DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning HCBS BI Incorporation by Reference cleanup, Section 8.515.1
Rule Number: MSB 19-03-29-A
Division / Contact / Phone: Health Programs Office / Russell Zigler / 303-866-5927

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 19-03-29-A, Revision to the Medical Assitance Rule concerning HCBS BI Incorporation by Reference cleanup, Section 8.515.1

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) 8.515.1, 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 language at 8.515.1 with the proposed language beginning at 8.515.1 through the end of 8.515.1. This rule is effective July 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning HCBS BI Incorporation by Reference cleanup, Section 8.515.1
Rule Number: MSB 19-03-29-A
Division / Contact / Phone: Health Programs Office / Russell Zigler / 303-866-5927

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).

   This rule removes unnecessary incorporation by reference language at 10 CCR 2505-10, Section 8.515.1, which was included in Medical Services Board (MSB) rule number MSB 18-08-21-A, adopted at the March 8, 2019 MSB meeting. This rule is a technical update to remove unnecessary incorporation by reference language and includes no substantive policy changes. For the purpose of the original rule MSB 18-08-21-A, see the statement of basis and purpose for that rulemaking.

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 USC 1396a(a)(10)(B) (2019)

   42 USC 1396n (2019)

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   24-4-103(12.5), C.R.S. (2018)

Initial Review
Proposed Effective Date

Final Adoption
Emergency Adoption

DOCUMENT #01

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning HCBS BI Incorporation by Reference cleanup, Section 8.515.1
Rule Number: MSB 19-03-29-A
Division / Contact / Phone: Health Programs Office / Russell Zigler / 303-866-5927

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.

   No classes or persons are affected by the proposed rule. The rule is a technical update to remove unnecessary incorporation by reference language. There are no costs to the proposed rule. The benefit of the proposed rule is removing unnecessary language from 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 is no quantitative or qualitative impact of the proposed rule. The rule is a technical removal of unnecessary incorporation by reference language.

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 costs to the Department or to any other agency to implement or enforce the proposed rule. No anticipated effect on state revenues. The rule is a technical removal of unnecessary incorporation by reference language.

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

   There are no costs of the propose rule. The benefit of the proposed rule is removing unnecessary incorporation by reference language. The cost of inaction is unnecessary incorporation by reference remains in rule. There are no benefits of inaction.

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

   There are no less costly or less intrusive methods for removing unnecessary incorporation by reference from rule.

DO NOT PUBLISH THIS PAGE

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 no alternative methods for removing unnecessary incorporation by reference from rule.

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~~2018). This waiver is granted by the United States Department of Health and Human Services under Section 1915(c) of the Social Security Act, 42 U.S.C. Section 1396n (~~2011~~2018). ~~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.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning General Eligibility Requirements and Verification Requirements, Sections 8.100.3.I, 8.100.4.B, and 8.100.5.B
Rule Number: MSB 19-02-12-A
Division / Contact / Phone: Eligibility Policy / Jennifer VanCleave / 303-866-6204

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 19-02-12-A
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) 8.100.3.I, 8.100.4.B, and 8.100.5.B, 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 8.100.3.I with the proposed text beginning at 8.100.3.I through the end of 8.100.3.I. Replace the current text at 8.100.4.B with the proposed text beginning at 8.100.4.B.1.a through the end of 8.100.4.B.1.a. Replace the current text at 8.100.5.B. with the proposed text beginning at 8.100.5.B.1.a through the end of 8.100.5.B.1.a. This rule is effective July 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning General Eligibility Requirements and Verification Requirements, Sections 8.100.3.I, 8.100.4.B, and 8.100.5.B
Rule Number: MSB 19-02-12-A
Division / Contact / Phone: Eligibility Policy / Jennifer VanCleave / 303-866-6204

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 proposed rule change will amend 10 CCR 2505-10 §§ 8.100.I, 8.100.4.B, and 8.100.5.B to incorporate the exceptions to the requirement to provide a Social Security Number (SSN) when applying for, or receiving Medical Assistance, as detailed in 42 C.F.R. § 435.910. In particular, 42 C.F.R. § 435.910(h) lists the following exemptions: not eligible to receive an SSN, does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 C.F.R. § 422.104, or refuses to obtain an SSN because of a well-established religious objection. Currently, § 8.100.3.I does not list any of the federally allowable exceptions to the requirement to provide an SSN, while §§ 8.100.4.B and 8.100.5.B only reference an exception to the requirement to provide an SSN due to a religious exemption. The SSN exemptions will be listed in § 8.100.3.I as part of the Additional General Eligibility Requirements to clearly indicate the rule applies to all applicants and recipients of Medical Assistance. The exemptions to be added to § 8.100.3.I will also be referenced in § 8.100.4.B and § 8.100.5.B, and additional language edits will be made to reinforce that an individual must not be required to submit an SSN if they meet one of the exemptions in federal regulations. The current paper and online applications for Medical Assistance already allow an individual to report these exceptions as a reason why an SSN is not provided on the application.

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:

   N/A

3. Federal authority for the Rule, if any:

   42 C.F.R. § 435.910(h)

4. State Authority for the Rule:

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
Section 25.5-4-205, C.R.S. (2018)

Initial Review	**[date]**	Final Adoption	**[date]**
Proposed Effective Date	**[date]**	Emergency Adoption	**[date]**

DOCUMENT #04

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Eligibility Rules Concerning General Eligibility Requirements and Verification Requirements, Sections 8.100.3.I, 8.100.4.B, and 8.100.5.B
Rule Number: MSB 19-02-12-A
Division / Contact / Phone: Eligibility Policy / Jennifer VanCleave / 303-866-6204

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.

   With the proposed rule, applicants and recipients of Medical Assistance will now see the same exceptions listed on the application reflected in rule. This will clarify who must not be required to provide an SSN to be eligible for Medical Assistance. This may remove perceived barriers to applying for and receiving Medical Assistance, particularly to the populations who do not have an SSN due to an allowable federal exception. No class of persons will bear costs of the proposed rule. The benefit of the proposed rule is to bring rule in alignment with federal regulations. The Department will also benefit from aligning rule with the current paper and online applications.

