitative environments: specialized habilitation services, supported community connections, and prevocational services.

c. Specialized Habilitation (SH) services are provided to enable the client to attain the maximum functioning level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services:

    i) Are provided in a non-integrated setting where a majority of the clients have a disability,

    ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

    iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported Community Connections Services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

    i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan,

    ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings,

    iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

    iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan.

    v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational Services are provided to prepare a client for paid community employment. Services consist of teaching concepts including attendance, task completion, problem solving and safety, and are associated with performing compensated work.

i) Prevocational Services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations separate from the participant's private residence or other residential living arrangement.

ii) Goals for Prevocational Services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than fifty (50) percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor Regulations.

iv) Prevocational Services are provided to support the client to obtain paid community employment within five (5) years. Prevocational services may continue longer than five (5) years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving Prevocational Services shall occur at least once every five (5) years to determine whether or not the person has developed the skills necessary for paid community employment.

vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under ~~Section~~Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA) (20 U.S.C. ~~§~~Section 1400~~1~~ *et seq.*).

f. The number of units available for day habilitation services in combination with prevocational services is four thousand eight hundred (4,800). When used in combination with supported employment services, the total number of units available for day habilitation services in combination with prevocational services will remain at four thousand eight hundred (4,800) units and

g. The cumulative total, including supported employment services, may not exceed seven thousand one hundred and twelve (7,112) units. One unit equals fifteen (15) minutes of service.

3~~4~~. Dental services are available to individuals age twenty-~~-~~one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and co-pays/co-insurance,

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv). Non-intravenous sedation,

v) Basic and deep cleanings,

vi). Mouth guards,

vii) Topical fluoride treatment, and

viii) Retention or recovery of space between teeth when indicated.

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of dentures, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures. Implants are a benefit only when the procedure is necessary to support a dental bridge for the replacement of multiple missing teeth, or is necessary to increase the stability of dentures. The cost of implants is reimbursable only with prior approval.

e. Implants shall not be a benefit for a client who uses tobacco daily due to a substantiated increased rate of implant failures for tobacco users. Subsequent implants are not a benefit when prior implants fail.

f. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at ~~10 CCR 2505-10, Section~~Section ~~Section~~ Section 8.076.1.8~~8011.11~~ or available through a third party. General limitations to dental services including frequency will follow the

Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client.

g. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodotic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

h. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

i. Preventative and basic services are limited to $2,000 per service plan year. Major services are limited to $10,000 for the five (5) year renewal period of the waiver.

4. Home Delivered Meals as defined at ~~10 CCR 2505-10, §~~Section 8.553.1.

5. Non-Medical Transportation enables clients to gain access to Day Habilitation Services and Supports, Prevocational Services and Supported Employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

a. Whenever possible, family, neighbors, friends or community agencies that can provide this service without charge must be utilized and documented in the Service Plan.

b. Non-Medical Transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-Medical Transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip accessed each way to and from day habilitation and supported employment services.

c. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. ~~§~~Section 431.53 or transportation services under the Medicaid State Plan, defined at 42 C.F.R. ~~§~~Section 440.170(A).

~~5.~~

6. Peer Mentorship as defined at ~~10 CCR 2505-10, §~~Section 8.553.1.

7. Residential Habilitation Services and Supports (RHSS) are delivered to ensure the health and safety of the client and to assist in the acquisition, retention or improvement in skills necessary to support the client to live and participate successfully in the community.

a. Services may include a combination of lifelong, or extended duration supervision, training or support that is essential to daily community living, including assessment and evaluation, and includes training materials, transportation, fees and supplies.

b. The living environment encompasses two (2) types that include individual Residential Services and Supports (IRSS) and Group Residential Services and Supports (GRSS).

c. All RHSS environments shall provide sufficient staff to meet the needs of the client as defined in the service plan.

d. The following RHSS activities assist clients to reside as independently as possible in the community:

i) Self-advocacy training, which may include training to assist in expressing personal preferences, increasing self-representation, increasing self-protection from and reporting of abuse, neglect and exploitation, advocating for individual rights and making increasingly responsible choices,

ii) Independent living training, which may include personal care, household services, infant and childcare when the client has a child, and communication skills,

iii) Cognitive services, which may include training in money management and personal finances, planning and decision making,

iv) Implementation of recommended follow-up counseling, behavioral, or other therapeutic interventions. Implementation of physical, occupational or speech therapies delivered under the direction of a licensed or certified professional in that discipline.

v) Medical and health care services that are integral to meeting the daily needs of the client and include such tasks as routine administration of medications or tending to the needs of clients who are ill or require attention to their medical needs on an ongoing basis,

vi) Emergency assistance training including developing responses in case of emergencies and prevention planning and training in the use of equipment or technologies used to access emergency response systems,

vii) Community access services that explore community services available to all people, natural supports available to the client and develop methods to access additional services, supports, or activities needed by the client,

viii) Travel services, which may include providing, arranging, transporting or accompanying the client to services and supports identified in the service plan, and

ix) Supervision services which ensure the health and safety of the client or utilize technology for the same purpose.

e. All direct care staff not otherwise licensed to administer medications must complete a training class approved by the Colorado Department of Public Health and Environment and successfully complete a written test and a practical and competency test.

f. Reimbursement for RHSS does not include the cost of normal facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of clients or to meet the requirements of the applicable life safety code.

8~~6~~. Specialized Medical Equipment and Supplies include:

a. Devices, controls or appliances that enable the client to increase the client's ability to perform activities of daily living,

b. Devices, controls or appliances that enable the client to perceive, control or communicate within the client's environment,

c. Items necessary to address physical conditions along with ancillary supplies and equipment necessary to the proper functioning of such items,

d. Durable and non-durable medical equipment not available under the Medicaid State Plan that is necessary to address client functional limitations, or

e. Necessary medical supplies in excess of Medicaid State Plan limitations or not available under the Medicaid State Plan.

f. All items shall meet applicable standards of manufacture, design and installation.

g. Specialized medical equipment and supplies exclude those items that are not of direct medical or remedial benefit to the client.

9~~7~~. Supported Employment includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting.

a. Supported Employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client.

b. Supported Employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those individuals who are providing services to the client, to the same extent that individuals without disabilities employed in comparable positions would interact.

c. Supported Employment is work outside of a facility-based site, which is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities.

d. Supported Employment is provided in community jobs, enclaves or mobile crews.

e. Group Employment including mobile crews or enclaves shall not exceed eight (8) clients.

f. Supported Employment includes activities needed to sustain paid work by clients including supervision and training.

g. When Supported Employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a client as a result of the client's disabilities.

h. Documentation of the client's application for services through the Colorado Department of Human Services Division of Vocational Rehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education CCT (20 U.S.C. §Section 1400~~1~~ *et ~~seq~~seq.*).

i. Supported Employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

j. Supported Employment shall not take the place of nor shall it duplicate services received through the Division of Vocational Rehabilitation.

k. The limitation for Supported Employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of Supported Employment and shall not be reimbursed:

i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a client's supported employment.

10~~8~~. Transition Setup services as defined at ~~10 CCR 2505-10,~~ §Section 8.553.1.

11. Vision Services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least twenty-one (21) years of age.

a. Lasik and other similar types of procedures are only allowable when:

i) The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective.

ii) Prior authorized in accordance with Operating Agency procedures.

8.500.6 SERVICE PLAN

8.500.6.A The Case Management Agency shall complete a Service Plan for each client enrolled in the HCBS-DD Waiver ~~in accordance with 10 CCR 2505-10 Section 8.400~~.

8.500.6.B The Service Plan shall:

1. Address client's assessed needs and personal goals, including health and safety risk factors, either by waiver services or through other means,

2. Be in accordance with the Department's rules, policies and procedures, and

3. Include updates and revisions at least annually or when warranted by changes in the client's needs.

8.500.6.C The Service Plan shall document that the client has been offered a choice:

1. Between waiver services and institutional care,

2. Among waiver services, and

3. Among qualified providers.

8.500.94 HCBS-SLS WAIVER SERVICES

8.500.94.A. SERVICES PROVIDED

1. Assistive Technology
2. Behavioral Services
3. Day Habilitation services and supports
4. Dental Services
5. Health Maintenance
6. Home Accessibility Adaptations
7. Home Delivered Meals
8. Homemaker Services
9. Life Skills Training (LST)
10. Mentorship
11. Non-Medical Transportation
12. Peer Mentorship
13. Personal Care

14. Personal Emergency Response System (PERS)

15. Professional Services, defined below in 8.500.94.B.14~~15~~

16. Respite

17. Specialized Medical Equipment and Supplies

18. Supported Employment

19. Transition Setup

20. Vehicle Modifications

21. Vision Services

8.500.94.B~~A~~ The following services are available through the HCBS-SLS Waiver within the specific limitations as set forth in the federally approved HCBS-SLS Waiver.

1. Assistive technology includes services, supports or devices that assist a client to increase, maintain or improve functional capabilities. This may include assisting the client in the selection, acquisition, or use of an assistive technology device and includes:

   a. The evaluation of the assistive technology needs of a client, including a functional evaluation of the impact of the provision of appropriate assistive technology and appropriate services to the client in the customary environment of the client,

   b. Services consisting of selecting, designing, fitting, customizing, adapting, applying, maintaining, repairing, or replacing assistive technology devices,

   c. Training or technical assistance for the client, or where appropriate, the family members, guardians, caregivers, advocates, or authorized representatives of the client,

   d. Warranties, repairs or maintenance on assistive technology devices purchased through the HCBS-SLS Waiver, and

   e. Adaptations to computers, or computer software related to the client's disability. This specifically excludes cell phones, pagers, and internet access unless prior authorized in accordance with the Operating Agency procedure.

   f. Assistive technology devices and services are only available when the cost is higher than typical expenses, and are limited to the most cost effective and efficient means to meet the need and are not available through the Medicaid state plan or third party resource.

   g. Assistive technology recommendations shall be based on an assessment provided by a qualified provider within the provider's scope of practice.

   h. When the expected cost is to exceed $2,500 per device three estimates shall be obtained and maintained in the case record.

i. Training and technical assistance shall be time limited, goal specific and outcome focused.

j. The following items and services are specifically excluded under HCBS-SLS waiver and not eligible for reimbursement:

i) Purchase, training or maintenance of service animals,

ii) Computers,

iii) Items or devices that are generally considered to be entertainment in nature including but not limited to CDs, DVDs, iTunes®, any type of game,

iv) Training or adaptation directly related to a school or home educational goal or curriculum.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five year life of the waiver unless an exception is applied for and approved. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests for an exception shall be prior authorized in accordance with the Operating Agency's procedures within thirty (30) days of the request.

2. Behavioral services are services related to the client's developmental disability which assist a client to acquire or maintain appropriate interactions with others.

a. Behavioral services shall address specific challenging behaviors of the client and identify specific criteria for remediation of the behaviors.

b. A client with a co-occurring diagnosis of a developmental disability and mental health diagnosis covered in the Medicaid state plan shall have identified needs met by each of the applicable systems without duplication but with coordination by the behavioral services professional to obtain the best outcome for the client.

c. Services covered under Medicaid EPSDT or a covered mental health diagnosis in the Medicaid State Plan, covered by a third party source or available from a natural support are excluded and shall not be reimbursed.

d. Behavioral Services:

i) Behavioral consultation services include consultations and recommendations for behavioral interventions and development of behavioral support plans that are related to the client's developmental disability and are necessary for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management.

ii) Intervention modalities shall relate to an identified challenging behavioral need of the client. Specific goals and procedures for the behavioral service shall be established.

iii). Behavioral consultation services are limited to eighty (80) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

iv) Behavioral plan assessment services include observations, interviews of direct care staff, functional behavioral analysis and assessment, evaluations and completion of a written assessment document.

v) Behavioral plan assessment services are limited to forty (40) units and one (1) assessment per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

vi) Individual or group counseling services include psychotherapeutic or psychoeducational intervention that:

1) Is related to the developmental disability in order for the client to acquire or maintain appropriate adaptive behaviors, interactions with others and behavioral self-management, and

2) Positively impacts the client's behavior or functioning and may include cognitive behavior therapy, systematic desensitization, anger management, biofeedback and relaxation therapy.

3) Counseling services are limited to two hundred and eight (208) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. Services for the sole purpose of training basic life skills, such as activities of daily living, social skills and adaptive responding are excluded and not reimbursed under behavioral services.

vii) Behavioral line services include direct one on one (1:1) implementation of the behavioral support plan and are:

1) Under the supervision and oversight of a behavioral consultant,

2) To include acute, short term intervention at the time of enrollment from an institutional setting, or

3) To address an identified challenging behavior of a client at risk of institutional placement, and that places the client's health and safety or the safety of others at risk

4) Behavioral line services are limited to nine hundred and sixty (960) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service. All behavioral line services shall be prior authorized in accordance with Operating Agency procedure

3. Day habilitation services and supports include assistance with the acquisition, retention or improvement of self-help, socialization and adaptive skills that take place in a non-residential setting, separate from the client's private residence or other residential living arrangement, except when services are necessary in the residence due to medical or safety needs.

a. Day habilitation activities and environments shall foster the acquisition of skills, appropriate behavior, greater independence, and personal choice.

b. Day habilitation services and supports encompass three (3) types of habilitative environments; specialized habilitation services, supported community connections, and prevocational services.

c. Specialized habilitation (SH) services are provided to enable the client to attain the maximum functional level or to be supported in such a manner that allows the client to gain an increased level of self-sufficiency. Specialized habilitation services:

i) Are provided in a non-integrated setting where a majority of the clients have a disability,

ii) Include assistance with self-feeding, toileting, self-care, sensory stimulation and integration, self-sufficiency and maintenance skills, and

iii) May reinforce skills or lessons taught in school, therapy or other settings and are coordinated with any physical, occupational or speech therapies listed in the service plan.

d. Supported community connections services are provided to support the abilities and skills necessary to enable the client to access typical activities and functions of community life, such as those chosen by the general population, including community education or training, retirement and volunteer activities. Supported community connections services:

i) Provide a wide variety of opportunities to facilitate and build relationships and natural supports in the community while utilizing the community as a learning environment to provide services and supports as identified in a client's service plan,

ii) Are conducted in a variety of settings in which the client interacts with persons without disabilities other than those individuals who are providing services to the client. These types of services may include socialization, adaptive skills and personnel to accompany and support the client in community settings,

iii) Provide resources necessary for participation in activities and supplies related to skill acquisition, retention or improvement and are provided by the service agency as part of the established reimbursement rate, and

iv) May be provided in a group setting or may be provided to a single client in a learning environment to provide instruction when identified in the service plan.

v) Activities provided exclusively for recreational purposes are not a benefit and shall not be reimbursed.

e. Prevocational services are provided to prepare a client for paid community employment. Services include teaching concepts including attendance, task completion, problem solving and safety and are associated with performing compensated work.

i) Prevocational services are directed to habilitative rather than explicit employment objectives and are provided in a variety of locations

separate from the participant's private residence or other residential living arrangement.

ii) Goals for prevocational services are to increase general employment skills and are not primarily directed at teaching job specific skills.

iii) Clients shall be compensated for work in accordance with applicable federal laws and regulations and at less than 50 percent of the minimum wage. Providers that pay less than minimum wage shall ensure compliance with the Department of Labor regulations.

iv) Prevocational services are provided to support the client to obtain paid community employment within five years. Prevocational services may continue longer than five years when documentation in the annual service plan demonstrates this need based on an annual assessment.

v) A comprehensive assessment and review for each person receiving prevocational services shall occur at least once every five years to determine whether or not the person has developed the skills necessary for paid community employment.

vi) Documentation shall be maintained in the file of each client receiving this service that the service is not available under a program funded under ~~section~~Section 110 of the rehabilitation act of 1973 or the Individuals with Educational Disabilities Act (20 U.S.C. ~~Section~~Section 1401~~1~~ *et ~~seq~~seq.*).

f. Day habilitation services are limited to seven thousand one hundrend and twelve (7,112) units per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. The number of units available for day habilitation services in combination with prevocational services and supported employment shall not exceed seven thousand one hundred and twelve (7,112) units.