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 proposed change will update rule to include all federally allowable exceptions to the requirement to provide an SSN when applying for or receiving Medical Assistance. The Department, stakeholders, and the public will benefit from a clear list of exceptions found in the General Eligibility Requirements section of rule, and referenced in the MAGI and Non-MAGI sections. This will insure that those who do not have an SSN, but meet a federal exception to the requirement to provide one, are clearly notified that they must not be required to provide an SSN, and may potentially remove barriers to seeking Medical Assistance. The proposed rule will also ensure that individuals who meet an SSN exception will not be requested to provide an SSN, or denied for failing to supply an SSN.

   By moving the SSN exceptions to general eligibility, it is clearer that the rule applies to all applicants and recipients of Medical Assistance, regardless of the category for which they might be eligible. The Department will also benefit from the rule change by aligning rule language with current paper and online applications. The proposed language will not change the eligibility criteria for citizenship or eligible non-citizen status, as the SSN exceptions apply to all individuals.

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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 proposed rule will have no effect on costs for the Department or on other agencies. The rule is codifying existing practice, which is in alignment with federal regulation. There will be no change to eligibility determination criteria.

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

   The proposed rule updates language to align with federal regulation. There is no benefit of inaction; the cost of inaction is that there will continue to be a discrepancy between our rule and federal regulation, as well as current practice. There are no costs of action as the rule will not affect eligibility criteria. The benefit of the rule change is that it will bring rule into alignment with the Department's current practice.

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

   There are no less costly or less intrusive methods for aligning this rule to current federal regulation.

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 were no alternative methods considered for the proposed rule.

8.100.3. Medical Assistance General Eligibility Requirements

8.100.3.I. Additional General Eligibility Requirements

1. Each person for whom Medical Assistance is being requested shall furnish a Social Security Number (SSN) ~~unless they meet the an exception below is met~~; or, if one has not been issued or is unknown, shall apply for the number and submit verification of the application, unless an exception below applies. The application for an SSN shall be documented in the case record by the eligibility site. Upon receipt of the assigned SSN, the client shall provide the number to the eligibility site. This requirement does not apply to those individuals who are not requesting Medical Assistance yet appear on the application, nor does it apply to individuals applying for emergency medical services or eligible newborns born to a Medical Assistance eligible mother.

    a. An applicant's or client's refusal to furnish or apply for a Social Security Number affects the family's eligibility for assistance as follows:

        i) that person cannot be determined eligible for the Medical Assistance Program; and/or

        ii) if the person with no SSN or proof of application for SSN is the only dependent child on whose behalf assistance is requested or received, assistance shall be denied or terminated.

    b. Exception: A~~The requirement in paragraph (1) of this section does not apply to a~~n individual who ~~meets~~qualifies for any of the following exceptions must not be required to provide an SSN:

        i.) The individual is not eligible to receive an SSN; or

        ii) The individual does not have an SSN and may only be issued an SSN for a valid non-work reason in accordance with 20 CFR 422.104; or

        iii) The individual refuses to obtain an SSN because of a well-established religious objection.

2. A person who is applying for or receiving Medical Assistance shall assign to the State all rights against any other person (including but not limited to the sponsor of an alien) for medical support or payments for medical expenses paid on the applicant's or client's behalf or on the behalf of any other person for whom application is made or assistance is received.

    All appropriate clients of the Medical Assistance Program shall have the option to be referred for child support enforcement services using the form as specified by the Department.

3. A person who is applying for or receiving Medical Assistance shall provide information regarding any third party resources available to any member of the assistance unit. Third party resources are any health coverage or insurance other than the Medical Assistance Program. A client's refusal to supply information regarding third party resources may result in loss of Medical Assistance Program eligibility.

4. A person who is eligible for Medical Assistance shall be free to choose any qualified and approved participating institution, agency, or person offering care and services which are benefits of the program unless that person is enrolled in a managed care program operating under Federal waiver authority.

8.100.4 MAGI Medical Assistance Eligibility [Eff. 01/01/2014]

8.100.4.B. MAGI Category Verification Requirements

1. Minimal Verification – At minimum, applicants seeking Medical Assistance shall provide all of the following:

   a. Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, ~~Social Security Number. Members of religious groups whose faith will not permit them to obtain Social Security Numbers shall be exempt from providing a Social Security Number~~ unless they~~.~~ ~~Meet~~qualify for an exception listed in 8.100.3.I.1.b. Individuals who ~~meet~~qualify for an exception must not be required to provide an SSN~~Social Security Number~~.

   b. Verification of citizenship and identity as outlined in section 8.100.3.H under Citizenship and Identity Documentation Requirements.

   c. Earned Income: Income shall be self-attested by an applicant and verified through an electronic data source. Individuals who provide self-attestation of income must also provide a Social Security Number for wage verification purposes.

      If earned income is not or cannot be self-attested, it shall be verified by wage stubs, tax documents, written documentation from the employer stating the employee's gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

      Estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

d. Unearned income: Unearned income can be self-attested by an applicant. Certain types of unearned income, such as unemployment and survivor benefits may be verified through electronic data sources.

e. Verification of Legal Immigrant Status: Immigration status can be self-declared by an applicant applying for Medical Assistance, to determine eligibility for full Medical Assistance benefits. This declaration of legal immigration status will be verified through the Verify Lawful Presence (VLP) interface. The VLP interface connects to the Systematic Alien Verification for Entitlements (SAVE) program to verify legal immigration status. See section 8.100.3.G for a description of the VLP interface. If status cannot be verified, or if the applicant does not provide the necessary documents within the reasonable opportunity period, then the applicant's Medical Assistance application shall be terminated.

2. Additional Verification: No other verification shall be required of the client unless information is found to be questionable on the basis of fact.

3. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

4. Information that exists in another case record or in CBMS shall be used by the eligibility site to verify those factors that are not subject to change, if the information is reasonably accessible.