4. Dental services are available to individuals age twenty one (21) and over and are for diagnostic and preventative care to abate tooth decay, restore dental health, are medically appropriate and include preventative, basic and major dental services.

a. Preventative services include:

i) Dental insurance premiums and co-payments

ii) Periodic examination and diagnosis,

iii) Radiographs when indicated,

iv) Non-intravenous sedation,

v) Basic and deep cleanings,

vi) Mouth guards,

vii) Topical fluoride treatment,

viii) Retention or recovery of space between teeth when indicated, and

b. Basic services include:

i) Fillings,

ii) Root canals,

iii) Denture realigning or repairs,

iv) Repairs/re-cementing crowns and bridges,

v) Non-emergency extractions including simple, surgical, full and partial,

vi) Treatment of injuries, or

vii) Restoration or recovery of decayed or fractured teeth,

c. Major services include:

i) Implants when necessary to support a dental bridge for the replacement of multiple missing teeth or is necessary to increase the stability of, crowns, bridges, and dentures. The cost of implants is only reimbursable with prior approval in accordance with Operating Agency procedures.

ii) Crowns

iii) Bridges

iv) Dentures

d. Dental services are provided only when the services are not available through the Medicaid state plan due to not meeting the need for medical necessity as defined in Health Care Policy and Financing rules at ~~10 CCR 2505-10,~~ Section 8.076.1.8 ~~8011.11 o~~r available through a third party. General limitations to dental services including frequency will follow the Operating Agency's guidelines using industry standards and are limited to the most cost effective and efficient means to alleviate or rectify the dental issue associated with the client

e. Implants shall not be a benefit for clients who use tobacco daily due to substantiated increased rate of implant failures for chronic tobacco users.

f. Subsequent implants are not a covered service when prior implants fail.

g. Full mouth implants or crowns are not covered.

h. Dental services do not include cosmetic dentistry, procedures predominated by specialized prosthodotic, maxillo-facial surgery, craniofacial surgery or orthodontia, which includes, but is not limited to:

i) Elimination of fractures of the jaw or face,

ii) Elimination or treatment of major handicapping malocclusion, or

iii) Congenital disfiguring oral deformities.

i. Cosmetic dentistry is defined as aesthetic treatment designed to improve the appearance of the teeth or smile, including teeth whitening, veneers, contouring and implants or crowns solely for the purpose of enhancing appearance.

j. Preventative and basic services are limited to two thousand ($2,000) per service plan year. Major services are limited to ten thousand ($10,000) for the five (5) year renewal period of the waiver.

5. Health maintenance activities are available only as a participant directed supported living service in accordance with Section 8.500.94.C. Health maintenance activities means routine and repetitive health related tasks furnished to an eligible client in the community or in the client's home, which are necessary for health and normal bodily functioning that a person with a disability is unable to physically carry out. Services may include:

a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection. Skin care may include~~:~~ wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional,

b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation,

c. Mouth care performed when:

i) there is injury or disease of the face, mouth, head or neck,

ii) in the presence of communicable disease,

iii) the client is unconscious, or~~OR~~

iv) oral suctioning is required,

d. Dressing, including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary,

e. Feeding

i) W~~w~~hen suctioning is needed on a stand-by or other basis,

ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study,

iii) Syringe feeding, OR

iv) Feeding using an apparatus,

f. Exercise prescribed by a licensed medical professional including passive range~~E~~ of motion,

g. Transferring a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed,

h. Bowel care provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist,

i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters,

j. Medical management required by a medical professional to monitor blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections,

k. Respiratory care, including:

i. Postural drainage,

ii) Cupping,

iii) Adjusting oxygen flow within established parameters,

iv) Suctioning of mouth and nose,

v) Nebulizers,

vi) Ventilator and tracheostomy care,

vii) Prescribed respiratory equipment.

6. Home Accessibility Adaptations are physical adaptations to the primary residence of the client, that are necessary to ensure the health, and safety of the client or that enable the client to function with greater independence in the home. All adaptations shall be the most cost effective means to meet the identified need. Such adaptations include:

a. The installation of ramps,

b. Widening or modification of doorways,

c. Modification of bathroom facilities to allow accessibility and assist with needs in activities of daily living,

d. The installation of specialized electric and plumbing systems that are necessary to accommodate the medical equipment supplies that are necessary for the welfare of the client, and

e. Safety enhancing supports such as basic fences, door and window alarms.

f. The following items are specifically excluded from home accessibility adaptations and shall not be reimbursed:

i) Adaptations or improvements to the home that are considered to be on-going homeowner maintenance and are not related to the client's disability,

ii) Carpeting,

iii) Roof repair,

iv). Central air conditioning,

v) Air duct cleaning,

vi) Whole house humidifiers,

vii) Whole house air purifiers,

viii) Installation or repair of driveways and sidewalks,

ix) Monthly or ongoing home security monitoring fees,

x) Home furnishings of any type, and

xi) Luxury upgrades.

g. When the HCBS-SLS waiver has provided modifications to the client's home and the client moves to another home, those modifications shall not be duplicated in the new residence unless prior authorized in accordance with Operating Agency procedures.

Adaptation to rental units, when the adaptation is not portable and cannot move with the client shall not be covered unless prior authorized in accordance with Operating Agency procedures.

h. Adaptations that add to the total square footage of the home are excluded from this benefit except when necessary to complete an adaptation to:

i. improve entrance or egress to a residence; or,

ii. configure a bathroom to accommodate a wheelchair.

i. Any request to add square footage to the home shall be prior authorized in accordance with Operating Agency procedures.

j. All devices and adaptations shall be provided in accordance with applicable state or local building codes or applicable standards of manufacturing, design and installation. Medicaid state plan, EPSDT or third party resources shall be utilized prior to authorization of waiver services.

k. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five-year life of the waiver without an exception granted by the Operating Agency. Costs that exceed this limitation may be approved by the Operating Agency for devices to ensure the health, and safety of the client or that enable the client to function with greater independence in the home, or if it decreases the need for paid assistance in another waiver service on a long-term basis. Requests to exceed the limit shall be prior authorized in accordance with Operating Agency procedure.

~~6.~~

7. Home Delivered Meals as defined at ~~10 CCR 2505-10, §~~Section 8.553.1.

8. Homemaker services are provided in the client's home and are allowed when the client's disability creates a higher volume of household tasks or requires that household tasks are performed with greater frequency. There are two types of homemaker services:

   a. Basic homemaker services include cleaning, completing laundry, completing basic household care or maintenance within the client's primary residence only in the areas where the client frequents.

      i) Assistance may take the form of hands-on assistance including actually performing a task for the client or cueing to prompt the client to perform a task.

      ii) Lawn care, snow removal, air duct cleaning, and animal care are specifically excluded under the HCBS-SLS waiver and shall not be reimbursed.

   b. Enhanced homemaker services includes basic homemaker services with the addition of either procedures for habilitation or procedures to perform extraordinary cleaning

      i) Habilitation services shall include direct training and instruction to the client in performing basic household tasks including cleaning, laundry, and household care which may include some hands-on assistance by actually performing a task for the client or enhanced prompting and cueing.

      ii) The provider shall be physically present to provide step-by-step verbal or physical instructions throughout the entire task:

         1) When such support is incidental to the habilitative services being provided, and

         2) To increase the independence of the client,

      iii) Incidental basic homemaker service may be provided in combination with enhanced homemaker services; however, the primary intent must be to provide habilitative services to increase independence of the client.

      iv) Extraordinary cleaning are those tasks that are beyond routine sweeping, mopping, laundry or cleaning and require additional cleaning or sanitizing due to the client's disability.

9~~7~~. Life Skills Training (LST) as defined at ~~10 CCR 2505-10, §~~Section 8.553.1.

10. Mentorship services are provided to clients to promote self-advocacy through methods such as instructing, providing experiences, modeling and advising and include:

   a. Assistance in interviewing potential providers,

   b. Assistance in understanding complicated health and safety issues,

c. Assistance with participation on private and public boards, advisory groups and commissions, and

d. Training in child and infant care for clients who are parenting children.

e. Mentorship services shall not duplicate case management or other HCBS-SLS waiver services.

f. Mentorship services are limited to one hundred and ninety two (192) units (forty eight (48) hours) per service plan year. One (1) unit is equal to fifteen (15) minutes of service.

g. Units to provide training to clients for child and infant care shall be prior authorized beyond the one hundred and ninety two (192) units per service plan year in accordance with Operating Agency procedures.

118. Non-medical transportation services enable clients to gain access to day habilitation, prevocational and supported employment services. A bus pass or other public conveyance may be used only when it is more cost effective than or equivalent to the applicable mileage band.

a. Whenever possible, family, neighbors, friends, or community agencies that can provide this service without charge must be utilized and documented in the service plan.

b. Non-medical transportation to and from day program shall be reimbursed based on the applicable mileage band. Non-medical transportation services to and from day program are limited to five hundred and eight (508) units per service plan year. A unit is a per-trip charge assessed each way to and from day habilitation and supported employment services.

c. Transportation provided to destinations other than to day program or supported employment is limited to four (4) trips per week reimbursed at mileage band one

d. Non-Medical Transportation does not replace medical transportation required under 42 C.F.R. 440.170 the applicable mileage band. Non-emergency medical transportation is a benefit under the Medicaid State Plan, defined at 42 C.F.R. §Section 440.170(aA)(4).

129. Peer Mentorship as defined at 10 CCR 2505-10, §Section 8.553.

Personal Emergency Response System (PERS) is an electronic device that enables clients to secure help in an emergency. The client may also wear a portable "help" button to allow for mobility. The system is connected to the client's phone and programmed to a signal a response center once a "help" button is activated. The response center is staffed by trained professionals.

a. The client and the client's case manager shall develop a protocol for identifying who should to be contacted if the system is activated.

130. Personal Care is assistance to enable a client to accomplish tasks that the client would complete without assistance if the client did not have a disability. This assistance may take the form of hands-on assistance by actually performing a task for the client or cueing to prompt the client to perform a task. Personal care services include:

a. Personal cceare services include:

i) Assistance with basic self-care including hygiene, bathing, eating, dressing, grooming, bowel, bladder and menstrual care.

ii) Assistance with money management,

iii) Assistance with menu planning and grocery shopping, and

iv) Assistance with health related services including first aide, medication administration, assistance scheduling or reminders to attend routine or as needed medical, dental and therapy appointments, support that may include accompanying clients to routine or as needed medical, dental, or therapy appointments to ensure understanding of instructions, doctor's orders, follow up, diagnoses or testing required, or skilled care that takes place out of the home.

b. Personal care services may be provided on an episodic, emergency or on a continuing basis. When personal care service is required, it shall be covered to the extent the Medicaid state plan or third party resource does not cover the service.

c. If the annual functional needs assessment identifies a possible need for skilled care: then the client shall obtain a home health assessment.

i. The client shall obtain a home health assessment, or

ii. The client shall be informed of the option to direct his/her health maintenance activities pursuant to sectionSection 8.510.12, et seq.

141. Personal Emergency Response System (PERS) is an electronic device that enables clients to secure help in an emergency. The client may also wear a portable “help” button to allow for mobility. PERS services are covered when Tthe PERS system is connected to the client’s phone and programmed to a signal a response center whenonce a “help” button is activated,. and Tthe response center is staffed by trained professionals.

a. The client and the client’s case manager shall develop a protocol for identifying who should to be contacted if the system is activated.

15. Professional services are provided by licensed, certified, registered or accredited professionals and the intervention is related to an identified medical or behavioral need. Professional services include:

a. Hippotherapy includes a therapeutic treatment strategy that uses the movement of the horse to assist in the development or enhancement of skills including gross motor, sensory integration, attention, cognitive, social, behavior and communication.

b. Movement therapy includes the use of music or dance as a therapeutic tool for the habilitation, rehabilitation and maintenance of behavioral, developmental, physical, social, communication, or gross motor skills and assists in pain management and cognition.

c. Massage includes the physical manipulation of muscles to ease muscle contractures or spasms, increase extension and muscle relaxation and decrease muscle tension and includes watsu.

d. Professional services ~~can~~ may be reimbursed only when:

i) The provider is licensed, certified, registered or accredited by an appropriate national accreditation association in the profession,

ii) The intervention is related to an identified medical or behavioral need, and

iii) The Medicaid State plan therapist or physician identifies the need for the service, establishes the goal for the treatment and monitors the progress of that goal at least quarterly.

e. A pass to community recreation centers shall only be used to access professional services and when purchased in the most cost effective manner including day passes or monthly passes.

f. The following services are excluded under the HCBS Waiver from reimbursement;

i) Acupuncture,

ii) Chiropractic care,

iii) Fitness trainer

iv) Equine therapy,

v) Art therapy,

vi) Warm water therapy,

vii) Experimental treatments or therapies, and.

viii) Yoga.

16~~2~~. Respite service is provided to clients on a short-term basis, because of the absence or need for relief of the primary caregivers of the client.

a. Respite may be provided:

i) In the client's home and private place of residence,

ii) The private residence of a respite care provider, or

iii) In the community.

b. Respite shall be provided according to individual or group rates as defined below:

i) Individual: the client receives respite in a one-on-one situation. There are no other clients in the setting also receiving respite services. Individual respite occurs for ten (10) hours or less in a twenty four (24)-hour period.

ii) Individual Day: the client receives respite in a one-on-one situation for cumulatively more than 10 hours in a 24-hour period. A full day is 10 hours or greater within a 24- hour period.

iii) Overnight Group: the client receives respite in a setting which is defined as a facility that offers 24 hour supervision through supervised overnight group accommodations. The total cost of overnight group within a 24-hour period shall not exceed the respite daily rate.

iv) Group: the client receives care along with other individuals, who may or may not have a disability. The total cost of group within a 24-hour period shall not exceed the respite daily rate.

c. The following limitations to respite services shall apply:

i) Federal financial participation shall not be claimed for the cost of room and board except when provided~~,~~ as part of respite care furnished in a facility approved pursuant to ~~2 CCR 503-1, Section 16.221~~. by the state that is not a private residence.

ii) Overnight group respite may not substitute for other services provided by the provider such as personal care, behavioral services or services not covered by the HCBS-SLS Waiver.

iii) Respite shall be reimbursed according to a unit rate or daily rate whichever is less. The daily overnight group respite rate shall not exceed the respite daily rate.

1~~7~~3. Specialized Medical Equipment and Supplies include: devices, controls, or appliances that are required due to the client's disability and that enable the client to increase the client's ability to perform activities of daily living or to safely remain in the home and community. Specialized medical equipment and supplies include:

a. Kitchen equipment required for the preparation of special diets if this results in a cost savings over prepared foods;

b. Specially designed clothing for a client if the cost is over and above the costs generally incurred for a client's clothing;

c. Maintenance and upkeep of specialized medical equipment purchased through the HCBS-SLS waiver.

d. The following items are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement:

i) Items that are not of direct medical or remedial benefit to the client are specifically excluded under the HCBS-SLS waiver and not eligible for reimbursement. These include but are not limited to; vitamins, food supplements, any food items, prescription or over the counter medications, topical ointments, exercise equipment, hot tubs, water

walkers, resistance water therapy pools, experimental items or wipes for any purpose other incontinence.

184. Supported Employment services includes intensive, ongoing supports that enable a client, for whom competitive employment at or above the minimum wage is unlikely absent the provision of supports, and who because of the client's disabilities needs supports to perform in a regular work setting.

a. Supported employment may include assessment and identification of vocational interests and capabilities in preparation for job development, and assisting the client to locate a job or job development on behalf of the client.

b. Supported employment may be delivered in a variety of settings in which clients interact with individuals without disabilities, other than those individuals who are providing services to the client, to the same extent that individuals without disabilities employed in comparable positions would interact.

c. Supported employment is work outside of a facility-based site, that is owned or operated by an agency whose primary focus is service provision to persons with developmental disabilities,

d. Supported employment is provided in community jobs, enclaves or mobile crews.

e. Group employment including mobile crews or enclaves shall not exceed eight clients.

f. Supported employment includes activities needed to sustain paid work by clients including supervision and training.

g. When supported employment services are provided at a work site where individuals without disabilities are employed, service is available only for the adaptations, supervision and training required by a client as a result of the client's disabilities.

h. Documentation of the client's application for services through the Colorado Department of Human Services Division for Vocational Rehabilitation shall be maintained in the file of each client receiving this service. Supported employment is not available under a program funded under ~~Section~~Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. ~~§~~Section 1400~~1~~, et seq.).

i. Supported employment does not include reimbursement for the supervisory activities rendered as a normal part of the business setting.

j. Supported employment shall not take the place of nor shall it duplicate services received through the Division for Vocational Rehabilitation.

k. The limitation for supported employment services is seven thousand one hundred and twelve (7,112) units per service plan year. One (1) unit equals fifteen (15) minutes of service.

l. The following are not a benefit of supported employment and shall not be reimbursed:

i) Incentive payments, subsidies or unrelated vocational training expenses, such as incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment,

ii) Payments that are distributed to users of supported employment, and

iii) Payments for training that are not directly related to a client's supported employment.

195. Transition Setup as defined at ~~10 CCR 2505-10, §~~Section 8.553.1.

20. Vehicle modifications are adaptations or alterations to an automobile or van that is the client's primary means of transportation; to accommodate the special needs of the client; are necessary to enable the client to integrate more fully into the community; and to ensure the health and safety of the client.

a. Upkeep and maintenance of the modifications are allowable services.

b. Items and services specifically excluded from reimbursement under the HCBS Waiver include:

i) Adaptations or improvements to the vehicle that are not of direct medical or remedial benefit to the client,

ii) Purchase or lease of a vehicle, and

iii) Typical and regularly scheduled upkeep and maintenance of a vehicle.

c. The total cost of home accessibility adaptations, vehicle modifications, and assistive technology shall not exceed $10,000 over the five (5) year life of the HCBS Waiver except that on a case by case basis the Operating Agency may approve a higher amount. Such requests shall ensure the health and safety of the client, enable the client to function with greater independence in the home, or decrease the need for paid assistance in another HCBS-SLS Waiver service on a long-term basis. Approval for a higher amount will include a thorough review of the current request as well as past expenditures to ensure cost-efficiency, prudent purchases and no duplication.