5. The criteria of age and relationship can be declared by the client unless questionable. If questionable, these criteria can be established with information provided from:

   a. official papers such as: a birth certificate, order of adoption, marriage license, immigration or naturalization papers; or

   b. records or statements from sources such as: a court, school, government agency, hospital, or physician.

6. Establishing that a dependent child meets the eligibility criteria of:

   a. age, if questionable requires (1) viewing the birth certificate or comparably reliable document at eligibility site discretion, and (2) documenting the source of verification in the case file and CBMS case comments;

   b. living in the home of the caretaker relative, if questionable requires (1) viewing the appropriate documents which identify the relationship, (2) documenting these sources of verification in the case file and CBMS case comments.

8.100.5. Aged, Blind, and Disabled, Long Term Care, and Medicare Savings Plan Medical Assistance General Eligibility

8.100.5.B. Verification Requirements

1. The particular circumstances of an applicant will dictate the appropriate documentation needed for a complete application. The following items shall be verified for individuals applying for Medical Assistance:

   a. ~~A~~ Social Security Number: Each individual requesting assistance on the application shall provide a Social Security Number (SSN), or each shall submit proof of an application to obtain an SSN, ~~shall be provided for each individual on the application for whom Medical Assistance is being requested, or proof shall be submitted that an application for a Social Security Number has been made. Members of religious groups whose faith will not permit them to obtain Social Security Numbers shall be exempt from providing a Social Security Number~~unless they ~~meet~~qualify for an exception listed in 8.100.3.I.1.b. Individuals who ~~meet~~qualify for an exception must not be required to provide an SSN ~~Social Security Number~~.

   b. Verification of citizenship and identity as outlined in the section 8.100.3.H under Citizenship and Identity Documentation Requirements.

   c. Earned income may be self-declared by an individual and verified by the Income and Eligibility Verification System (IEVS). Individuals who provide self-declaration of earned income must also provide a Social Security Number for wage verification purposes. If a discrepancy occurs between self-declared income and IEVS wage data reports, IEVS wage data will be used to determine eligibility. An individual may dispute IEVS wage data by submitting all wage verification for all months in which there is a wage discrepancy.

      When discrepancies arise between self-attested income and electronic data source results, the applicant shall receive every reasonable opportunity to establish his/her financial eligibility through the test for reasonable compatibility, by providing a reasonable explanation of the discrepancy, or by providing paper documentation in accordance with this section. For Reasonable Opportunity Period please see section 8.100.3.H.9.

      Income information obtained through an electronic data source shall be considered reasonably compatible with income information provided by or on behalf of an applicant in the following circumstances:

      i) If the amount attested by the applicant and the amount reported by an electronic data source are both below the applicable income standard for the requested program, that income shall be determined reasonably compatible and the applicant shall be determined eligible.

      ii) If the amount attested by the applicant is below the applicable income standard for that program, but the amount reported by the electronic data source is above, and the difference is within the reasonable compatibility threshold percentage of 10%, the income shall be determined reasonably compatible and the applicant shall be determined eligible.

      iii) If both amounts are above the applicable income standard for that program, the income shall be determined reasonably compatible, and the applicant shall be determined ineligible due to income.

      If income information provided by or on behalf of an applicant is not determined reasonably compatible with income information obtained through an electronic data source, a reasonable explanation of the discrepancy shall be requested. If the applicant is unable to provide a reasonable explanation, paper documentation shall be requested.

i) The Department may request paper documentation only if the Department does not find income to be reasonably compatible and if the applicant does not provide a reasonable explanation or if electronic data are not available.

If the applicant is self-employed, ledgers are sufficient for verification of earnings, if a ledger is not available, receipts are acceptable. The ledger included in the Medical Assistance application is sufficient verification of earnings, unless questionable. If an individual cannot provide verification through self-declaration, income shall be verified by wage stubs, written documentation from the employer stating the employees' gross income or a telephone call to an employer. Applicants may request that communication with their employers be made in writing.

As of CBMS implementation, estimated earned income shall be used to determine eligibility if the applicant/client provides less than a full calendar month of wage stubs for the application month. A single recent wage stub shall be sufficient if the applicant's income is expected to be the same amount for the month of application. Written documentation from the employer stating the employees' gross income or a telephone call to an employer, if the applicant authorizes the telephone call shall also be acceptable verification of earned income. Verification of earned income received during the month prior to the month of application shall be acceptable if the application month verification is not yet available. Actual earned income shall be used to determine eligibility if the client provides verification for the full calendar month.

d. Verification of all unearned income shall be provided if the unearned income was received in the month for which eligibility is being determined or during the previous month. If available, information that exists in another case record or verification system shall be used to verify unearned income.

e. Verification of all resources shall be provided if the resources were available to the applicant in the month for which eligibility is being determined.

Resource information that is verified through an electronic data source, such as the Asset Verification Program, shall be a valid verification. Supplemental physical verifications for the same resource is not required unless further information is needed for clarification.

f. Immigrant registration cards or papers, if applicable, to determine if the client is eligible for full Medical Assistance benefits. If an applicant does not provide this, he/she shall only be eligible for emergency Medical Assistance if they meet all other eligibility requirements.

g. Additional verification-If the requested verification is submitted by the applicant, no other additional verification shall be required unless the submitted verification is found to be questionable on the basis of fact.

h. The determination that information is questionable shall be documented in the applicant's case file and CBMS case comments.

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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 19-03-01-B, Revision to the Medical Assistance Rule concerning In-Home Support Services, Section 8.552
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) 8.552, 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). No

PUBLICATION INSTRUCTIONS*

Replace the current text beginning at 8.552.1 through the end of 8.552.9.F with the proposed text beginning at 8.552.1 through th end of 8552.9.F. This rule is effective July 30, 2019.

*to be completed by MSB Board Coordinator

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning In-Home Support Services, Section 8.552
Rule Number: MSB 19-03-01-B
Division / Contact / Phone: Benefits and Services Management / Erin Thatcher / 303-866-5788

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).

   In-Home Support Services is a service-delivery option for waiver participants. This revision adds mandatory provider training, task definitions, service inclusions, and clarification of secondary / contiguous tasks. Amending the rule will improve implementation of In-Home Support Services and provide clarity to participants, agencies, and case managers. Stakeholders have a strong interest in mandating training for this service-delivery option. Additionally, the task definitions have been added to the rule to be consistent with definitions in the regulations for other delivery options including Consumer Directed Attendant Support Services (CDASS) and Long Term Home Health (LTHH).

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:

4. State Authority for the Rule:

   25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   25.5-6-1201, C.R.S. (2017)

Initial Review **05/10/19** Final Adoption **06/14/19**
Proposed Effective Date **07/30/19** Emergency Adoption

DOCUMENT #03

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Rule concerning In-Home Support Services, Section 8.552
Rule Number: MSB 19-03-01-B
Division / Contact / Phone: Benefits and Services Management / Erin Thatcher / 303-866-5788

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.

   IHSS participants, case managers, and IHSS provider agencies will benefit from clearer service definitions. IHSS provider agencies will be required to attend training, which will be provided at no cost to providers.

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

   As a result of clarified service definitions, some participants' authorized services may change. For example, current rule language permits IHSS agencies to bill non-skilled personal care services as skilled health maintenance activities (HMA) at a higher rate. When the amendment is enacted, there may be instances in which participant's authorizations are increased or decreased in accordance with their reported needs. There may be transitions to and from other delivery options such as CDASS and LTHH.

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 has enlisted the Training and Operations Vendor to complete Provider Training as part of their existing contract with no additional costs to the state. The contract was under RFP and was awarded to the same vendor, with some associate cost savings due to change in structure from a flat fee to fee for service.

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

   The benefits of this amendment are clarified services for Stakeholders. Currently there is no required training specific to IHSS. Clients interested in IHSS will be able to transition from other service-delivery options with ease. If not approved, the Department will be unable to mandate Provider Training as a requirement for IHSS Agencies. Without action, IHSS agencies may inappropriately utilize Long Term

Home Health definitions in their implementation of IHSS, resulting in higher utilization and payment rates which do not correspond with participant need.

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

   The Department has participated in robust stakeholder engagement and has determined that a rule change is the best solution for this rapidly growing service-delivery option.

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.

   The Department has utilized training and communications to inform participants, case management, and IHSS provider agencies of rule interpretations. It was determined that for the Department and CDPHE to be able to hold provider agencies accountable for IHSS implementation, the requirements would need to be in rule.

8.552 IN-HOME SUPPORT SERVICES

8.552.1 DEFINITIONS

A. Assessment means a comprehensive evaluation with the client seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department prescribed tool to complete assessments.

B. Attendant means a person who is directly employed by an In-Home Support Services (IHSS) Agency to provide IHSS to a client and meets the qualifications as defined at Section 8.552.6.K.

C~~B~~. Authorized Representative (AR) means an individual designated by the client, or by the parent or guardian of the client receiving services, if appropriate, who has the judgment and ability to assist the client in acquiring and receiving services as defined in ~~C.R.S.~~ Section 25.5-6-1202, C.R.S.

D~~C~~. Care Plan means a written plan of care developed between the client or the client's Authorized Representative, IHSS Agency and Case Management Agency that is authorized by the Case Manager.

E~~D~~. Case Management Agency (CMA) means a public or private entity 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 §§ 25.5-10-209.5 and 25.5-6- 106, C.R.S., and has a current provider participation agreement with the Department.

F. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for the Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and the periodic reassessment of such client's needs.

G~~E~~. Extraordinary Care means a service which exceeds the range of care a Family Member would ordinarily perform in a household on behalf of a person without a disability or chronic illness of the same age, and which is necessary to assure the health and welfare of the client and avoid institutionalization.

H~~F~~. Family Member means any person related to the client by ~~virtue of~~ blood, marriage, adoption, or common law as determined by a court of law.

I~~G~~. Health Maintenance Activities means those routine and repetitive skilled health-~~-~~related tasks, which are necessary for health and normal bodily functioning, that an individual with a disability would carry out if they were physically able, or that would be carried out by Family Members or friends if they were available. These activities include ~~any excluded Personal Care tasks as defined in 10 C.C.R 2505-10 § 8.489, as well as~~ skilled tasks typically performed by a Certified Nursing Assistant (CNA) or licensed nurse that do not require the clinical assessment and judgement of a licensed nurse.

J~~H~~. Homemaker Services means general household activities provided by an Attendant in the client's primary living space ~~in the home of an eligible client~~ to maintain a healthy and safe home environment for a client, when the person ordinarily responsible for these activities is absent or unable to manage these tasks.

KI. Inappropriate Behavior means documented verbal, sexual or physical threats or abuse committed by the client or Authorized Representative toward Attendants, Case Managers, or the IHSS Agency.

LJ. Independent Living Core Services means services that advance and support the independence of individuals with disabilities and to assist those individuals to live outside of institutions. These services include but are not limited to: information and referral services, independent living skills training, peer and cross-disability peer counseling, individual and systems advocacy, transition services or diversion from nursing homes and institutions to home and community-based living, or upon leaving secondary education.

MK. In-Home Support Services (IHSS) means services that are provided in the home and in the community by an Attendant under the direction of the client or client's Authorized Representative, including Health Maintenance Activities and support for activities of daily living or instrumental activities of daily living, Personal Care services and Homemaker services.

NL. In-Home Support Services (IHSS) Agency means an agency that is certified by the Colorado Department of Public Health and Environment, enrolled in the Medicaid program and provides Independent Living Core Services.

O. Licensed Health Care Professional means a state-licensed Registered Nurse (RN) who contracts with or is employed by the IHSS Agency,

PM. Licensed Medical Professional means the primary care provider of the client, who possesses one of the following medical licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN) as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

QN. Personal Care means services which are furnished to an eligible client in the client's home to meet the client's physical, maintenance and supportive needs, when those services are not skilled Personal Care, do not require the supervision of a nurse, and do not require physician's orders.