2116. Vision services include eye exams or diagnosis, glasses, contacts or other medically necessary methods used to improve specific dysfunctions of the vision system when delivered by a licensed optometrist or physician for a client who is at least 21 years of age

a. Lasik and other similar types of procedures are only allowable when:

b. The procedure is necessary due to the client's documented specific behavioral complexities that result in other more traditional remedies being impractical or not cost effective, and

c. Prior authorized in accordance with Operating Agency procedures.

~~17. HEALTH MAINTENANCE ACTIVITIES ARE AVAILABLE ONLY AS A PARTICIPANT DIRECTED SUPPORTED LIVING SERVICE IN ACCORDANCE WITH 8.500.94.B. HEALTH MAINTENANCE ACTIVITIES MEANS ROUTINE AND REPETITIVE HEALTH~~

~~RELATED TASKS FURNISHED TO AN ELIGIBLE CLIENT IN THE COMMUNITY OR IN THE CLIENT'S HOME, WHICH ARE NECESSARY FOR HEALTH AND NORMAL BODILY FUNCTIONING THAT A PERSON WITH A DISABILITY IS UNABLE TO PHYSICALLY CARRY OUT. SERVICES MAY INCLUDE:~~

~~a. Skin care provided when the skin is broken or a chronic skin condition is active and could potentially cause infection. Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when prescribed by a licensed medical professional~~

~~b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation~~

~~c. Mouth care performed when:~~

~~i) there is injury or disease of the face, mouth, head or neck~~

~~ii) in the presence of communicable disease~~

~~iii) the client is unconscious, OR~~

~~iv) oral suctioning is required~~

~~d. Dressing, including the application of anti-embolic or other prescription pressure stockings and orthopedic devices such as splints, braces, or artificial limbs if considerable manipulation is necessary~~

~~e. Feeding~~

~~i) when suctioning is needed on a stand-by or other basis~~

~~ii) When there is high risk of choking that could result in the need for emergency measures such as CPR or the Heimlich maneuver as demonstrated by a swallow study~~

~~iii) Syringe feeding, OR~~

~~iv) Feeding using apparatus~~

~~f. Exercise prescribed by a licensed medical professional including passive rangE of motion~~

~~g. Transferring a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed~~

~~h. Bowel care provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist~~

~~i. Bladder care when it involves disruption of the closed system for a Foley or suprapubic catheter, such as changing from a leg bag to a night bag and care of external catheters~~

~~j. Medical management required by a medical professional to monitor blood pressures, pulses, respiratory assessment, blood sugars, oxygen saturations, pain management, intravenous, or intramuscular injections~~

~~k. Respiratory care:~~

~~i. Postural drainage~~

~~ii) Cupping~~

~~iii) Adjusting oxygen flow within established parameters~~

~~iv) Suctioning of mouth and nose~~

~~v) Nebulizers~~

~~vi) Ventilator and tracheostomy care~~

~~vii) Prescribed respiratory equipment~~

8.500.94.CB PARTICIPANT-DIRECTED SUPPORTED LIVING SERVICES

Participant direction of HCBS-SLS waiver services is authorized pursuant to the provisions of the federally approved Home and Community Based Supported Living Services (HCBS-SLS) Waiver, CO.0293 and ~~C.R.S.~~ 25.5-6-1101, et seq. C.R.S.~~(2014).~~

1. Participants may choose to direct their own services through the Consumer Directed Attendant Support Services delivery OPTION SET FORTH at Section 8.510, et seq.

2. Services that may be participant-directed UNDER THIS OPTION are as follows:

   i) Personal Care as defined at Section ~~10 CCR 2505-10 §~~8.500.94.B~~A~~.1230

   ii) Homemaker services as defined at Section ~~10 CCR 2505-10 §~~8.500.94.B~~A~~.~~86~~

   iii) Health Maintenance ~~ActivitIES~~Activities as defined at Section ~~10 CCR 2505-10 §~~8.500.94.B~~A~~.~~517~~

3. The case manager shall conduct the case management functions SET FORTH at ~~s~~Section 8.510.14, et~~.~~ seq.

8.509 HOME AND COMMUNITY BASED SERVICES FOR COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS)

8.509.10 GENERAL PROVISIONS

8.509.11 LEGAL BASIS

A. The Home and Community Based Services for COMMUNITY MENTAL HEALTH SUPPORTS (HCBS-CMHS) program in Colorado is authorized by a waiver of the amount, duration, and scope

of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act. The waiver was granted by the United States Department of Health and Human Services, under Section 1915(c) of the Social Security Act. The HCBS-CMHS program is also authorized under state law at Sections 25.5-6-601 through 25.5-6-607, C.R.S. ~~(2012).~~ The number of recipients served in the HCBS-CMHS program is limited to the number of recipients authorized in the waiver.

B. All congregate facilities where any HCBS client resides ~~must be in compliance with the "Keys Amendment" as required under Section 1616(e) of the Social Security Act of 1935 and 45 CFR Part 1397 (October 1, 1991)~~, ~~by~~ must be in possession of a valid Assisted Living Residence license issued under Ssection 25-27-105, C.R.S. ~~(1999)~~, and regulations of the Colorado Department of Public Health and Environment at 6 CCR 1011-1, Chapters 2 and 7. ~~Pursuant to 24-4-103(12.5), C.R.S., the Department of Health Care Policy and Financing maintains with electronic or written copies of the incorporated texts for public inspection. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO, 80203. Additionally, any incorporated material in these rules may be examined at any State depository library.~~

8.509.12 SERVICES PROVIDED [Eff. 7/1/2012]

A. HCBS-CMHS services provided as an alternative to nursing facility placement include:

1. Adult Day Services

2. Alternative ~~Care Facility Services~~Care Services (which includes Homemaker and Personal Care services)

3. Consumer Directed Attendant Support Services (CDASS)

4. Electronic Monitoring

5. Home Delivered Meals

6. Home Modification

7~~6~~. Homemaker Services

8~~7~~. Life Skills Training (LST)

9. Non-Medical Transportation

10~~8~~. Peer Mentorship

11. Personal Care

12~~9~~. Respite Care

13. Transition Setup

B. Case management is not a service of the HCBS-CMHS program, but shall be provided as an administrative activity through case management agencies.

C. HCBS-CMHS clients are eligible for all other Medicaid State plan benefits.

8.509.13 DEFINITIONS OF SERVICES

A. Adult Day Services is defined at Section 8.491~~, ADULT DAY SERVICES~~.

B. Alternative Care ~~Facility~~ Services is defined at Section 8.495.1~~, ALTERNATIVE CARE FACILITY~~.

C. Consumer Directed Attendant Support Services (CDASS) is defined at Section 8.510.1.~~, CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES~~

D~~C~~. Electronic Monitoring services is defined at Section 8.488.11~~, ELECTRONIC MONITORING~~.

E~~D~~. Home Delivered Meals is defined at ~~10 CCR 2505-10, §~~Section 8.553.1~~, HOME DELIVERED MEALS~~.

F. Home Modification is defined at Section 8.493.1~~, HOME MODIFICATION~~.

G~~E~~. Homemaker Services is defined at Section 8.490.1~~, HOMEMAKER SERVICES~~.

H~~F~~. Life Skills Training (LST) is defined at ~~10 CCR 2505-10, §~~Section 8.553.1 ~~LIFE SKILLS TRAINING~~.

I. Non-Medical Transportation is defined at Section 8.494.1~~, NON-MEDICAL TRANSPORTATION~~.

J~~G~~. Peer Mentorship is defined at ~~10 CCR 2505-10,~~ Section~~§~~ 8.553~~, PEER MENTORSHIP~~.

K. Personal Care is defined at Section 8.~~489~~500.94.B.12~~, PERSONAL CARE~~.

~~H.~~ ~~Transition Setup is defined at 10 CCR 2505-10, § 8.553, TRANSITION SETUP.~~

L. Respite is defined at Section 8.492~~, RESPITE~~.

M. Transition Setup is defined at ~~10 CCR 2505-10, §~~Section 8.553~~, TRANSITION SETUP~~.

8.509.14 GENERAL DEFINITIONS

A. Assessment shall be defined as a client evaluation according to requirements at Section 8.509.31~~, (~~.B~~)~~.

B. Case Management shall be defined as administrative functions performed by a case management agency according to requirements at Section 8.509.30.

C. Case Management Agency shall be defined as an agency that is certified and has a valid contract with the state to provide HCBS-CMHS case management.

D. Case Plan shall be defined as a systematized arrangement of information which includes the client's needs; the HCBS-CMHS services and all other services which will be provided, including the funding source, frequency, amount and provider of each service; and the expected outcome or purpose of such services. This case plan shall be written on a state-prescribed case plan form.

E. Categorically Eligible, shall be defined in the HCBS-CMHS Program, as any person who is eligible for Medical Assistance (Medicaid), or for a combination of financial and Medical Assistance; and who retains eligibility for Medical Assistance even when the client is not a resident of a nursing facility or hospital, or a recipient of an HCBS program. Categorically eligible

shall not include persons who are eligible for financial assistance, or persons who are eligible for HCBS-CMHS as three hundred percent eligible persons, as defined at 8.509.14.S~~(S)~~.

F. Congregate Facility shall be defined as a residential facility that provides room and board to three or more adults who are not related to the owner and who, because of impaired capacity for independent living, elect protective oversight, personal services and social care but do not require regular twenty-four hour medical or nursing care.

G. Uncertified Congregate Facility is a facility as defined in Section 8.509.14.G~~(F)~~ that is not certified as an Alternative Care Facility, which is defined at Section 8.495.1~~1~~.

H. Continued Stay Review shall be defined as a re-assessment conducted as ~~defined~~ described at Section 8.402.60.

I. Cost Containment shall be defined at Section 8.485.50(I~~J~~)

J. Department shall be defined as the State Agency designated as the Single State Medicaid Agency for Colorado~~, or any division or sub-units within that agency~~, or another state agency operating under the authority of a memorandum of understanding with the Single State Medicaid Agency.

K. Deinstitutionalized shall be defined as waiver clients who were receiving nursing facility services reimbursed by Medicaid, within forty-five (45) calendar days of admission to HCBS-CMHS waiver. These include hospitalized clients who were in a nursing facility immediately prior to inpatient hospitalization and who would have returned to the nursing facility if they had not elected the HCBS-CMHS waiver.

L. Diverted shall be define as HCBS-CMHS waiver recipients who were not deinstitutionalized, as defined at Section 8.485.50(K).

M. Home and Community Based Services for Community Mental Health Supports (HCBS-CMHS) shall be defined as services provided in a home or community based setting to clients who are eligible for Medicaid reimbursement for long term care, who would require nursing facility care without the provision of HCBS-CMHS, and for whom HCBS-CMHS services can be provided at no more than the cost of nursing facility care.

N. Intake/Screening/Referral shall be as defined at Section 8.390.1(~~J~~M) and as the initial contact with clients by the case management agency. This shall include, but not be limited to, a preliminary screening in the following areas: an individual's need for long term care services; 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 long term care client assessment.

O. Level Of Care Screen shall be defined~~described~~ as an assessment conducted in accordance with ~~in~~ Section 8.401.

P. Non-Diversion shall be defined as a client who was certified by the Utilization Review Contractor (URC) as meeting the level of care screen and target group for the HCBS-CMHS program, but who did not receive HCBS-CMHS services for some other reason.

Q. Provider Agency shall be defined as an agency certified by the Department and which has a contract with the Department, in accordance with Section 8.487, HCBS-EBD PROVIDER AGENCIES, to provide one of the services listed at Section 8.509.13. A case management agency may also become a provider if the criteria at Sections 8.390-8.393~~8, 393.6~~ and 8.487 are met.

R. Reassessment shall be defined as a periodic revaluation according to the requirements at Section 8.509.32.-C.

S. Three Hundred Percent (300%) Eligible persons shall be defined as persons:

1) Whose income does not exceed 300% of the SSI benefit level, and

2) Who, except for the level of their income, would be eligible for an SSI payment; and

3) Who are not eligible for medical assistance (Medicaid) unless they are recipients in an HCBS program, or are in a nursing facility or hospitalized for thirty (30) consecutive days.

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

8.515.1 LEGAL BASIS

The Home and Community-Based Services for Persons with Brain Injury (HCBS-BI) program is authorized by waiver of the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act, 42 U.S.C. ~~§~~Section 1396a(a)(10)B) (2011). This waiver is granted by the United States Department of Health and Human Services under ~~Section~~Section 1915(c) of the Social Security Act, 42 U.S.C. ~~§~~Section 1396n (2011). 42 U.S.C. ~~§~~ ~~§~~Sections 1396a and 1396n are incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material.

This regulation is adopted pursuant to the authority in Section 25.5-1-303, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Sections 24-4-101 et seq., C.R.S. and the Home and Community-Based Services for Persons with Brain Injury Act, Sections 25.5-6-701 et seq., C.R.S.

~~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. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO 80203. Additionally, any incorporated material in these rules may be examined at any State depository library.~~

8.515.2 HCBS-BI WAIVER SERVICES

8.515.2.A SERVICES PROVIDED

1. Adult Day Services

2. Behavioral Programming and Education

3. Consumer Directed Attendant Support Services (CDASS)

4. Counseling Services

5. Day Treatment

6. Electronic Monitoring Services

7. Home Delivered Meals

8. Home Modification

9. Independent Living Skills Training (ILST)

10. Non-Medical Transportation Services

11. Peer Mentorship

12. Personal Care

13. Respite Care

14. Specialized Medical Equipment and Supplies

15. Substance Abuse Counseling

16. Supported Living

17. Transition Setup

18. Transitional Living Program

8.515.2.B DEFINITIONS OF SERVICES

1. Adult Day Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.491.

2. Behavioral Programming and Education means services as defined at ~~10 CCR 2505-10, §~~Section 8.516.40.

3. Consumer Directed Attendant Support Services (CDASS) means services as defined at ~~10 CCR 2505-10, §~~Section 8.510.

4. Counseling Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.516.50.

5. Day Treatment means services as defined at ~~10 CCR 2505-10, §~~Section 8.515.80.

6. Electronic Monitoring Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.488.

7. Home Delivered Meals means services as defined at ~~10 CCR 2505-10, §~~Section 8.553.

8. Home Modification means services as defined at ~~10 CCR 2505-10, §~~Section 8.493.

9. Independent Living Skills Training (ILST) means services as defined at ~~10 CCR 2505-10, §~~Section 8.516.10.

10. Non-Medical Transportation Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.494.

11. Peer Mentorship means services as defined at ~~10 CCR 2505-10, §~~Section 8.553.

12. Personal Care means services as defined at ~~10 CCR 2505-10, §~~Section 8.489.

13. Respite Care means services as defined at ~~10 CCR 2505-10, §~~Section 8.516.70.

14. Specialized Medical Equipment and Supplies means services as defined at ~~10 CCR 2505-10, §~~Section 8.515.50.

15. Substance Abuse Counseling means services as defined at ~~10 CCR 2505-10, §~~Section 8.516.60.

16. Supported Living means services delivered by a community-based residential program that has been certified by the Department to provide the services defined at §Section 25.5-6-703(8), C.R.S. (2018).

17. Transition Setup means services defined at ~~10 CCR 2505-10, §~~Section 8.553.

18. Transitional Living Program means services as defined at ~~10 CCR 2505-10, §~~Section 8.516.30.

~~**8.515.2 DEFINITIONS OF SERVICES PROVIDED**~~

~~Adult Day Services means services as defined at Section 8.515.70~~

~~Behavioral Programming and Education means services as defined at Section 8.516.40.~~

~~Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510~~

~~Counseling Services means services as defined at Section 8.516.50.~~

~~Day Treatment means services as defined at Section 8.515.80.~~

~~Electronic Monitoring Services means services as defined at Section 8.488.~~

~~Home Modification means services as defined at Section 8.493.~~

~~Independent Living Skills Training (ILST) means services as defined at Section 8.516.10.~~

~~Non-Medical Transportation Services means services as defined at Section 8.494.~~

~~Personal Care means services as defined at Section 8.489.~~

~~Respite Care means services as defined at Section 8.516.70.~~

~~Specialized Medical Equipment and Supplies means services as defined at Section 8.515.50.~~

~~Substance Abuse Counseling means services as defined at Section 8.516.60.~~

~~Supported Living means services delivered by a community-based residential program that has been certified by the Department to provide the services defined at Section 25.5-6-703(8), C.R.S.~~

~~Transitional Living Program means services as defined at Section 8.516.30.~~

8.515.3 GENERAL DEFINITIONS

Brain Injury means an injury to the brain of traumatic or acquired origin which results in residual physical, cognitive, emotional, and behavioral difficulties of a non-progressive nature and is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Nonpsychotic mental disorders due to brain damage; or
2. Anoxic brain damage; or
3. Compression of the brain; or
4. Toxic encephalopathy; or
5. Subarachnoid and/or intracerebral hemorrhage; or
6. Occlusion and stenosis of precerebral arteries; or
7. Acute, but ill-defined cerebrovascular disease; or
8. Other and ill-defined cerebrovascular disease; or
9. Late effects of cerebrovasular disease; or
10. Fracture of the skull or face; or
11. Concussion resulting in an ongoing need for assistance with activities of daily living; or
12. Cerebral laceration and contusion; or
13. Subarachnoid, subdural, and extradural hemorrhage, following injury; or
14. Other unspecified intracranial hemorrhage following injury; or
15. Intracranial injury; or
16. Late effects of musculoskeletal and connective tissue injuries; or
17. Late effects of injuries to the nervous system; or
18. Unspecified injuries to the head resulting in ongoing need for assistance with activities of daily living.