R. Prior Authorization Request (PAR) means the Department prescribed process used to authorize HCBS waiver services before they are provided to the client, pursuant to Section 8.485.90.

8.552.2 ELIGIBILITY

8.552.2.A. To be eligible for IHSS a the client shall meet the following eligibility criteria:

1. Be enrolled in a Medicaid program approved to offer IHSS.

2. Provide a signed Physician Attestation of Consumer Capacity form at enrollment and following any change in condition stating that the client has sound judgment and the ability to self-direct care. If the client is in unstable health with an unpredictable progression or variation of disability or illness, the Physician Attestation of Consumer Capacity form shall also include a recommendation regarding whether additional supervision is necessary and if so, the amount and scope of supervision requested.

3. If a client is required by the Physicians AttestationClients who elect or are required to have an Authorized Representative or elects to have an Authorized Representative, the client must delegate appoint an Authorized Representative who has the judgment and ability to assist the client in acquiring and using services, or

a. Obtain assistance from an IHSS Agency that is able and willing to support the client as necessary to participate in IHSS.

4. Demonstrate a current need for covered Attendant support services.

8.552.2.B. IHSS eligibility for a client will end if:

1. The client is no longer enrolled in a Medicaid program approved to offer IHSS.

2. The client's medical condition deteriorates causing an unsafe situation for the client or the Attendant as determined by the client's Licensed Medical Professional.

3. The client refuses to designate an Authorized Representative or receive assistance from an IHSS Agency when the client is unable to direct their own care as documented by the client's Licensed Medical Professional on the Physician Attestation of Consumer Capacity form.

4. The client provides false information or false records.

5. The client no longer demonstrates a current need for Attendant support services.

8.552.3 ~~IHSS~~ COVERED SERVICES

8.552.3.A. Services are for the benefit of the client. Services for the benefit of other persons are not reimbursable.

8.552.3.B. Services available for eligible adults:

1. Homemaker ~~as defined at 10 C.C.R. 2505-10, § 8.490~~

2. Personal Care ~~as defined at 10 C.C.R. 2505-10, § 8.489~~

3. Health Maintenance Activities.

8.552.3.C. Services available for eligible children:

1. Health Maintenance Activities.

8.552.3.D. Service Inclusions:

1. Homemaker:

a. Routine housekeeping such as: dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas;

b. Meal preparation;

c. Dishwashing;

d. Bed making;

e. Laundry;

f. Shopping for necessary items to meet basic household needs.

2. Personal Care:

a. Eating/feeding which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;

b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling distilled water reservoirs, and moving a cannula or mask to or from the client's face;

c. Preventative skin care when skin is unbroken, including the application of non-medicated/non-prescription lotions, sprays and/or solutions, and monitoring for skin changes.

d. Bladder/Bowel Care:

i) Assisting client to and from the bathroom;

ii) Assistance with bed pans, urinals, and commodes;

iii) Changing incontinence clothing or pads;

iv) Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v) Emptying ostomy bags;

vi) Perineal care.

e. Personal hygiene:

i) Bathing including washing, shampooing;

ii) Grooming;

iii) Shaving with an electric or safety razor;

iv) Combing and styling hair;

v) Filing and soaking nails;

vi) Basic oral hygiene and denture care.

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints, and the application of artificial limbs when the client is able to assist or direct.

g. Transferring a client when the client has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the client and Attendant are fully trained in the use of the equipment and the client can direct and assist with the transfer.

h. Mobility assistance when the client has the ability to reliably balance and bear weight or when the client is independent with an assistive device.

i. Positioning when the client is able to verbally or non-verbally identify when their position needs to be changed including simple alignment in a bed, wheelchair, or other furniture.

j. Medication Reminders when medications have been preselected by the client, a Family Member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders, and:

i) Medication minders are clearly marked with the day, time, and dosage and kept in a way as to prevent tampering;

ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable to do so independently.

k. Cleaning and basic maintenance of durable medical equipment.

l. Protective oversight when the client requires supervision to prevent or mitigate disability related behaviors that may result in imminent harm to people or property.

m. Accompanying includes going with the client, as indicated on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the client may include providing one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands-on assistance when the task cannot be completed without the support of the attendant.

3. Health Maintenance Activities:

a. Skin care, when the skin is broken, or a chronic skin condition is active and could potentially cause infection, and the client is unable to apply prescription creams, lotions, or sprays independently due to illness, injury or disability. Skin care may include wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when directed by a Licensed Medical Professional.

b. Hair care including shampooing, conditioning, drying, and combing when performed in conjunction with health maintenance level bathing, dressing, or skin care. Hair care may be performed when:

i) Client is unable to complete task independently;

ii) Application of a prescribed shampoo/conditioner which has been dispensed by a pharmacy; or

iii) Client has open wound(s) or neck stoma(s).

c. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing and trimming.

d. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:

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

ii) In the presence of communicable disease;

iii) When the client is unable to participate in the task;

iv) Oral suctioning is required;

v) There is decreased oral sensitivity or hypersensitivity;

vi) Client is at risk for choking and aspiration.

e. Shaving performed when health maintenance level skin care is required in conjunction with the shaving, or:

i. The client has a medical condition involving peripheral circulatory problems;

ii. The client has a medical condition involving loss of sensation;

iii. The client has an illness or takes medications that are associated with a high risk for bleeding;

iv. The client has broken skin at/near shaving site or a chronic active skin condition.

f. Dressing performed when health maintenance level skin care or transfers are required in conjunction with the dressing, or;

i. The client is unable to assist or direct care;

ii. Assistance with the application of prescribed anti-embolic or pressure stockings is required;

iii. Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.

g. Feeding is considered a health maintenance task when the client requires health maintenance level skin care or dressing in conjunction with the task, or:

i) Oral suctioning is needed on a stand-by or intermittent basis;

ii) The client is on a prescribed modified texture diet;

iii) The client has a physiological or neurogenic chewing or swallowing problem;

iv) Syringe feeding or feeding using adaptive utensils is required;

v) Oral feeding when the client is unable to communicate verbally, non-verbally or through other means.