Case Management Agency means the agency designated by the Department to provide the Single Entry Point Functions detailed at Section 8.393.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Service Plan means the plan developed by the case manager in coordination with the HCBS-BI client and/or the legal guardian to identify and document the HCBS-BI services, other Medicaid services, and any other non-Medicaid services or supports that the HCBS-BI client requires in order to live successfully in the community.

8.515.4 SCOPE AND PURPOSE

The HCBS-BI program provides those services listed at Section 8.515.2.A to eligible individuals with brain injury that require long term supports and services in order to remain in a community-based setting.

8.516.10 INDEPENDENT LIVING SKILLS TRAINING

A. DEFINITIONS

1. Independent Living Skills Training (ILST) means services designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community. ILST may be provided in the client's residence, in the community, or in a group living situation.

2. ILST program service plans are plans that describe the ILST ~~designed and directed specifically to the~~ services ~~inclusions of the ILST program that~~ necessary ~~meet the need of the~~to enable the client ~~in their ability~~ to independently sustain himself/herself physically, emotionally, and economically in the community. This plan is developed with the client and the provider.

3. ILST Trainers are individuals trained in accordance with guidelines listed below tasked with providing the service inclusions to the program participant.

4. Person-Centered Care Plan is a plan of care created by a process that is driven by the individual and ~~can~~ may also include people chosen by the individual, as well as the appropriate health care professional and the designated independent living ILST trainer(s). It provides necessary information and support to the individual to ensure that the individual directs the process to the maximum extent possible. It documents client choice, establishes goals, identifies potential risks, assures health and safety, and identifies the services and supports the client needs to function safely in the community. This plan is developed by the client with the case management agency.

B. INCLUSIONS

1. Reimbursable services are limited to the assessment, training, maintenance, supervision, assistance, or continued supports of the following skills:

   a. Self-care, including but not limited to basic personal hygiene;

   b. Medication supervision and reminders;

   c. Household management;

   d. Time management skills training;

   e. Safety awareness skill development and training;

   f. Task completion skill development and training;

g. Communication skill building;

h. Interpersonal skill development;

i. Socialization, including but not limited to acquiring and developing appropriate social norms, values, and skills;

j. Recreation, including leisure and community integration activities;

k. Sensory motor skill development;

l. Benefits coordination, including activities related to the coordination of Medicaid services;

m. Resource coordination, including activities related to coordination of community transportation, community meetings, neighborhood resources, and other available public and private resources;

n. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting.

2. All Independent Living Skills Training shall be documented in the person-centered care plan. Reimbursement is limited to services described in the person-centered care plan.

C. PROVIDER CERTIFICATION STANDARDS

1. Provider agencies must have valid licensure and certification as well as appropriate professional oversight.

a. Agencies seeking to provide ILST services must have a valid Home Care Agency Class A or B license or an Assisted Living Residency license and Transitional Living Program provider certification from the Department of Public Health and Environment.

b. Agencies must employ an ILST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, brain injury, and a degree within a relevant field.

i. This coordinator must review ILST program service plans to ensure client plan is designed and directed at the development and maintenance of the program participant's ability to independently sustain himself/herself physically, emotionally, and economically in the community.

c. Any component of the ILST plan that may contain activities outside the scope of the ILST trainer must be created by the appropriate licensed professional within their scope of practice to meet the needs of the client. These professionals must ~~be in good standing~~hold licenses with no limitations ~~as~~in one of the following professions:

i. Occupational Therapist;

ii. Physical Therapist;

iii. Registered Nurse;

iv. Speech Language Pathologist;

v. Psychologist;

vi. Neuropsychologist;

vii. Medical Doctor;

viii. Licensed Clinical Social Worker;

ix. Licensed Professional Counselor.

d. Professionals providing components of the ILST plan ~~can~~ may include individuals who are members of agency staff, contracted staff, or external licensed and certified professionals who are fully aware of duties conducted by ILST trainers.

e. All ILST service plans containing any professional activity must be reviewed and authorized at least every 6 months, or as needed, by professionals responsible for oversight as referenced in 8.516.10.C.1.c~~b~~.i-ix.

2. ILST trainers must meet one of the following education, experience, or certification requirements:

a. Licensed health care professionals with experience in providing functionally based assessments and skills training for individuals with disabilities; or

b. Individuals with a Bachelor's degree and one year of experience working with individuals with disabilities; or

c. Individuals with an Associate's degree in a social service or human relations area and two years of experience working with individuals with disabilities; or

d. Individuals currently enrolled in a degree program directly related to but not limited to special education, occupational therapy, therapeutic recreation, and/or teaching with at least 3 years of experience providing services similar to ILST services; or

e. Individuals with 4 years direct care experience teaching or working with individuals with a brain injury or other cognitive disability either in a home setting, hospital setting, or rehabilitation setting.

3. The agency shall administer a series of training programs to all ILST trainers.

a. Prior to delivery of and reimbursement for any services, ILST trainers must complete the following trainings:

i. Person-centered care approaches; and

ii. HIPAA and client confidentiality; and

iii. Basics of brain injury including at a minimum;

1. Basic neurophysiology; and

2. Impact of a brain injury on an individual; and

3. Epidemiology of brain injury; and

4. Common physical, behavioral, and cognitive impairments and interactions strategies; and

5. Best practices in brain injury recovery; and

6. Screening for a history of brain injury.

iv. On-the-job coaching by an incumbent ILST trainer; and

v. Basic safety and de-escalation techniques; and

vi. Training on community and public resource availability; and

vii. Understanding of current brain injury recovery guidelines; and

viii. First aid.

b. ILST trainers must also receive ongoing training, required annually, in the following areas:

i. Cultural awareness; and

ii. Updates on brain injury recovery guidelines; and

iii. Updates on resource availability.

D. REIMBURSEMENT

1. ILST shall be ~~R~~reimbursed according to the number of units billed, with one unit equal to 15 minutes of service.~~ment shall be on an hourly basisa 15 minute basis~~. Payment may include travel time to and from the client's residence, to be billed under the same procedure code and rate as independent living services. The time billed for travel shall be listed separately from the time for service provision on each visit but must be documented on the same form. Travel time to one client's residence may not also be billed as travel time from another client's residence, as this would represent duplicate billing for the same time period.

8.516.30 TRANSITIONAL LIVING

A. DEFINITIONS

1. Transitional living means programs, which occur outside of the client's residence, designed to improve the client's ability to live in the community by provision of 24 hour services, support and supervision.

2. Program services include but are not limited to assessment, therapeutic rehabilitation and habilitation, training and supervision of self-care, medication management,

communication skills, interpersonal skills, socialization, sensory/motor skills, money management, and ability to maintain a household.

3. Extraordinary therapy needs mean, for purposes of this program, a client who requires more than three hours per day of any combination of therapeutic disciplines. This includes, but is not limited to, physical therapy, occupational therapy, and speech therapy.

B. INCLUSIONS

1. All services must be documented in an approved plan of care and be prior authorized by the ~~Department of Health Care Policy and Financing (the~~ Department~~)~~.

2. Clients must need available assistance in a milieu setting for safety and supervision and require support in meeting psychosocial needs.

3. Clients must require available paraprofessional nursing assistance on a 24 hour basis due to dependence in activities of daily living, locomotion, or cognition.

4. The per diem rate paid to transitional living programs shall be inclusive of standard therapy and nursing charges necessary at this level of care. If a client requires extraordinary therapy, additional services may be sought through outpatient services as a benefit of regular Medicaid services. The need for the Transitional Living Program service for a client must be documented and authorized individually by the Department.

C. EXCLUSIONS

1. Transportation between therapeutic tasks in the community, recreational outings, and activities of daily living is included in the per diem reimbursement rate and shall not be billed as separate charges.

2. Transportation to outpatient medical appointments is exempted from transportation restrictions noted above.

3. Room and board charges are not a billable component of transitional living services.

4. Items of personal need or comfort shall be paid out of money set aside from the client's, income, and accounted for in the determination of financial eligibility for the HCBS-BI program.

5. The duration of transitional living services shall not exceed 6 months without additional approval, treatment plan review and reauthorization by the Department.

D. CERTIFICATION STANDARDS

Transitional living programs shall meet all standards established to operate as an Assisted Living Residence according to C.R.S. 25-~~1-107~~27-104~~, et, seq~~.~~,~~

1. The Department of Public Health and Environment shall survey and license the physical facility of Transitional Living Programs.

2. Transitional living programs shall adhere to all additional programmatic, and policy requirements listed in the~~SECTIONS~~ following sections entitled POLICIES, TRAINING, DOCUMENTATION, and HUMAN RIGHTS.

3. The Department of Health Care Policy and Financing shall review and provide certification of programmatic, standards.

4. If the program holds a current Commission of the Accreditation of Rehabilitation Facilities (CARF) accreditation for the specific program for which they are seeking state certification, on-site review for initial certification may be waived. However, on-site reviews of all programs shall occur on at least a yearly basis.

5. The building shall meet all local and state fire and safety codes.

E. POLICIES

1. Clients must have sustained recent neurological damage (within 18 months) or have realized a significant, measurable, and documented change in neurological function within the past three months. This change in neurological function must have resulted in hospitalization.

2. Clients, families, medical proxies, or other substitute decision makers shall be made aware of accepting the inherent risk associated with participation in a community-based transitional living program. Examples might include a greater likelihood of falls in community outings where curbs are present.

3. Understanding that clients of transitional living programs frequently experience behavior which may be a danger to ~~themselves~~ himself/herself or others, the program will be suitably equipped to handle such behaviors without posing a significant threat to other residents or staff. The transitional living program must have written agreements with other providers, in the community who may provide short term crisis intervention to provide a safe and secure environment for a client who is experiencing severe, behavioral difficulties, or who is actively homicidal or suicidal.

4. The history of behavior problems shall not be sufficient grounds for denying access to transitional living services: however, programs shall retain clinical discretion in refusing to serve clients for whom they lack adequate resources to ensure safety of program participants and staff.

5. Upon entry into the program, discharge planning shall begin with the client and family. Transitional living programs shall work with the client and case manager to develop a program of services and support which leads to the location of a permanent residence at the completion of transitional living services.

6. Transitional living programs shall provide assurances that the services will occur in the community or in natural settings and be non-institutional in nature.

7. During daytime hours, the ratio of staff to clients shall be at least 1:3 and overnight, shall be at least 2:8. The use of contract employees, except in the case of an unexpected staff shortage during documented emergencies, is not acceptable.

8. The duration of transitional living services shall not exceed six months without additional approval, treatment plan review and re-authorization by the Department.

F. TRAINING

1. At a minimum, the program director shall have an advanced degree in a health or human service related profession plus three years experience providing direct services to

individuals with brain injury. A bachelor's degree with five years experience or similar combination of education and experience shall be an acceptable substitute for a master's level education.

2. Transitional living programs must demonstrate and document that employees providing direct care and support have the educational background, relevant experience, and/or training to meet the needs of the client. These staff members will have successfully completed a training program of at least 40 hours duration.

3. Facility operators must satisfactorily complete an introductory training course on brain injury and rules and regulations pertaining to transitional living centers prior to certification of the facility.

4. The operator, staff, and volunteers who provide direct client care or protective oversight must be trained in first aid universal precautions, emergency procedures, and at least one staff per shift shall be certified as a medication aide prior to assuming responsibilities. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

5. Training in the use of universal precautions for the control of infectious or communicable disease shall be required of all operators, staff, and volunteers. Facilities certified prior to the effective date of these rules shall have sixty days to satisfy this training requirement.

6. Staffing of the program must include at least one individual per shift who has certification as a medication aide prior to assuming responsibilities.

G. DOCUMENTATION

1. Intake information shall include a completed neuropsychological assessment, all pertinent medical documentation from impatient and outpatient therapy and a detailed social history' to identify key treatment components and the functional implication of treatment goals.

2. Initial treatment plan development and evaluations will occur within a two week period following admission.

3. Goals and objectives reference specific outcomes in the degree of personal and living independence, work productivity, and psychological and social adjustment, quality of life and degree of community participation.

4. Specific treatment modalities outlined in the treatment plan are systematically implemented with techniques that are consistent functionally based, and active throughout the day. Treatment methods will be appropriate to the goals and will be reviewed and modified as appropriate.

5. Behavioral programs shall contain specific guidelines on treatment parameters and methods.

6. All transitional services must utilize licensed psychologists win two years experience in brain injury services for the oversight of treatment plan development, implementation and revision. There shall be regular contact and meetings with the client and family. Meetings shall include written recommendations and referral suggestions, as well as information on how the family will transition and incorporate treatment modalities into the home environment.

7. Programs shall have a process verified in writing by which a client is made aware of the process for filing a grievance. Complaints by the client or family shall be handled via telephone or direct contact with the client or family.

8. Customer satisfaction surveys will be regularly performed and reviewed.

9. Records must be signed and dated by individuals providing the intervention. Daily progress notes shall be kept for each treatment modality rendered.

10. Client safety in the community will be assessed: safety status and recommendations will be documented.

11. Progress towards the accomplishment of goals is monitored and reported in objective measurable terms on a weekly basis, with formal progress notes submitted to the case manager on a monthly basis.

H. HUMAN RIGHTS

All people receiving HCBS-BI transitional living services have the following rights:

1. All Human Rights listed in 8.515.80 C. apply.

2. Every person has the right to receive and send sealed correspondence. No incoming or outgoing correspondence will be opened, delayed, or censored by the personnel of the facility.

I. REIMBURSEMENT

Providers of Transitional Living shall agree to accept the acuity-based per diem reimbursement rate established by the Department ~~of Health Care Policy and Financing~~ and will not bill the client in excess of his/her SSI payment or $400 per month, whichever is less for room and board charges.

All transitional living services shall be prior authorized through submission to the Department. A Medicaid Prior Authorization Request must be submitted with tentative goals and rationale of the need for intensive transitional living services.

Transitional living services which extend beyond six months duration must be reauthorized with treatment plan justification and shall be submitted through the reconsideration process established by the.

8.516.40 BEHAVIORAL PROGRAMMING

A. DEFINITION

Behavioral programming and education is an individually developed intervention designed to decrease/control the client's severe maladaptive behaviors which, if not modified, will interfere with the individuals ability to remain integrated in the community.

B. INCLUSIONS

1. Programs should consist of a comprehensive assessment of behaviors, development of a structured behavioral intervention plan, and ongoing training of family and caregivers for feedback about plan effectiveness and revision. Consultation with other providers may be

necessary to ensure comprehensive application of the program in all facets of the person's environment.

2. Behavioral programs may be provided in the community or in the client's residence unless the residence is a transitional living center which provides behavioral intervention as a treatment component

3. All behavioral programming must be documented in the plan of care and reauthorized after 30 units of service with the Brain Injury Program Coordinator.

C. CERTIFICATION STANDARDS

1. The program should have as its director a Licensed Psychologist who has one year of experience in providing neurobehavioral services or services to persons with brain injury or a health care professional such as a Licensed Clinical Social Worker, Registered Occupational Therapist, Registered Physical Therapist, Speech Language Pathologist, Registered Nurse or Masters level Psychologist with three years of experience in caring for persons with neurobehavioral difficulties. Behavioral specialists who directly implement the program shall have two years of related experience in the implementation of behavioral management concepts.

2. Behavioral specialists will complete a 24-hour training program dealing with unique aspects of caring for and working with individuals with brain injury if their work experience does not include at least one year of same.

D. REIMBURSEMENT

Behavioral programming must be documented on the client's care plan and prior authorized through the State Brain Injury Program Coordinator. Behavioral programming services will be paid on an hourly basis as established by the Department

8.516.50 COUNSELING

A. DEFINITIONS

Counseling services mean individualized services designed to assist the participants and their support systems to more effectively manage and overcome the difficulties and stresses confronted by people with brain injuries.

B. INCLUSIONS

1. Counseling is available to the program participant's family in conjunction with the client if they: a) have a significant role in supporting the client or b) live with or provide care to the client. “Family” includes a parent, spouse, child, relative, foster family, in-laws or other person who may have significant ongoing interaction with the waiver participant.

2. Services may be provided in the waiver participant's residence, in community settings, or in the provider's office.

3. Intervention may be provided in either a group or individual setting: however, charges for group and individual therapy shall reflect differences.

4. All counseling services must be documented in the plan of care and must be provided by individuals or agencies approved as providers of waiver services by the Department ~~of Health Care Policy and Financing~~ as directed by certification standards listed below.

5. Family training/counseling must be carried out for the direct benefit of the client of the HCBS-BI program.

6. Family training is considered an integral part of the continuity of care in transition to home and community environments. Services are directed towards instruction about treatment regimens and use of equipment specified in the plan of care, and shall include updates as may be necessary to safely maintain the individual at home.

7. Prior authorization is required after thirty visits of individual, group, family or combination of modalities have been provided. Re-authorization is submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

1. Family training is not available to individuals who are employed to care for the recipient.

D. CERTIFICATION STANDARDS

1. Professionals providing counseling services must hold the appropriate license or certification for their discipline according to state law or federal regulations and represent one of the following professional categories: Licensed Clinical Social Worker. Certified Rehabilitation Counselor. Licensed Professional Counselor, or Licensed Clinical Psychologist.

2. All professionals applying as providers of counseling services must demonstrate or document a minimum of two years experience in providing counseling to individuals with brain injury and their families.

3. Master's or doctoral level counselors who meet experiential and educational requirements but lack certification or credentialing as stated above, may submit their professional qualifications via curriculum vitae or resume for consideration.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling, Individual Counseling, and Group Counseling.

8.516.60 SUBSTANCE ABUSE COUNSELING

A. DEFINITION

Substance abuse programs are individually designed interventions to reduce or eliminate the use of alcohol and/or drugs by the water participant which, if not effectively dealt with, may interfere with the individual's ability to remain integrated in the community.

B. INCLUSIONS

1. Only outpatient individual, group, and family counseling services are available through the brain injury waiver program

2. Substance abuse services are provided in a non-residential setting and must include assessment, development of an intervention plan, implementation of the plan, ongoing education and training of the waiver participant, family or caregivers when appropriate, periodic reassessment, education regarding appropriate use of prescription medication, culturally responsive individual and group counseling, family counseling for persons if directly involved in the support system of the client, interdisciplinary care coordination meetings, and an aftercare plan staffed with the case manager.

3. Prior authorization is required after thirty visits have been provided of individual, group, or family counseling or a combination of modalities. Re-authorization requests shall he submitted to the State Brain Injury Program Coordinator.

C. EXCLUSIONS

Inpatient treatment is not a covered benefit.

D. CERTIFICATION STANDARDS

1. Substance abuse services may be provided by any agency or individual licensed or certified by the Alcohol and Drug Abuse Division (ADAD) of the Department of Human Services and jointly certified by ADAD and the Department of Health Care Policy and Financing.

2. Programs must demonstrate a fully developed plan entailing the method by which coordination will occur with existing community agencies and support programs to provide ongoing support to individuals with substance abuse problems. The program should promote training to improve the ability of the community resources to provide ongoing supports to individuals with brain injury.

3. Counselors should be certified at the Certified Addiction Counselor II level or a doctoral level psychologist with the same level of experience in substance abuse counseling. All counseling professionals within the substance abuse area shall receive specialized training prior to providing services to any individual with a brain injury or their family members. A recommended training curriculum will include a three day session combining didactic and experiential components. A test will be administered by the ADAD and the resulting certification shall be valid for a period of two years.

E. REIMBURSEMENT

Reimbursement will be on an hourly basis per modality as established by the Department. There are three separate modalities allowable under HCBS-BI counseling services including Family Counseling (if the individual is present). Individual Counseling, and Group Counseling.

8.516.70 RESPITE CARE

A. DEFINITIONS

1. Respite care means services provided to an eligible client on a short-term basis because of the absence or need for relief of those persons normally providing the care.

2. Respite care provider means a Class I nursing facility, an alternative care facility or an employee of a certified personal care agency which meets the certification standards for respite care specified below.

B. INCLUSIONS

1. A nursing facility shall provide all the skilled and maintenance services ordinarily provided by a nursing facility which are required by the individual respite client, as ordered by the physician.

C. RESTRICTIONS

1. An individual client shall be authorized for no more than a cumulative total of thirty (30) days of respite care in each certification period unless otherwise authorized by the Department. This total shall include respite care provided in both the home or in a nursing facility.

   A. A mix of delivery options is allowable as long as the aggregate amount of services is below thirty (30) days, or 720 hours, of respite care.

      1. In home respite is limited to no more than eight (8) hours ~~a day~~per day.

      2. Nursing facility respite billed on a per diem.

2. Only those portions of the facility that are Medicaid certified for nursing facility services may be utilized for respite clients.

D. CERTIFICATION STANDARDS AND PROCEDURES

1. Respite care standards and procedures for nursing facilities are as follows:

   A. The nursing facility must have a valid contract with the State as a Medicaid certified nursing facility. Such contract shall constitute automatic certification for respite care. A respite care provider billing number shall automatically be issued to all certified nursing facilities.

   B. The nursing facility does not have to maintain or hold open separately designated beds for respite clients, but may accept respite clients on a bed available basis.

   C. For each HCBS-BI respite client, the nursing facility must provide an initial nursing assessment, which will serve as the plan of care, must obtain physician treatment orders and diet orders; and must have a chart for the client. The chart must identify the client as a respite client. If the respite stay is for fourteen (14) days or longer, the MDS must be completed.

   D. An admission to a nursing facility under HCBS-BI respite does not require a new ULTC-100.2, a PASARR review, an AP-5615 form, a physical, a dietitian assessment, a therapy assessment, or lab work as required on an ordinary nursing facility admission. The MDS does not have to be completed if the respite stay is shorter than fourteen (14) days.

   E. The nursing facility shall have written policies and procedures available to staff regarding respite care clients. Such policies could include copies of these respite rules, the facility's policy regarding self-administration of medication, and any other policies and procedures which may be useful to the staff in handling respite care clients.

F. The nursing facility should obtain a copy of the ULTC-100.2 and the approved Prior Authorization Request (PAR) form from the case manager prior to the respite client's entry into the facility.

3. Individual respite care providers shall be employees of certified personal care agencies. Family members providing respite services shall meet the same competency standards as all other providers and be employed by the certified provider agency.

E. REIMBURSEMENT

1. Respite care reimbursement to nursing facilities shall be as follows:

A. The nursing facility shall bill using the facility's assigned respite provider number, and on the HCBS-BI claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the nursing facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges or the average weighted rate for administrative and health care for Class I nursing facilities in effect on July 1 of each year.

2. Respite care reimbursement to alternative care facilities shall be as follows:

A. The alternative care facility shall bill using the alternative care facility provider number, on the HCBS-BI claim form according to fiscal agent instructions.

B. The unit of reimbursement shall be a unit of one day. The day of admission and the day of discharge may both be reimbursed as full days, provided that there was at least one full twenty-four hour day of respite provided by the alternative care facility between the date of admission and the date of discharge. There shall be no other payment for partial days.

C. Reimbursement shall be the lower of billed charges; or the maximum Medicaid rate for alternative care services, plus the standard alternative care facility room and board amount prorated for the number of days of respite.

3. Individual respite providers shall bill according to an hourly rate or daily institutional rate, whichever is less.

4. The respite care provider shall provide all the respite care that is needed, and other HCBS-BI services shall not be reimbursed during the respite stay.

5. There shall be no reimbursement provided under this section for respite care in uncertified, congregate facilities.

8.517 HOME AND COMMUNITY-BASED SERVICES FOR PERSONS WITH SPINAL CORD INJURY WAIVER

8.517.1.A SERVICES PROVIDED

1. Adult Day Services
2. Complementary and Integrative Health Services
3. Consumer Directed Attendant Support Services (CDASS)
4. Electronic Monitoring
5. Home Delivered Meals
6. Home Modification
7. Homemaker Services
8. In-Home Support Services
9. Life Skills Training (LST)
10. Non-Medical Transportation
11. Peer Mentorship
12. Personal Care Services
13. Respite Care
14. Transition Setup

8.517.1.B DEFINITIONS OF SERVICES

1. Adult Day Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.491.
2. Complementary and Integrative Health Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.517.B.2.
3. Consumer Directed Attendant Support Services (CDASS) means services as defined at ~~10 CCR 2505-10, §~~Section 8.510.
4. Electronic Monitoring means services as defined at ~~10 CCR 2505-10, §~~Section 8.488.
5. Home Delivered Meals means services as defined at ~~10 CCR 2505-10, §~~Section 8.553.
6. Home Modification means services as defined at ~~10 CCR 2505-10, §~~Section 8.493.
7. Homemaker Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.490.
8. In-Home Support Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.552.
9. Life Skills Training (LST) means services as defined at ~~10 CCR 2505-10, §~~Section 8.553.
10. Non-Medical Transportation means services as defined at ~~10 CCR 2505-10, §~~Section 8.494.

11. Peer Mentorship means services as defined at ~~10 CCR 2505-10, §~~Section 8.553.

12. Personal Care Services means services as defined at ~~10 CCR 2505-10, §~~Section 8.489.

13. Respite Care means services as defined at ~~10 CCR 2505-10, §~~Section 8.492.

14. Transition Setup means services as defined at ~~10 CCR 2505-10, §~~Section 8.553.

~~**8.517.1 DEFINITIONS OF SERVICES PROVIDED**~~

~~Adult Day Services means services as defined at Section 8.491.~~

~~Complementary and Integrative Health Services means services as defined at Section 8.517.11.~~

~~Consumer Directed Attendant Support Services (CDASS) means services as defined at Section 8.510.~~

~~Electronic Monitoring means services as defined at Section 8.488.~~

~~Home Modification means services as defined at Section 8.493.~~

~~Homemaker Services means services as defined at Section 8.490.~~

~~In-Home Support Services means services as defined at Section 8.552.~~

~~Non-Medical Transportation means services as defined at Section 8.494.~~

~~Personal Care Services means services as defined at Section 8.489.~~

~~Respite Care means services as defined at Section 8.492.~~

8.517.2 GENERAL DEFINITIONS

Acupuncture means the stimulation of anatomical points on the body by penetrating the skin with thin, solid, metallic, single-use needles that are manipulated by the hands or by electrical stimulation for the purpose of bringing about beneficial physiologic and /or psychological changes.

Chiropractic Care means the use of manual adjustments (manipulation or mobilization) of the spine or other parts of the body with the goal of correcting alignment and other musculoskeletal problems.

Complementary and Integrative Health Care Plan means the plan developed prior to the delivery of Complementary and Integrative Health Services in accordance with ~~Section~~Section 8.517.11.D.

Complementary and Integrative Health Provider means an individual or agency certified annually by the Department ~~of Health Care Policy and Financing~~ to have met the certification standards listed at ~~Section~~Section 8.517.11.Denver Metro Area means the counties of Adams, Arapahoe, Denver, Douglas, and Jefferson.

Emergency Systems means procedures and materials used in emergent situations and may include, but are not limited to, an agreement with the nearest hospital to accept patients; an Automated External Defibrillator; a first aid kit; and/or suction, AED, and first aid supplies.

Individual Cost Containment Amount means the average cost of services for a comparable population institutionalized at the appropriate level of care, as determined annually by the Department.

Massage Therapy means the systematic manipulation of the soft tissues of the body, (including manual techniques of gliding, percussion, compression, vibration, and gentle stretching) for the purpose of bringing about beneficial physiologic, mechanical, and/or psychological changes.

Medical Director means an individual that is contracted with the Department ~~of Health Care Policy and Financing~~ to provide oversight of the Complementary and Integrative Health Services and the program evaluation.

Spinal Cord Injury means an injury to the spinal cord which is further defined at 8.517.2.1.

8.517.2.1 SPINAL CORD INJURY DEFINITION

A spinal cord injury is limited to the following broad diagnoses found within the most current version of the International Classification of Diseases (ICD) at the time of assessment:

1. Spinal cord injury unspecified
2. Complete lesion of spinal cord
3. Anterior cord syndrome
4. Central cord syndrome
5. Other specified spinal cord injury
6. Lumbar spinal cord injury without spinal bone injury
7. Sacral spinal cord injury without spinal bone injury
8. Cauda equina spinal cord injury without spinal bone injury
9. Multiple sites of spinal cord injury without spinal bone injury
10. Unspecified site of spinal cord injury without spinal bone injury
11. Injury to cervical nerve root
12. Injury to dorsal nerve root
13. Injury to lumbar nerve root
14. Injury to sacral nerve root
15. Injury to brachial plexus
16. Injury to lumbosacral plexus
17. Injury to multiple sites of nerve roots and spinal plexus
18. Injury to unspecified site of nerve roots and spinal plexus
19. Injury to cervical sympathetic nerve excluding shoulder and pelvic girdles

20. Injury to other sympathetic nerve excluding shoulder and pelvic girdles

21. Injury to other specified nerve(s) of trunk excluding shoulder and pelvic girdles

22. Injury to unspecified nerve of trunk excluding shoulder and pelvic girdles

23. Paraplegia

24. Paraplegia, Unspecified

25. Paraplegia, Complete

26. Paraplegia, Incomplete

27. Quadriplegia/Tetraplegia/Incomplete – unspecified

28. Quadriplegia – C1-C4/Complete

29. Quadriplegia – C1-C4/Incomplete

30. Quadriplegia – C5-C7/Complete

31. Quadriplegia – C5-C7/Incomplete

8.517.3 LEGAL BASIS

The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver is created upon authorization of a waiver of the state-wideness requirement contained in Section 1902(a)(1) of the Social Security Act (42 U.S.C. §Section 1396a); and the amount, duration, and scope of services requirements contained in Section 1902(a)(10)(B) of the Social Security Act (42 U.S.C. §Section 1396a). Upon approval by the United States Department of Health and Human Services, this waiver is granted under SectionSection 1915(c) of the Social Security Act (42 U.S.C. §Section 1396n~~). 42 U.S.C. § § 1396a and 1396n are incorporated by reference. Such incorporation, however, excludes later amendments to or editions of the referenced material. 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. Copies may be obtained at a reasonable cost or examined during regular business hours at 1570 Grant Street, Denver, CO 80203. Additionally, any incorporated material in these rules may be examined at any State depository library. This regulation is adopted pursuant to the authority in Section 25.5-1-301, C.R.S. and is intended to be consistent with the requirements of the State Administrative Procedures Act, Section 24-4-101 et seq., C.R.S. and the Colorado Medical Assistance Act, Sections 25.5-6-1301 et seq., C.R.S.~~

~~The addition of "individual" to the Complementary and Integrative Health Provider definition in section 8.517.2, the addition of hospital level of care eligibility criteria in section 8.517.5.C, the elimination of the waitlist at section 8.517.6.1, the addition of the client's residence as a service location at section 8.517.11.B.3 and all Medical Director responsibilities are contingent and shall not be in effect until the HCBS-SCI Waiver Renewal CO.0961.R01.00 has been approved by the Centers for Medicare and Medicaid Services (CMS).~~

8.517.4 SCOPE AND PURPOSE

8.517.4.A. The Home and Community-Based Services for Persons with Spinal Cord Injury (HCBS-SCI) waiver provides assistance to individuals with spinal cord injuries in the Denver Metro Area that require long term supports and services in order to remain in a community setting.

8.517.4.B. The HCBS-SCI waiver provides an opportunity to study the effectiveness of Complementary and Integrative Health Services and the impact the provision of these service may have on the utilization of other HCBS-SCI waiver and/or acute care services.

8.517.4.C. An independent evaluation shall be conducted no later than January 1, 2020 to determine the effectiveness of the Complementary and Integrative Health Services.

~~8.553 COMMUNITY TRANSITION SERVICES~~

~~8.553.1 DEFINITIONS~~

~~Authorization Request (AR) means a request submitted by the Transition Coordination Agency to the Single Entry Point agency to authorize payment for delivery of Community Transition Services.~~

~~Case Management means the assessment of a long-term care client's needs, the development and implementation of a care plan for such client, the coordination and monitoring of long-term care service delivery, the evaluation of service effectiveness, and the periodic assessment of such client's needs.~~

~~Case Management Agency means the organization selected to provide case management functions for person in need of long term care services.~~

~~Community Transition Services (CTS) means activities essential to move a client from a skilled nursing facility and establish a community-based residence.~~

~~Independent Living Core Services means information and referral services; independent living skills training; peer counseling, including cross-disability peer counseling; and individual and systems advocacy.~~

~~Transition Coordinator means a person employed by a Transition Coordination Agency to provide Transitional Case Management.~~

~~Transition Coordination Agency (TCA) means an agency that is certified by the Department to provide CTS and provides at least two Independent Living Core Services.~~

~~Transition Options Team means a group of individuals, chosen by the client and/or providing services to the client, who participate in the transition assessment and planning process.~~

~~8.553.2 BENEFITS~~

~~8.553.2.A. CTS shall only be available to clients currently residing in a skilled nursing facility or an Intermediate Care Facility-Individuals with Intellectual Disabilities (ICF-IID) who are eligible for adult Home and Community- Based Services (HCBS) waivers except the Spinal Cord Injury Waiver.~~

8.553.2.B. CTS includes transition coordination services and funds to assist the client to set-up a household.

8.553.2.C. CTS shall be provided by Transition Coordinators who are employed by Transition Coordination Agencies certified by the Department.

8.553.2.D. CTS shall be provided using procedures and guidelines provided in the Department transition coordination and intensive case management training.

8.553.2.E. The CTS household set-up assistance shall only be for the benefit of the client to set up a less restrictive living arrangement and may include the following:

1. Security deposits that are required to obtain a lease on a residence.

2. Set-up fees or deposits for utility or service access, including telephone, electricity, heating and water.

3. Essential household items and furnishings such as a bed, linens, seating, lighting, dishes, utensils and food preparation items.