h. Exercise including passive range of motion. Exercises must be specific to the client's documented medical condition and require hands on assistance to complete.

i. Transferring a client when they are not able to perform transfers due to illness, injury or disability, or:

i) The client lacks the strength and stability to stand, maintain balance or bear weight reliably;

ii) The client has not been deemed independent with adaptive equipment or assistive devices by a Licensed Medical Professional;

iii) The use of a mechanical lift is needed.

j. Bowel care performed when health maintenance level skin care or transfers are required in conjunction with the bowel care, or:

i) The client is unable to assist or direct care;

ii) Administration of a bowel program including but not limited to digital stimulation, enemas, or suppositories;

iii) Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.

k. Bladder care performed when health maintenance level skin care or transfers are required in conjunction with bladder care, or;

i) The client is unable to assist or direct care;

ii) Care of external, indwelling and suprapubic catheters;

iii) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.

l. Medical management as directed by a Licensed Medical Professional to routinely monitor a documented health condition, including but not limited to: blood pressures, pulses, respiratory rate, blood sugars, oxygen saturations, intravenous or intramuscular injections

m. 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) Assistance with set-up and use of respiratory equipment

n. Bathing is considered a health maintenance task when the client requires health maintenance level skin care, transfers or dressing in conjunction with bathing.

o. Medication Assistance, which may include setup, handling and assisting the client with the administration of medications. The IHSS Agency's Licensed Health Care Professional must validate Attendant skills for medication administration and ensure that the completion of task does not require clinical judgement or assessment skills.

p. Accompanying includes going with the client, as necessary on the care plan, to medical appointments and errands such as banking and household shopping. Accompanying the client also may include providing one or more health maintenance tasks as needed during the trip. Attendant may assist with communication, documentation, verbal prompting and/or hands on assistance when the task cannot be completed without the support of the Attendant.

q. Mobility assistance is considered a health maintenance task when health maintenance level transfers are required in conjunction with the mobility assistance, or:

i) The client is unable to assist or direct care;

ii) When hands-on assistance is required for safe ambulation and the client is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or

iii) the client has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional.

r. Positioning includes moving the client from the starting position to a new position while maintaining proper body alignment, support to a client's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;

i) the client is unable to assist or direct care, or

ii) the client is unable to complete task independently.

8.552.4 CLIENT AND AUTHORIZED REPRESENTATIVE PARTICIPATION AND SELF-DIRECTION

8.552.4.A. A client or their Authorized Representative may self-direct the following aspects of service delivery:

1. Present a person(s) of their own choosing to the IHSS Agency as a potential Attendant. The client must have adequate Attendants to assure compliance with all tasks in the Care Plan.

2. Train Attendant(s) to meet their needs.

3. Dismiss Attendants who are not meeting their needs.

4. Schedule, manage, and supervise Attendants with the support of the IHSS Agency.

5. Determine, in conjunction with the IHSS Agency, the level of in-home supervision as recommended by the client's Licensed Medical Professional.

6. Transition to alternative service delivery options at any time. The Case Manager shall coordinate the transition and referral process.

7. Communicate with the IHSS Agency and Case Manager to ensure safe, accurate and effective delivery of services.

8. Request a reassessment, as described at ~~10 C.C.R. 2505-10, §~~Section 8.393.2.D, if level of care or service needs have changed.

8.552.4.B. An Authorized Representative is not allowed to be reimbursed for IHSS Attendant services for the client they represent.

8.552.4.C. If the client is required to or elects to have an Authorized Representative, the Authorized Representative shall meet the requirements:

1. Must be at least 18 years of age.

2. Must have known the client for at least two years. For children under the age of two, the Authorized Representative must have known the child for the duration of their life.

3. Has not been convicted of any crime involving exploitation, abuse, neglect, or assault on another person.

8.552.4.D. The Authorized Representative must attest to the above requirement on the Authorized Representative Designation for In-Home Support Services (IHSS) form.

8.552.4.E. IHSS clients who personally require an Authorized Representative may not serve as an Authorized Representative for another IHSS client.

8.552.4.F. The client and their Authorized Representative must adhere to IHSS Agency policies and procedures.

8.552.5 IHSS AGENCY ELIGIBILITY

8.552.5.A. The IHSS Agency must be a licensed home care agency. The IHSS Agency shall ~~conform to~~ be in compliance with all requirements ~~set forth~~ of their certification and licensure, in addition to requirements outlined at ~~10 C.C.R. 2505-10, §~~Section 8.487.

8.552.5.B. The provider agreement for an IHSS Agency may be terminated, denied, or non-renewed pursuant to ~~10 C.C.R. 2505-10, §~~Section 8.076.5.

8.552.5.C. Administrators or managers as defined at 6 CCR 1011-1 Chapter 26 shall satisfactorily complete the Department authorized training on IHSS rules and regulations prior to Medicaid certification and annually thereafter.

8.552.6 IHSS AGENCY RESPONSIBILITIES

8.552.6.A. The IHSS Agency shall assure and document that all clients are provided the following:

1. Independent Living Core Services

a. An IHSS Agency must provide a list of the full scope of Independent ~~Core~~ Living Core Services provided by the agency to each client on an annual basis. The IHSS Agency must keep a record of each client's choice to utilize or refuse these services, and document services provided~~.~~

2. Attendant training, oversight and supervision by a licensed health care professional. ~~employed by the IHSS who is at minimum a Registered Nurse (RN)~~.

3. The IHSS agency shall provide 24-hour back-up service for scheduled visits to clients at any time an Attendant is not available. At the time the Care Plan is developed the IHSS Agency shall ensure that adequate staffing is available. Staffing must include backup Attendants to ensure necessary services will be provided in accordance with the Care Plan.

8.552.6.B. The IHSS Agency shall adhere to the following:

1. If the IHSS Agency admits clients with needs that require care or services to be delivered at specific times or parts of day, the IHSS Agency shall ensure qualified staff in sufficient quantity are employed by the agency or have other effective back-up plans to ensure the needs of the client are met.

2. The IHSS Agency shall only accept clients for care or services based on a reasonable assurance that the needs of the client can be met adequately by the IHSS Agency in the individual's temporary or permanent home or place of residence.

a. There shall be documentation in the Care Plan or client record of the agreed upon days and times of services to be provided based upon the client's needs that is updated at least annually.

3. If an IHSS Agency receives a referral of a client who requires care or services that are not available at the time of referral, the IHSS Agency shall advise the client or their Authorized Representative and the Case Manager of that fact.

a. The IHSS Agency shall only admit the client if the client or their Authorized Representative and Case Manager agree the recommended services can be delayed or discontinued.

4. The IHSS Agency shall ensure orientation is provided to clients or Authorized Representatives who are new to IHSS or request re-orientation through The Department's prescribed process. Orientation shall include instruction in the philosophy, policies and procedures of IHSS and information concerning client rights and responsibilities.

5. The IHSS Agency will keep written service notes documenting the services provided at each visit.

8.552.6.C. The IHSS Agency is the legal employer of a client's Attendants and must adhere to all requirements of federal and state law, and to the rules, regulations, and practices as prescribed by The Department.

8.552.6.D. The IHSS Agency shall assist all clients in interviewing and selecting an Attendant when requested. ~~,~~ and maintain documentation of the IHSS Agency's assistance and/or the client's refusal of such assistance.

8.552.6.E. The IHSS Agency will complete an intake assessment following referral from the Case Manager. The IHSS Agency will develop a Care Plan in coordination with the Case Manager and client. Any proposed services outlined in the Care Plan that may result in an increase in authorized services and units must be submitted to the Case Manager for review. The Care Plan must be approved prior to start of services.

8.552.6.F. The IHSS Agency shall ensure that a current Care Plan is in the client's record, and that Care Plans are updated with the client at least annually or more frequently in the event of a client's change in condition. The IHSS Agency will send the Care Plan to the Case Manager for review and approval.

1. The Care Plan will include a statement of allowable Attendant hours and a detailed listing of frequency, scope and duration of each service to be provided to the client for each day and visit. The Care Plan shall be signed by the client or the client's Authorized Representative and the IHSS Agency.

   a. Secondary or contiguous tasks must be outlined on the care plan as described in Section 8.552.8.F.

2. In the event of the observation of new symptoms or worsening condition that may impair the client's ability to direct their care, the IHSS Agency, in consultation with the client or their Authorized Representative and Case Manager, shall contact the client's Licensed Medical Professional to receive direction as to the appropriateness of continued care. The outcome of that consultation shall be documented in the client's revised Care Plan, with the client and/or Authorized Representative's input and approval. The IHSS Agency will submit the revised Care Plan to the Case Manager for review and approval.

8.552.6.G. ~~The IHSS Agency shall either contract with or employ a state-licensed health care professional, who is at the minimum a Registered Nurse (RN).~~ The IHSS Agency's Llicensed Hhealth Ccare Pprofessional is responsible for the following activities:

1. Administer a skills validation test for Attendants who will perform Health Maintenance Activities. Skills validation for all assigned tasks must be completed prior to service delivery unless postponed by the client or Authorized Representative to prevent interruption in services. The reason for postponement shall be documented by the IHSS in the client's file. In no event shall the skills validation be postponed for more than thirty (30) days after services begin to prevent interruption in services.

2. Verify and document Attendant skills and competency to perform IHSS and basic client safety procedures.

3. Counsel Attendants and staff on difficult cases and potentially dangerous situations.

4. Consult with the client, Authorized Representative or Attendant in the event a medical issue arises.

5. Investigate complaints and critical incidents within ten (10) calendar days as defined in ~~10 C.C.R 2505-10 §~~Section 8.487.15.

6. Verify the Attendant follows all tasks set forth in the Care Plan.

7. Review the Care Plan and Physician Attestation for Consumer Capacity form upon initial enrollment, following any change of condition, and upon the request of the client, their Authorized Representative, or the Case Manager.

8. Provide in-home supervision for the client as recommended by their Licensed Medical Professional and as agreed upon by the client or their Authorized Representative.

8.552.6.H. At the time of enrollment and following any change of condition, the IHSS Agency will review recommendations for supervision listed on the Physician Attestation of Consumer Capacity form. This review of recommendations shall be documented by the IHSS Agency in the client record.

1. The IHSS Agency shall collaborate with the client or client's Authorized Representative to determine the level of supervision provided by the IHSS Agency's Llicensed Hhealth Ccare Pprofessional beyond the requirements set forth at C.R.S. Section 25.5-6-1203, C.R.S.

2. The client may decline recommendations by the Licensed Medical Professional for in-home supervision. The IHSS Agency must document this choice in the client record and notify the Case Manager. The IHSS Agency and their Llicensed Hhealth Ccare Pprofessional, Case Manager, and client or their Authorized Representative shall discuss alternative service delivery options and the appropriateness of continued participation in IHSS.

8.552.6.I. The IHSS Agency shall assure and document that all Attendants have received basic training in the delivery of IHSS prior to the start of services. Attendant training shall include:

1. Development of interpersonal skills focused on addressing the needs of persons with disabilities.

2. Overview of IHSS as a service-delivery option of consumer direction.

3. Instruction on basic first aid administration.

4. Instruction on safety and emergency procedures.

5. Instruction on infection control techniques, including universal precautions.

6. Mandatory reporting and critical incident reporting procedures.

7. Skills validation test for unskilled tasks assigned on the care plan.

8.552.6.J. The IHSS Agency shall allow the client or Authorized Representative to provide individualized Attendant training that is specific to their own needs and preferences.

8.552.6.K. With the support of the IHSS Agency, Attendants must adhere to the following:

1. Must be at least 18 years of age and demonstrate competency in caring for the client to the satisfaction of the client or Authorized Representative.