4. Moving expenses required to occupy a community-based residence.

5. Health and safety assurances including a one-time pest eradication and one-time cleaning prior to occupancy.

6. A one-time purchase of food not to exceed $100.

7. Purchase of a cell phone to be used for safety monitoring.

8. First month rent.

9. Bus pass for period that covers the time period from referral to CTS to 30 days past the date of discharge from a facility described at 10 C.C.R. 2505-10, Section 8.553.2.A.

10. Computer that is determined to be medically necessary to sustain a less restrictive living arrangement. (Client is required to complete computer training prior to receiving computer).

11. Clothing that is appropriate for the community.

8.553.2.F. The cost of CTS shall not exceed the established amount per client unless otherwise authorized by the Department.

8.55.3.2.G. Items purchased through CTS, returned security deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.a. and returned deposits described at 10 C.C.R. 2505-10, Section 8.553.2.E.b. shall be the property of the client. The client may take the property with him or her in the event of a move to another residence.

8.553.3 NON-BENEFITS

8.553.3.A. CTS shall not include the following:

1. Monthly rental expenses or other ongoing periodic residential expenses.

2. Recreation, entertainment or convenience items.

3. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.E when already provided through other means.

4. Items as described in 10.C.C.R. 2505-10, Section 8.553.2.E when provided for the benefit of persons other than the client.

5. Monthly cell phone expenses.

6. Monthly bus pass expenses not described in 10 C.C.R. 2505-10, Section 8.553.2.E.i.

8.553.4 TCA QUALIFICATIONS

8.553.4.A. A TCA shall conform to all certification standards and procedures described in 10 C.C.R. 2505-10, Section 8.487, HCBS-EBD Provider Agencies.

8.553.4.B. A TCA shall meet all requirements as set forth in 10 C.C.R. 2505-10, Section 8.553.5.

8.553.5 TCA RESPONSIBILITIES

8.553.5.A. TCAs shall administer the CTS benefit.

8.553.5.B. The TCA shall perform administrative functions, including supervision of Transition Coordinators, attendance at required meetings, timely reporting, compliance with transition procedures defined by the Department with input from stakeholders, community coordination and outreach, client monitoring and on-site visits.

8.553.5.C. Staffing Requirements

1. The TCA shall ensure and document that each Transition Coordinator has completed the required Department Transition Coordinator training and has received a satisfactory proficiency rating.

2. The TCA shall ensure that each Transition Coordinator has received training in the following:

a. Knowledge of populations served by the TCA and the target population served by waivers.

b. Client interviewing and assessment skills.

c. Intervention and interpersonal communication skills.

d. Knowledge of available community resources and public assistance programs.

e. Team coordination skills.

f. Meeting facilitation skills.

3. The TCA supervisor(s), at a minimum, shall have two years supervisory experience and meet all qualifications for a Transition Coordinator.

4. The TCA supervisor shall complete the Department transition coordination supervision training.

5. Supervision of Transition Coordinators shall include, but not be limited to, the following activities:

a. Arrangement and documentation of training or skills validation testing.

b. Review of transition assessments and plans and risk mitigation plans.

c. Oversight of transition coordination activities.

d. Assessment of client's satisfaction with services.

e. Investigation of complaints regarding provision of CTS.

f. Counseling with staff on difficult cases.

g. Oversight of recordkeeping by staff.

6. Training shall be completed prior to the delivery of CTS.

8.553.5.D. The Transition Coordinator shall conduct transition activities in accordance with training, policies and procedures defined by the Department.

8.553.5.E. The Transition Coordinator shall work with the client to create and implement a transition plan agreed upon by the Transition Coordinator and the client. The Transition Coordinator and the client shall sign the transition plan to signify agreement.

1. The Transition Coordinator shall submit the signed transition plan to the client's Single Entry Point (SEP) case manager for approval prior to plan implementation.

2. The plan shall include the items needed for the client to transition to a community-based residence. If after the plan has been approved the Transition Coordinator determines additional purchases are required, the Transition Coordinator shall submit a plan revision for approval prior to the purchases.

8.553.5.F. The Transition Coordinator shall work with the client to obtain a residence and any items necessary to establish a community based residence.

8.553.5.G. The Transition Coordinator shall conduct a minimum of four on-site visits of the residence to ensure all essential furnishings, utilities, community resources and services are in place. If the Transition Coordinator finds any of the supports to be insufficient for the client to successfully live in the community, the Transition Coordinator shall correct the deficiencies. The on-site visits shall occur at the following intervals:

1. Prior to the client's discharge from the skilled nursing facility.

a. If possible, the client shall accompany the Transition Coordinator during the on-site visit prior to discharge. If the client is unable to participate in the on-site visit, the Transition Coordinator shall document the reason in the client's file.

2. The day of the move.

3. One week after the transition to ensure the client has the proper supports to continue successfully living in the community.

4. One month after the transition to ensure the client has the proper supports to continue successfully living in the community.

8.553.6 SINGLE ENTRY POINT AGENCY RESPONSIBILITIES

8.553.6.A. The SEP case manager shall perform a review to assure all items in the transition plan meet the criteria of the benefit described in 8.553.2.

1. The SEP case manager shall complete a review of the transition plan and shall notify the TCA of approval or denial of the plan within ten business days of receipt.

8.553.7 AUTHORIZATION REQUESTS

8.553.7.A. The TCA shall submit the Department prescribed Authorization Request (AR) form to the SEP case manager to authorize payment for CTS.

1. The TCA shall only submit the AR to authorize payment for any purchases or deposits after the client transitions to the community. The AR shall include a Department-approved cost report including copies of cancelled checks and copies of receipts detailing the items purchased and the cost.

a. Any expenses submitted on the cost report for items that are not included in the approved transition plan shall be considered non-allowable expenses and shall not be reimbursed.

b. The SEP case manager shall complete a review of the AR and the cost report and shall notify the TCA of approval or denial of the AR and if applicable, any non-allowable expenses on the cost report within ten business days of receipt.

2. The TCA shall only submit the AR for Transitional Case Management once the Transition Coordinator has conducted the on-site visit one month after the client's transition.

a. The SEP case manager shall approve the AR only after verifying that the client is established in a community-based residence.

b. The SEP case manager shall complete a review of the AR and shall notify the TCA of approval or denial within ten business days of receipt.

8.553.7.B. The SEP case manager shall complete a review of the AR and the cost report within ten business days of receipt. The SEP case manager shall notify the TCA of approval of the AR and if applicable, any non-allowable expenses on the cost report.

1. Approval of the AR by the SEP case manager shall authorize the TCA to submit claims to the Department's fiscal agent for authorized CTS provided during the authorized period. Payment of claims is conditional upon the client's financial eligibility on the dates of service and the TCA's use of correct billing procedures.

8.553.7.C. Incomplete ARs shall be returned to the TCA for correction within ten business days of receipt by the SEP agency.

8.553.8 REIMBURSEMENT

~~8.553.8.A. The TCA shall conform to all reimbursement procedures described in 10 C.C.R. 2505-10, Section 8.487.200 Provider Reimbursement.~~

~~8.553.8.B. Payment for CTS shall be the lower of the billed charges or the maximum rate of reimbursement.~~

~~8.553.8.C. The cost of Transitional Case Management shall be reimbursed by one unit of service completed when the client is established in a community-based residence as verified by the SEP case manager.~~

~~8.553.8.D. Reimbursement shall be made only for items listed on the transition plan with an accompanying receipt.~~

8.553 ~~HOME DELIVERED MEALS,~~ LIFE SKILLS TRAINING, HOME DELIVERED MEALS, PEER MENTORSHIP, & TRANSITION SETUP SERVICES

8.553.1 GENERAL DEFINITIONS

A. Case Management means the assessment of an individual receiving long-term services and supports' needs, the development and implementation of a service 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.

B. Case Management Agency (CMA) means a public or private, not-for-profit or for-profit agency that meets all applicable state and federal requirements and is certified by the Department to provide case management services for Home and Community Based Services waivers pursuant to ~~section~~Sections 25.5-10-209.5 and Section ~~CRS~~ 25.5-6-106, C.R.S, and pursuant to a provider participation agreement with the ~~state department~~Department.

C. Community risk level means the potential for a client living in a community-based arrangement to require emergency services, to be admitted to a hospital or nursing facility, ~~be~~ evicted from their home or ~~be~~ involved with law enforcement due to identified risk factors.

D. Department means the Colorado Department of Health Care Policy and Financing, the single State Medicaid agency.

E. Home and Community Based Services (HCBS) Waivers means services and supports provided through a waiver authorized in §Section 1915(c) of the Social Security Act, 42 U.S.C. §Section 1396n(c) and provided in community settings to a client who requires 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).

F. Home Delivered Meals means nutritional counseling, planning, preparation, and delivery of meals to clients who have dietary restrictions or specific nutritional needs, are unable to prepare their own meals, and have limited or no outside assistance.

G. Institutional Setting means~~:~~ an i~~I~~nstitution~~s~~ or institution-like setting~~s~~, including a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), Regional Center or Home and Community Based ~~S~~setting that is operated by the state.

H. Life Skills Training (LST) means individualized training designed and directed with the client to develop and maintain ~~their~~his/her ability to independently sustain ~~themselves~~himself/herself—physically, emotionally, socially and economically —in the community. LST may be provided in the client's residence, in the community, or in a group living situation.

I. Life Skills Training ~~(LST)~~ program service plan~~s~~ is a~~are~~ plan~~s~~ ~~designed and inclusive of~~that describes the type of services that will be provided as part of the LST ~~service~~, and the~~to include~~ scope, frequency, and duration of services~~, that~~ necessary to meet the ~~need of the client~~client's needs, enabling the client ~~in their ability~~ to independently sustain himself/herself physically, emotionally, socially, and economically in the community. This plan must be~~is~~ developed with input from the client and the provider.

J. Nutritional Meal Plan is a plan consisting of the complete nutritional regimen that the Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) recommends to the individual for overall health and wellness, and shall include additional recommendations outside of the Medicaid-authorized meals for additional nutritional support and education.

K. Peer Mentorship means support 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 examples, and modeling successful community living and problem-solving.

L. Service Plan means the written document that ~~specifies identified and needed~~identifies approved services, ~~to include~~including Medicaid and non-Medicaid services, regardless of funding source, necessary to assist a client to remain safely in the community and developed in accordance with the D~~d~~epartment rules.

M. Transition Setup Authorization Request Form is a ~~formal~~ document ~~delineating and requesting~~ used to request ~~the~~ authorization ~~of~~for delivery ~~payment for the~~of items and/or services required for the transition set up to occur. This document must be~~is~~ submitted to and approved by the Case Management Agency in order for the provider to receive payment.

N. Transition Setup means coordination and coverage of one-time, non-recurring expenses necessary for a member to establish a basic household upon transitioning from a nursing facility, Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or Regional Center to a community living arrangement that is not operated by the state.

8.553.2 SERVICE ACCESS AND AUTHORIZATION

A. To establish eligibility for Life Skills Training, Home Delivered Meals, or Peer Mentorship, the client must satisfy two sets of criteria: general criteria for accessing any of the three services, and criteria unique to each particular service. The client's Case Manager must not authorize Life Skills Training, Home Delivered Meals, or Peer Mentorship to continue for more than 365 days. The Department, in its sole discretion, may grant an exception based on extraordinary circumstances:

1. To be eligible for Life Skills Training, Home Delivered Meals, or Peer Mentorship, the client must satisfy the following general criteria:

i. The client is transitioning from an institutional setting to a home and community based setting; or from any change in life circumstance; and

ii. The client demonstrates a need to develop or sustain independence to live or remain in the community upon their transitioning; and

iii. The client demonstrates that they need the service to establish community supports or resources where they may not otherwise exist.

~~Life Skills Training (LST), Home Delivered Meals, and Peer Mentorship support a member to develop or sustain independence through change of circumstance, such as:~~

~~Establishment of specific community supports where they may not otherwise exist; or~~

~~The Member would be at risk of homelessness without these services; or~~

~~The need demonstrates risk to health or safety or a risk of moving to a nursing facility,~~

~~Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID), or~~

~~Regional Center; or~~

~~Following an absence from the community.~~

~~Services may not be authorized beyond 365 days from initial service provi~~
~~Exceptions will be granted based on extraordinary circumstances.~~

~~To be eligible for Life Skills Training, Home Delivered Meals, and Peer Mentorship,access a specific Service,~~ the client must participate in an assessment and satisfy the ~~demonstrate a need by meeting the~~ criteria unique to each particular service the client wishes to access. ~~respective service's additional criteria. Services and their respective additional criteria are~~:

1. To obtain approval for Life Skills Training ~~(LST), defined in 10 CCR 2505-10, § 8.553.3,~~ the client must demonstrate the following needs, which must be ~~an assessed need,~~ documented in the client's Service Plan~~, for which the client demonstrates the following~~:

    a. The client demonstrates a need for training designed and directed with the member to develop and maintain ~~their~~his/her ability to sustain ~~themselves~~himself/herself physically, emotionally, socially and economically in the community;

    b. The client identifies skills for which training is needed and demonstrates that without the skills, the client risks ~~their~~his/her health, safety, or ability to live in the community;

    c. The client demonstrates that without training ~~they~~he/she could not develop the skills needed;

    d. The client demonstrates that with training he/she~~they~~ has~~ve~~ ability to acquire these skills or services necessary within 365 days.

    LST is available in the ~~Department's~~ HCBS-CMHS Waiver under ~~Department's rule at 10 CCR 2505-10,~~ §Section 8.509.12.A.12, the HCBS-EBD Waiver under ~~10 CCR 2505-10,~~ §Section 8.485.31.M~~0~~; the HCBS-SCI Waiver under ~~10 CCR 2505-10,~~ §Section 8.517.1.A.13; and the HCBS-SLS Waiver under ~~10 CCR 2505-10,~~ §Section 8.500.94.A.20.

1. To ~~access~~obtain approval for Home Delivered Meals, ~~defined in 10 CCR 2505-10, § 8.553.4~~, the client must ~~participate in a needs assessment through which they~~ demonstrate a need for the service, as follows: ~~based on the following~~:

    a. The client demonstrates a need for nutritional counseling, meal planning, and preparation;

    b. The client ~~can~~ shows documented ~~special~~ dietary restrictions or specific nutritional needs;

c. The client ~~has limited or no~~lacks or has limited access to outside assistance, services, or resources through which he/she~~they~~ can access meals with the type of nutrition vital to meeting ~~their~~his/her ~~special~~ dietary restrictions or special nutritional needs;

d. The client ~~cannot~~is unable to prepare meals with the type of nutrition vital to meeting his/her~~their special~~ dietary restrictions or special nutritional needs;

e. The client's inability to access and prepare nutritious meals demonstrates a need--related risk to health, safety, or institutionalization; and

2. The assessed need is documented in the client's Service Plan as part of their acquisition process of gradually becoming capable of preparing their own meals or establishing the resources to obtain their needed meals.

3. ~~H~~Home Delivered Meals are~~is~~ available in the ~~Department's~~ HCBS-BI Waiver under ~~the Department's rule 10 CCR 2505-10, §~~Section 8.515.2.A.7; the HCBS-CMHS Waiver under ~~the Department's rule 10 CCR 2505-10, §~~Section 8.509.12.A.5; the HCBS-DD Waiver under ~~10 CCR 2505-10, §~~Section 8.500.5.A.4; the HCBS-EBD Waiver under ~~10 CCR 2505-10, §~~Section 8.485.31.E~~0~~; the HCBS-SCI Waiver under ~~10 CCR 2505-10, §~~Section 8.517.1.A.5; and the HCBS-SLS Waiver under ~~10 CCR 2505-10, §~~Section 8.500.94.A.7.

4. To obtain approval for~~access~~ Peer Mentorship, ~~defined in 10 CCR 2505-10, § 8.553.5,~~ a client must ~~participate in a needs assessment through which they~~ demonstrate ~~the need for the service based on the following~~:

a. ~~To access Peer Mentorship, a client must demonstrate~~ a need for soft skills, insight, or guidance from a peer;~~.~~

b. ~~The client must demonstrate~~ that without this service he/she~~they~~ may experience a health, safety, or institutional risk; and

c. There are no other services or resources available to meet the need.

Peer Mentorship is available in the ~~Department's~~ HCBS-BI Waiver under ~~the Department's rule 10 CCR 2505-10, §~~Section 8.515.2.A.11; the HCBS-CMHS Waiver under ~~the Department's rule 10 CCR 2505-10, §~~Section 8.509.12.A.9; the HCBS-EBD Waiver under ~~10 CCR 2505-10, §~~Section 8.485.31.J~~0~~; the HCBS-SCI Waiver under ~~10 CCR 2505-10, §~~Section 8.517.1.A.10; the HCBS-DD Waiver under ~~10 CCR 2505-10, §~~Section 8.500.5.A.6; and the HCBS-SLS Waiver under ~~10 CCR 2505-10, §~~Section 8.500.94.A.11.

8.553.3 LIFE SKILLS TRAINING (LST)

A. INCLUSIONS

1. Life Skills Training ~~(LST)~~ includes assessment, training, maintenance, supervision, assistance, or continued supports of the following skills:

a. Problem-solving;

b. Identifying and accessing mental and behavioral health services;

c. Self-care and activities of daily living;

d. Medication reminders and supervision, not ~~to include~~including medication administration;

e. Household management;

f. Time management;

g. Safety awareness;

h. Task completion;

i. Communication skill building;

j. Interpersonal skill development;

k. Socialization, including, but not limited to; acquiring and developing skills that promote healthy relationships;~~,~~ assistance with understanding social norms and values;~~,~~ and support with acclimating to the community;

l. Recreation, including leisure and community engagement;

m. Assistance with understanding and following plans for occupational or sensory skill development;

n. Accessing resources and benefit coordination, including activities related to coordination of community transportation, community meetings, community resources, housing resources, ~~activities related to the coordination of~~ Medicaid services, and other available public and private resources;

o. Financial management, including activities related to the coordination of financial management tasks such as paying bills, balancing accounts, and basic budgeting;

p. Acquiring and utilizing assistive technology when appropriate and not duplicative of training covered under other services.

All Life Skills Training shall be documented in the Life Skills Training (LST) program service plans. Reimbursement is limited to services described in the Life Skills Training (LST) program service plans.

B. LIMITATIONS AND EXCLUSIONS

1. Clients may utilize LST up to 24 units (six hours) ~~a day~~per day, for no more than 160 units (40 hours) ~~a week~~per week, for up to 365 days following the first day the service is provided.

2. LST is not to be delivered simultaneously during the direct provision of Adult Day Health, Adult Day Services, Group Behavioral Counseling, Consumer Directed Attendant Support Services (CDASS), Health Maintenance Activities, Homemaker, In Home Support Services (IHSS), Mentorship, Peer Mentorship, Personal Care, Prevocational Services,

Respite, Specialized Habilitation, Supported Community Connections, or Supported Employment.

a. ~~L may~~ LST may be provided with Non-Medical Transportation (NMT) ~~when the person providing NMT is different than the person providing LST to the client~~if the transportation of the client is part of the LST as indicated in the LST program service plan; if not part of the training, the provider may only bill for NMT if that provider is a certified NMT provider. .

b. LST may be delivered during the provision of services by ~~B~~behavioral ~~L~~line ~~S~~staff only when directly authorized by the Department ~~of Health Care Policy and Financing~~.

3. LST does not include services offered under the State Plan or other resources.

4. LST does not include services offered through other waiver services, except those that are incidental to the LST training activities or purposes, or are incidentally provided to ensure the client's health and safety during the provision of LST.

C. PROVIDER QUALIFICATIONS

1. The provider agency furnishing services to waiver clients shall abide by all general certification standards, conditions, and processes established for the client's respective waiver: HCBS-CMHS, -EBD, or -SCI waivers in ~~the Department's rule at 10 CCR 2505-10, §~~Section 8.487; HCBS-SLS waiver in ~~the Department's rule at 10 CCR 2505-10, §~~Section 8.500.98.

2. In accordance with 42 C.F.R §Section 441.301(c)(1)(vi), the LST provider, or those who have an interest in or are employed by the LST provider, must not be ~~of~~ the same provider or agency that authorizes services or develops the client's Service Plan with the client; and

3. The agency must employ an LST coordinator with at least 5 years of experience working with individuals with disabilities on issues relating to life skills training, or a degree within a relevant field; and

4. The agency must ensure any component of the LST plan that may contain activities outside the scope of the LST trainer's expertise or licensure must be created by an~~the~~ appropriately licensed professional acting within ~~their~~his/her scope of practice ~~to meet the needs of the client~~.

a. The professional must ~~be~~hold a license~~d~~ ~~in good standing~~with no limitations in the scope of practice appropriate to meet the client's LST needs. The following licensed professionals are authorized to furnish LST training ~~as relevant to one of the following~~:

i. Occupational Therapist;

ii. Physical Therapist;

iii. Registered Nurse;

iv. Speech Language Pathologist;

v. Psychologist;

vi. Neuropsychologist;

vii. Medical Doctor;

viii. Licensed Clinical Social Worker

ix. Licensed Professional Counselor; or

x. Board Certified Behavior Analyst (BCBA)

b. An appropriately licensed professional providing a component(s) of the LST plan ~~can~~may be an agency staff member, contract staff member, or external licensed and certified professionals who are full aware of duties conducted by LST trainersl. ~~; and~~

~~The appropriately licensed professional must be fully aware of duties conducted by LST trainers.~~

5. An agency must maintain a Class A or B Home Care Agency License issued by the Colorado Department of Public Health and Environment if that agency chooses to provide training ~~that requires hands-on assistance with a skill listed under~~on Personal Care ~~in the client's respective waiver~~as defined in one of the following listed regulations: Personal Care in the HCBS-CMHS, -EBD, or -SCI waivers as~~is~~ defined ~~in the Department's rule~~ at ~~10 CCR 2505-10, §~~Section 8.489.10; Personal Care in the HCBS-SLS waiver as~~is~~ defined ~~in the Department's rule~~ at ~~10 CCR 2505-10, §~~Section 8.500.94.B.12~~3~~. ~~The agency's Cclass A or B Home Care Agency License must be provided and monitored by the Department of Public Health and the Environment.~~

6. The agency must employ one or more LST Trainers to directly support clients, one-on-one, by ~~through~~ designing with the client an individualized LST program service plan~~s~~ and implementing the plan~~s through~~ for the client's training ~~with the client~~.

a. An individual is qualified to be an LST trainer~~s~~ only if he/she is~~must meet one of the following education, experience, or certification requirements~~:

i. A ~~l~~Licensed health care professional~~s~~ with experience in providing functionally based assessments and skills training for individuals with disabilities; ~~or~~

ii. An ~~i~~individual~~s~~ with a Bachelor's degree and 1 year of experience working with individuals with disabilities; ~~or~~

iii. An ~~i~~individual~~s~~ with an Associate's degree in a social service or human relations area and 2 years of experience working with individuals with disabilities; ~~or~~

iv. An ~~i~~individual~~s~~ currently enrolled in a degree program directly related to ~~but not limited to~~ special education, occupational therapy, therapeutic recreation, and/or teaching with at least 3 years of experience providing services similar to LST services; ~~or~~

v. An Individuals with 4 years direct care experience teaching or working with needs of individuals with disabilities; or

vi. An individuals with 4 years of lived experience transferable to training designed and directed with the member to develop and maintain theirhis/her ability to sustain themselveshimself/herself physically, emotionally, socially and economically in the community; and the provider must ensure that this individual receives member-specific training sufficient to enable the individual to competently provide LST to the client consistent with the LST Plan and the overall Service Plan.

a) For anyone qualifying as a trainer under this criteria, the provider must ensure that the trainer receives additional member-specific training sufficient to enable him/her to competently provide LST to the client that is consistent with the LST Plan.

b. Prior to delivery of and reimbursement for any services, LST trainers must complete the following trainings:

i. Person-centered support approaches; and

ii. HIPAA and client confidentiality; and

iii. Basics of working with the population to be served; and

iv. On-the-job coaching by the provider or an an incumbent LST trainer on the provision of LST training; and

v. Basic safety and de-escalation techniques; and

vi. CTraining on community and public resource availability; and

vii. Recognizing emergencies and knowledge of emergency procedures including basic first aid, home and fire safety.

For trainers qualified through Individuals with 4 years of lived experience transferable to supporting a member in training designed and directed with the member to develop and maintain their ability to sustain themselves physically, emotionally, socially and economically in the community, the provider must ensure that the trainer receives additional member-specific training sufficient to enable the individual to competently provide LST to the client consistent with the LST Plan and the overall Service Plan.

c. The provider must insure that staff acting as LST trainers receive ongoing training within 90 days of unsupervised contact with a client, and no less than once annually, in the following areas:LST trainers must also receive ongoing training, required within 90 days of unsupervised contact and annually, in the following areas:

i. Cultural awareness; and

ii. Updates on working with the population to be served; and

iii. Updates on resource availability.

d. ~~LST trainers or those interfacing with the client must undergo~~ The provider employing an LST Trainer must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment as an LST Trainer. The provider shall not employ or contract with ~~A~~any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients. ~~shall not be employed or contracted by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department.~~ All costs related to obtaining a criminal background check shall be borne by the provider.

D. PROVIDER RESPONSIBILITI~~I~~ES

1. Life Skills Training ~~(LST)~~ trainers directly support the client ~~through~~ by designing with the client an individualized LST program service plan,~~s~~ and by implementing the plan~~s~~ through training with the client to develop and maintain ~~their~~his/her ability to independently sustain ~~themselves~~himself/herself~~—~~ physically, emotionally, socially and economically~~—~~ in the community.

2. The LST coordinator must review the client's LST program service plan to ensure it is designed ~~and directed at~~to meet~~ing~~ the needs of the client ~~in their ability~~in order to enable him/her to independently sustain ~~themselves~~himself/herself physically, emotionally, and economically in the community; and

3. The LST coordinator must share the LST program service plan with the client's providers of other HCBS services that support or implement any LST services ~~inclusions of the client's LST program that meet the need of the client in their ability to independently sustain himself/herself physically, emotionally, and economically in the community. This plan is developed with the client and the provider.~~ The LST coordinator will seek permission from the client prior to sharing ~~in entirety or portions of~~ the LST program service plan, or any portion of it, with other providers; and

4. Any component of the LST program service plan that may contain activities outside the scope of the LST trainer's scope of expertise or licensure must be created by the appropriately licensed professional within his/her~~their~~ scope of practice. ~~to meet the needs of the client. The professional must be fully aware of duties conducted by LST trainers.~~

5. All LST program service plans containing any professional activity must be reviewed and authorized monthly ~~over~~during the service period, or as needed, by professionals responsible for ~~oversight~~ oversight~~as referenced above~~.

E. DOCUMENTATION

1. All LST providers must maintain a LST program service plan that includes:

   a. Monthly skills training plans to be developed and documented; and

   b. Skills training plans that include goals, goals achieved ~~met or not met~~or failed, and progress made towards accomplishment of ~~ongoing~~ continuing goals.

All documentation, including, but not limited to, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial

records, shall be maintained according to ~~10 CCR 2505-10, §~~Section 8.130.2 and provided to supervisor(s), program monitor(s), ~~and~~ auditor(s), and CDPHE surveyor(s) upon request. The LST service plan must include~~, including~~:

i. ~~S~~The start and end time/duration of service provision; ~~and~~

ii. The ~~N~~nature and extent of service; ~~and~~

iii. A ~~D~~description of LST activities, such as accompanying clients to complicated medical appointments or to attend board, advisory and commissions meetings;~~,~~ and support ~~provided~~ with interviewing potential providers; ~~and~~

iv. Progress toward Service Plan goals and objectives; and

v. ~~P~~The provider's signature and date.

2. The LST program service plan shall be sent to the Case Management Agency responsible for the Service Plan on a monthly basis, or as requested by the Case Management Agency.

3. The LST program service plan shall be shared, with the client's ~~with~~permission, with the client's providers of other HCBS services that support or implement any service inclusions of the client's LST program that meet the needs of the client, enabling him/her ~~in their ability~~ to independently sustain himself/herself physically, emotionally, socially, and economically in the community.

F. REIMBURSEMENT

1. LST may be~~is~~ billed in 15-minute units. Clients may utilize LST up to 24 units (six hours) ~~a day~~per day, no more than 160 units (40 hours) ~~a week~~per week, ~~up to~~for up to ~~no more than~~ 365 days following the first day the service is provided.

2. Payment for LST shall be the lower of the billed charges or the maximum rate of reimbursement.

3. LST may ~~be furnished to~~include escorting clients if doing so~~it~~ is incidental to performing an authorized LST service ~~in the service definition~~. However, ~~any~~ costs for transportation ~~costs beyond~~in addition to those for accompaniment may not be billed LST services. LST providers may furnish and bill separately for transportation, provided that they meet the state's provider qualifications for transportation services.~~, whether medical transportation under the State plan or non-medical transportation under the waiver.~~

4. If accompaniment and transportation are provided through the same agency, the person providing transportation ~~and billing Non-Medical Transportation (NMT) must be different~~may not be the same person who provided ~~than the person providing~~ accompaniment as a LST benefit to the client.

~~Personal Care or Homemaker services may be furnished within the scope of~~during the ~~provision of LST in order to assist a person to train on a skill (e.g. assisting a client with mobility as a support necessary for the client to train on a particular skill); or as an adjunct to the provision of training (e.g. training a client toward a household management goal(s) by performing a homemaker tasks for the purposes of demonstrating technique or steps toward completion); however, under these circumstances, the LST provider's~~

~~incidental, adjunct provision of such services is shall not to be billedreimbursed separately for the personal care or homemaker services performed as part of LST. as the provision of a distinct additional service. Such lincidental services are factored into the rate and are accordingly intrinsic to claims for LST service provision.~~

~~:~~

8.553.4 HOME DELIVERED MEALS

A. INCLUSIONS

1. Home Delivered Meals ~~includes~~ services ~~available to clients who have dietary restrictions or specific nutritional needs, are unable to prepare their own meals, and have limited or no outside assistance; services~~ include:

   a. ~~-~~Individualized nutritional counseling and developing an individualized Nutritional Meal Plan, which specifies the client's nutritional needs, selected meal types, and instructions for meal preparation and delivery; and

   b. ~~-~~Services to implement the individualized meal plan, ~~specifically~~including the client's ~~specifications~~requirements for preparing and delivering the ~~identified nutritional~~ meals ~~to the client~~.

B. SERVICE REQUIREMENTS

~~Clients who access Home Delivered Meals must have dietary restrictions or specific nutritional needs, be unable to prepare their own meals, and have limited or no outside assistance~~.

1. The client's Service Plan~~,~~ must ~~indicates~~specifically identify: ~~the assessed need for the Home Delivered Meal services, specifically the client's need for:~~

   a. the client's need for ~~Meeting with a certified Registered Dietitian (RD) or Registered Dietitian Nutritionist (RDN) for i~~individualized nutritional counseling and developing~~ment of a~~n ~~individualized~~ Nutritional Meal Plan, which ~~specifies~~ describes the client's nutritional needs~~,~~ and selected meal types, and provides instructions for meal preparation and delivery; and

   b. the client's specifications for preparation and delivery of meals, and any other detail necessary to effectively ~~Services to~~ implement the individualized meal plan.~~, specifically the client's specifications for preparing and delivering the identified nutritional meals to the client.~~

2. The service ~~is~~must be provided in the home or community and in accordance with the client's Service Plan. All Home Delivered Meal services shall be documented in the Service Plan.

3. Clients may be ~~utilize~~approved for Home Delivered Meals ~~over a period of~~for no more than 365 days ~~following the first day the service is provided~~.

4. Meals are to be delivered up to two meals per day, with a maximum of~~r~~ 14 meals delivered ~~one day~~ per week.

5. Meals may include liquid, mechanical soft, or other medically necessary types.

6. Meals may be ethnically or culturally-tailored.

7. Meals may be delivered hot, cold, frozen, or shelf-stable, depending on the client's or caregiver's ability ~~of the client or caregiver,~~ to complete the preparation of, and properly store the meal ~~and properly store them~~.

8. ~~Delivery of Service~~Services ~~shall be done~~delivered ~~in a face-to-face manner with the client, at home or in the community, in order for~~ The p~~P~~rovider shall confirm ~~to confirmation of~~ meal ~~reception~~delivery to e~~i~~nsure the client receives the meal in a timely fashion ~~and~~, and ~~a wellness check in order~~ to ~~check~~determine whether the client is satisfied with the quality of the meal.~~, and that the client receives the designated meal in a timely fashion.~~

9. The providing agency's certified RD or RDN will check ~~-~~in with the client ~~quarterly~~no less frequently than ~~once per calendar quarte~~every 90 days~~r~~ ~~with the client~~ to ensure the meals are satisfactory, that they promote~~ing~~ the client's health, and that the service is ~~address~~meeting~~ing~~ the~~ir~~ client's needs.

10. The RD or RDN will review client's progress toward~~s~~ ~~any/all~~ the nutritional ~~health and wellness~~ goal(s) outlined in the client's~~ir~~ Service Plan ~~in conjunction with the Nutritional Meal Plan~~ no less frequently than once per calendar quarter,~~at least quarterly~~ and~~or~~ more ~~frequently~~ frequently, as needed.

11. The RD or RDN shall make changes to the Nutritional Meal Plan if the quarterly assessment results show changes are necessary or appropriate. ~~The RD or RDN will recommend any changes assessed on the Nutritional Meal Plan.~~

12. The RD or RDN will send the Nutritional Meal Plan to the Case Management Agency ~~on~~ ano less frequently than once per quarter~~ly basis~~ to ~~inform~~allow the Case Management Agency~~'s~~ to verify the plan with the client during the quarterly check-in, and to make ~~with the client and~~ corresponding updates to the Person-Centered Service plan, as needed.

C. LIMITATIONS AND EXCLUSIONS

~~The unit designation for Home Delivered Meal services is per meal. Reimbursement is limited to services described in the Service Plan.~~

1. Home Delivered Meals are not available when the ~~person~~client resides in a provider-owned or controlled setting.

2. Delivery must not constitute a full nutritional regimen; and includes no more than two meals per day or 14 meals per week~~, over the 365 days following the first day the service is provided~~.

3. I~~Excluded are i~~tems or services through which the client's need for Home Delivered Meal services can otherwise be met, including any item or service available under the State Plan, applicable HCBS waiver, or other resources are excluded.

4. Meals ~~Excluded are meals~~ not identified in the Nutritional Meal Plan or any item outside of the meals not identified in the meal plan, such as additional food items or cooking appliances are excluded.

5. Meal plans and meals provided are reimbursable ~~only available~~when they ~~for the~~ benefit of the client, only. Services provided to someone other than the client are not reimbursable.

D. PROVIDER STANDARDS

A licensed provider enrolled with Colorado Medicaid ~~is eligible~~ to provide Home Delivered Meal services ~~if:~~

1. ~~The provider is~~M~~m~~ust be a legally constituted ~~entity~~domestic or foreign business entity ~~(outside of Colorado)~~ registered with the Colorado Secretary of State Colorado ~~with~~and holding a Certificate of Good Standing to do business in Colorado.~~; and~~

2. ~~The provider~~ M~~m~~ust conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, BI, or -SCI waivers in the Department's rule at ~~10 CCR 2505-10,~~ §Section 8.487; HCBS-DD waiver in the Department's rule at ~~10 CCR 2505-10,~~ §Section 8.500.9; HCBS-SLS waiver in the Department's rule at ~~10 CCR 2505-10,~~ §Section 8.500.98.~~; and~~

3. Must hold a Retail Food license, and must maintain Food Handling licenses for staff delivering meals. All licenses must be current, with no limitations. ~~The provider shall have~~maintain all licensures required by the State of Colorado Department of public health and Environment (CDPHE) for the performance of the service or support being provided, including necessary Retail Food License and Food Handling License for Staff or, if otherwise applicable, in accordance with the requirements of the City and County municipality in which the~~is service is provided.; and~~

4. ~~As a condition of enrollment as a Home Delivered Meals Providers must~~Must maintain a ~~must have an on-staff or contracted~~ Registered Dietitian (RD) OR Registered Dietitian Nutritionist (RDN) on staff or under contract.~~; and~~

5. In accordance with 42 C.F.R §Section 441.301(c)(1)(vi), the Home Delivered Meals provider, or those who have an interest in or are employed by the provider, must not be ~~of the same provider~~the same provider or agency that provides case management to the client or that develops the client's Service Plan with the client.~~t.~~

6. The provider furnishing Home Delivered Meals services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment who would be tasked with furnishing Home Delivered Meals services. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients. All costs related to obtaining a criminal background check shall be borne by the provider.~~Staff providing direct services or those interfacing with the client must Staff providing direct services to the client must undergo a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed or contracted by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider.~~

E. DOCUMENTATION

1. The provider shall maintain documentation in accordance with ~~10 CCR 2505-10,~~ §Section 8.130 and shall provide~~d~~ documentation to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request. Required documentation includes:

a. Documentation pertaining to the provider agency, including employee files, claim submission documents, program and financial records, insurance policies, and licenses, including a Retail Food License and Food Handling License for Staff, or, if otherwise applicable, documentation of compliance and good standing with the City and County municipality in which this service is provided; and

b. Documentation pertaining to services ~~provision~~, including:

i. A Signed authorization from appropriate licensed professional for dietary restrictions or specific nutritional needs; ~~and~~

ii. ~~Consumer~~Client demographic information; ~~and~~

iii. A Meal Delivery Schedule; ~~and~~

iv. Documentation of special diet requirements; ~~and~~

v. ~~D~~A determination of the type of meal to be provided (e.g. hot, cold, frozen, shelf stable); ~~and~~

vi. A record of the ~~D~~date(s) and place(s) of service delivery; ~~and~~

vii. Monitoring and follow-up (contacting the client after meal deliver to ensure the client is satisfied with the meal); and

viii. Provision of nutrition counseling.

F. REIMBURSEMENT

1. Home Delivered Meals services are reimbursed based on the number of units of service provided, with one unit equal to one meal. ~~The unit designation for Home Delivered Meal services is per meal.~~

2. Payment for Home Delivered Meals shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the Service Plan.

8.553.5 PEER MENTORSHIP

A. INCLUSIONS

1. Peer Mentorship means support provided by peers of the client on matters of community living, including:

a. Problem-solving issues drawing from shared experience.

b. Goal Setting, self-advocacy, community acclimation and integration techniques.

~~This service is ideally provided on a face-to-face basis, but mentorship can be provided in whichever medium is most suitable to both the mentee and mentor.~~

c. Assisting with interviewing potential providers, understanding complicated health and safety issues, and participating on private and public boards, advisory groups and commissions.

d. Activities that promote interaction with friends and companions of choice.

e. Teaching and modeling of social skills, communication, group interaction, and collaboration.

f. Developing community--client relationships with the intent of building social capital that results in the expansion of opportunities to explore personal interests.

g. Assisting the person in acquiring, retaining, and improving self-help, socialization, self-advocacy, and adaptive skills necessary for community living.

h. Support for integrated and meaningful engagement and awareness of opportunities for community involvement including volunteering, self-advocacy, education options, and other opportunities identified by the individual.

i. Assisting clients to be aware of and engage in community resources.

B. LIMITATIONS AND EXCLUSIONS

1. Clients may utilize Peer Mentorship up to 24 units (six hours) ~~a day~~per day, for no more than 160 units (40 hours) ~~a week~~per week, for no more than ~~up to~~ 365-days ~~following the first day the service is provided~~.

2. ~~Excluded are s~~Services covered under the State Plan, another waiver service, or by other resources are excluded.

3. ~~Excluded are s~~Services or activities that are solely diversional or recreational in nature are excluded.

C. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Peer Mentorship services if:

a. The provider is a legally constituted domestic ~~entity~~ or foreign business entity ~~(outside of Colorado)~~ registered with the Colorado Secretary of State ~~Colorado with~~and holding a Certificate of Good Standing to do business in Colorado; and

b. The provider ~~must~~ conforms to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, BI-, or -SCI waivers in the Department's rule at ~~10 CCR 2505-10, §~~Section 8.487; HCBS-DD waiver in the Department's rule at ~~10 CCR 2505-10, §~~Section 8.500.9; HCBS-SLS waiver in the Department's rule at ~~10 CCR 2505-10, §~~Section 8.500.98; and

c. The provider has a ~~governing body that~~ is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the provider's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; and

d. The provider ~~must~~ cooperates ~~comply~~ with CDPHE ~~for~~ compliance and complaint surveys, and obeys all CDPHE policies, regulations and directives regarding licensure.

In accord with 42 CFR 441.301(c)(1)(vi), the Peer Mentorship provider, or those who have an interest in or are employed by the Peer Mentorship provider, must not be ~~of the same provider~~the same provider or agency that provides case management to the member, authorizes services for the member, or develops the client's Service Plan.

Peer Mentorship shall not be provided by a peer who receives programming from the same residential location, day program location, or employment location as the client.

2. The provider must ensure services are delivered by a peer mentor staff who:

a. Has lived experience transferable to support a member with acclimating to community living through providing them member advice, guidance, and encouragement on matters of community living, including through describing real-world experiences, encouraging the member's self-advocacy and independent living goals, and modeling strategies, skills, and problem-solving.

b. Is qualified ~~in the~~to furnish the services customized to meet the needs of the client as described in the Service Plan.

c. Has completed training from the provider agency consistent with core competencies and training standards presented to agencies by the Department at Peer Mentorship provider agency training. Core competencies are:

i. Understanding ~~of~~ b~~B~~oundaries;

ii. ~~Goal Setting, and how to work towards it~~Setting and pursuing goals;

iii. Advocacy for Independence Mindset;

iv. Understanding of Disabilities, both visible and non-visible, and how they intersect with identity; and

v. Person-Centeredness

~~The Peer Mentor or those interfacing with the client undergone a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed or contracted by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider. Is not listed in state's Health Care Abuse Registry.~~

~~Is qualified in the customized needs of the client as described in the Service Plan.~~

d. Does not receive programming from the same residential location or day program location as the client.

3. The provider of peer mentorship services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment as a Peer Mentor, and on all staff who interface with Medicaid clients. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients. All costs related to obtaining a criminal background check shall be borne by the provider.

4. The provider must ensure that no staff member having contact with clients is substantiated in the Colorado Adult Protection Services (CAPS) registry for mistreatment of an at-risk adult.

~~The Agency employing a peer mentor must have a contingency plan identified in the client's Service Plan identifying how they will respond to an emergency issue, whether medical, behavioral or natural disaster, etc.~~

D. DOCUMENTATION

1. All documentation, including but not limited to, employee files, activity schedules, licenses, insurance policies, claim submission documents and program and financial records, shall be maintained according to ~~10 CCR 2505-10, §~~Section 8.130.2 and provided to supervisor(s), program monitor(s) and auditor(s), and CDPHE surveyor(s) upon request, including:

   a. Start and end time/duration of services ~~provision; and~~

   b. Nature and extent of services; ~~and~~

   c. Mode of contact (face-to-face, telephone, other); ~~and~~

   d. Description of peer mentorship activities such as accompanying clients to complicated medical appointments or to attend board, advisory and commissions meetings, and support provided interviewing potential providers; ~~and~~

   e. Client's Response as outlined in the Peer Mentorship Manual; ~~and~~

   f. Progress toward Service Plan goals and objectives; and

   g. Provider's signature and date.

E. REIMBURSEMENT

1. Peer Mentorship services are reimbursed based on the number of units billed, with one unit equal ~~in~~ to 15 minutes of service ~~units~~.

2. Payment for Peer Mentorship shall be the lower of the billed charges or the maximum rate of reimbursement.

3. Reimbursement is limited to services described in the Service Plan

8.553.6 TRANSITION SETUP

A. SERVICE ACCESS AND AUTHORIZATION

1. To access Transition Setup, defined in ~~10 CCR 2505-10, §~~Section 8.553.1~~5~~, a client must be transitioning from an institutional setting to a community living arrangement and participate in a needs based assessment through which they demonstrate a need for the service based on the following:

    a. The client demonstrates a need for the coordination and purchase of one-time, non-recurring expenses necessary for a client to establish a basic household in the community;

    b. The need demonstrates risk to the client's health, safety, or ability to live in the community.

    c. Other services/resources to meet need are not available.

2. The client's assessed need must be documented in the client's Transition Plan and Service Plan.

3. Transition Setup is available in the Department's HCBS-BI Waiver under the Department's rule ~~10 CCR 2505-10, §~~Section 8.515.2.A.17; HCBS-CMHS Waiver under the Department's rule ~~10 CCR 2505-10, §~~Section 8.509.12.A.13; HCBS-DD Waiver under ~~10 CCR 2505-10, §~~Section 8.500.5.A.10; HCBS-EBD Waiver under ~~10 CCR 2505-10, §~~Section 8.485.31.N~~0~~; HCBS-SCI Waiver under ~~10 CCR 2505-10, §~~Section 8.517.1.A.14; and HCBS-SLS Waiver under ~~10 CCR 2505-10, §~~Section 8.500.94.A.21.

B. INCLUSIONS

1. Transition Setup assists the client by coordinating the purchase of items or services needed to establish a basic household and to ensure the home environment is ready for move-in with all applicable furnishings set ~~-~~up and ~~functionally~~ operable; and

2. Transition Setup covers the purchase of one-time, non-recurring expenses necessary for a client to establish a basic household as they transition from an institutional setting to a community setting. Allowable expenses include:

    a. Security deposits that are required to obtain a lease on an apartment or home.

    b. Setup fees or deposits to access basic utilities or services (telephone, electricity, heat, and water).

    c. Services necessary for the individual's health and safety such as pest eradication or one-time cleaning prior to occupancy.

    d. Essential household furnishings required to occupy and use a community domicile, including furniture, window coverings, food preparation items, or bed or bath linens.

    e. Expenses incurred directly from the moving, transport, provision, or assembly of household furnishings to the residence.

    f. Housing application fees and fees associated with obtaining legal and/or identification documents necessary for a housing application such as a birth certificate, state ID, or criminal background check.

C. LIMITATIONS AND EXCLUSIONS

1. Transition Setup may be used to coordinate or purchase one-time, non-recurring expenses up to 30 days post-transition.

~~Transition Setup coordination is billed in 15 minute unit increments. Transition Setup coordination is available up to 40 units per eligible member.~~

2. Transition Setup expenses must not exceed a total of $1,500 per eligible member. The Department may authorize additional funds above the $1,500 ~~unit~~ limit, not to exceed a total value of $2,000, when it is demonstrated as a necessary expense to ensure the health, safety, and welfare of the member.

3. Transition Setup does to substitute services available under the Medicaid State Plan, other waiver services, or other resources.

4. Transition Setup is not available for a transition to a living arrangement that is owned or leased by a waiver provider ~~where~~if the ~~provision of these items and services~~ services offered as Transition Setup benefits are ~~inherent to the~~ services ~~they are already providing~~furnished under the waiver.

5. Transition Setup does not include payment for room and board.

6. Transition Setup does not include rental or mortgage expenses, ongoing food costs, regular utility charges, or items that are intended for purely diversional, recreational, or entertainment purposes.

7. Transition Setup is not available for a transition to a living arrangement that does not match or exceed HUD certification criteria.

8. Transition Setup is not available when the person resides in a provider-owned or -controlled setting.

9. Transition Setup does not include appliances or items that are intended for purely diversional, recreational, or entertainment purposes (e.g. television or video equipment, cable or satellite service, computers or tablets).

D. PROVIDER STANDARDS

1. A provider enrolled with Colorado Medicaid is eligible to provide Transition Setup services if:

   a. The provider is a legally constituted ~~entity~~domestic or foreign business entity ~~(outside of Colorado)~~ registered with the Colorado Secretary of State Colorado ~~with~~and holding a Certificate of Good Standing to do business in Colorado; and

   b. The provider ~~has a governing body that~~ is legally responsible for overseeing the management and operation of all programs conducted by the provider including ensuring that each aspect of the agency's programs operates in compliance with all local, State, and federal requirements, applicable laws, and regulations; and

2. The provider must conform to all general certification standards, conditions, and processes established for the respective waiver(s) through which they are furnishing services: HCBS-CMHS, -EBD, -BI, or -SCI waivers in the Department's rule at ~~10 CCR 2505-10, §~~Section 8.487; HCBS-DD waiver in the Department's rule at ~~10 CCR 2505-10,~~

§Section 8.500.9; HCBS-SLS waiver in the Department's rule at 10 CCR 2505-10, §Section 8.500.98; and

3. In accord with 42 C.F.R §Section 441.301(c)(1)(vi), the Transition Setup provider, or those who have an interest in or are employed by the Transition Setup provider, must not be of the same providerthe same provider or agency that provides case management to the client, authorizes services for the client, or develops the client's Service Plan with the client.

4. The provider of Transition Setup services must conduct a criminal background check through the Colorado Bureau of Investigation on any person seeking employment that would involve direct contact with Medicaid clients. The provider shall not employ or contract with any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients. All costs related to obtaining a criminal background check shall be borne by the provider.Staff providing direct services to the client must undergo a criminal background check through the Colorado Bureau of Investigation. Any person convicted of an offense that could pose a risk to the health, safety, and welfare of clients shall not be employed by the provider. If the provider or prospective staff disagree with assessment of risk they are allowed to appeal the decision to the Department. All costs related to obtaining a criminal background check shall be borne by the provider.

5. The product or service to be delivered shall meet all applicable manufacturer specifications, state and local building codes, and Uniform Federal Accessibility Standards.

E. DOCUMENTATION

1. Rendering and subsequent payment for these services requiresThe provider must maintain receipts for all services and/or items procured for the client.by the Provider and These must be attached to the claim and noted on the Prior Authorization Request.in the appropriate manner.

2. Providers must submit to the Case Management Agency the minimum documentation standards of the transition process, which includes:

   a. A Transition Services Referral Form,

   b. Release of Information (confidentiality) Forms, and

   c. A Transition Setup Authorization Request Form.

3. The provider must furnish to the client a receipt for any services or durable goods purchased on the client's behalf.All purchases require receipts be provided to the client to demonstrate the client's ownership.

F. REIMBURSEMENT

1. Transition Setup coordination is reimbursed according to the number of units billed, with one unit equal to -in-15-minutes unit incrementsof service.- The maximum number of Transition Setup units eligible for reimbursement is and coordination must not exceed 40 units per eligible client.

2. Transition Setup expenses must not exceed of $1,500 per eligible client. The Department may authorize additional funds above the $1,500 limit, up to $2,000, when the client

demonstrates ~~an~~ additional needs, and ~~for which~~if the expense(s) would ensure the client's health, safety and welfare.

3. Payment for Transition Setup shall be the lower of the billed charges or the maximum rate of reimbursement.

4. Reimbursement shall be made only for items or services described in the Service plan with an accompanying receipt.

5. When Transition Setup is furnished to individuals returning to the community from an institutional setting through ~~entrance to the~~enrollment in a waiver, the costs of such services are ~~incurred and~~ billable when the person leaves the institutional setting and ~~enters~~is enrolled in the waiver.