2. May be a Family Member subject to the reimbursement and service limitations in 10 C.C.R. 2505-10, Section 8.552.8.

3. Must be able to perform the assigned tasks on the Care Plan.

4. Shall not, in exercising their duties as an IHSS Attendant, represent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional

nurse, a registered nurse or a registered professional nurse as defined in ~~C.R.S.~~ Section 25.5-6-1203, C.R.S.

5. Shall not have had their license as a nurse or certified nurse aide suspended or revoked or their application for such license or certification denied.

8.552.6.L. The IHSS Agency shall provide functional skills training to assist clients and their Authorized Representatives in developing skills and resources to maximize their independent living and personal management of health care.

8.552.7 CASE MANAGEMENT AGENCY RESPONSIBILITIES

8.552.7.A. The Case Manager shall provide information and resources about IHSS to eligible clients, including a list of IHSS Agencies in their service area and an introduction to the benefits and characteristics of participant-directed programs.

8.552.7.B. The Case Manager will initiate a referral to the IHSS Agency of the client or Authorized Representative's choice, including an outline of approved services as determined by the Case Manager's most recent assessment. The referral must include the Physician Attestation, assessment information, and other pertinent documentation to support the development of the Care Plan.

8.552.7.C. The Case Manager must ensure that the following forms are completed prior to the approval of the Care Plan or start of services:

1. The Physician Attestation of Consumer Capacity form shall be completed upon enrollment and following any change in condition.

2. If the client requires an Authorized Representative, the Authorized Representative Designation for In-Home Support Services (IHSS) form or In-Home Support Services (IHSS) Client and Provider Agency Responsibilities form must be completed.

8.552.7.D. Upon the receipt of the Care Plan, the Case Manager shall:

1. Review the Care Plan ~~in a timely manner~~within five business days of receipt to ensure there is no disruption or delay in the start of services.

2. Ensure all required information is in the client's Care Plan and that services are appropriate given the client's medical or functional condition. If needed, request additional information from the client, their Authorized Representative, the IHSS Agency, or Licensed Medical Professional regarding services requested.

3. Review the Care Plan to ensure there is delineation for all services to be provided; including frequency, scope, and duration.

4. Review the Licensed Medical Professional's recommendation for in-home supervision as requested on the Physician Attestation of Consumer Capacity form. The Case Manager will document the status of recommendations and provide resources for services outside the scope of the client's eligible benefits.

5. Collaborate with the client or their Authorized Representative and the IHSS Agency to establish a start date for services. The Case Manager shall discontinue any services that are duplicative with IHSS.

6. Authorize cost-effective and non-duplicative services via the ~~prior authorization request (~~PAR~~)~~. Provide a copy of the PAR to the IHSS Agency in accordance with procedures established by The Department prior to the start of IHSS services.

7. Work collaboratively with the IHSS Agency, client, and their Authorized Representative to mediate Care Plan disputes following The Department's prescribed process.

   a. Case Manager will complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for denial of requested service frequency or duration, information about the client's rights to fair hearing, and appeal procedures.

8.552.7.E. The Case Manager shall ensure cost-effectiveness and non-duplication of services by:

1. Documenting the discontinuation of previously authorized agency-based care, including Homemaker, Personal Care, and long-term home health services that are being replaced by IHSS.

2. Documenting and justifying any need for additional in-home services including but not limited to acute or long-term home health services, hospice, traditional HCBS services, and private duty nursing.

   a. A client may receive non-duplicative services from multiple Attendants or agencies if appropriate for the client's level of care and documented service needs.

3. Ensuring the client's record includes documentation to substantiate all Health Maintenance Activities on the Care Plan, ~~,~~ and requesting additional information as needed.

4. Coordinating transitions from a hospital, nursing facility, or other agency to IHSS. Assisting client with transitions from IHSS to alternate services if appropriate.

5. Collaborating with the client or their Authorized Representative and the IHSS Agency in the event of any change in condition. The Case Manager shall request an updated Physician Attestation of Consumer Capacity form. The Case Manager may revise the Care Plan as appropriate given the client's condition and functioning.

6. Completing a reassessment if requested by the client as described at ~~10 C.C.R. 2505-10, §~~Section 8.393.2.D., if level of care or service needs have changed.

8.552.7.F. The Case Manager shall not authorize more than one consumer-directed program on the client's ~~prior authorization request (~~PAR~~)~~.

8.552.7.G. The Case Manager shall participate in training and consultative opportunities with The Department's Consumer-Directed Training & Operations contractor.

8.552.7.H. Additional requirements for Case Managers:

1. Contact the client or Authorized Representative once a month during the first three months of receiving IHSS to assess their IHSS management, their satisfaction with Attendants, and the quality of services received.

2. Contact the client or Authorized Representative quarterly, after the first three months of receiving IHSS, to assess their implementation of Care Plans, IHSS management, quality of care, IHSS expenditures and general satisfaction.

3. Contact the client or Authorized Representative when a change in Authorized Representative occurs , ~~,~~ and continue contact once a month for three months after the change takes place.

4. Contact the IHSS Agency semi-annually to review the Care Plan, services provided by the agency, and supervision provided. The Case Manager must document and keep record of the following:

   a. IHSS Care Plans;

   b. In-home supervision needs as recommended by the Physician;

   c. Independent Living Core Services offered and provided by the IHSS Agency; and

   d. Additional supports provided to the client by the IHSS Agency.

8.552.7.I. Start of Services

1. Services may begin only after the requirements defined at ~~10 C.C.R. 2505-10, §~~Sections 8.552.2, 8.552.6.E., 8.552.6.I., and 8.552.7.C. have been met.

2. Department review for cost-containment as defined at Sections 8.486.80 and 8.506.12 must be completed prior to issuance of the PAR to the IHSS Agency.

3~~2~~. The Case Manager shall establish a service period and submit a ~~prior authorization request (~~PAR~~)~~, providing a copy to the IHSS Agency prior to the start of services.

8.552.8 REIMBURSEMENT AND SERVICE LIMITATIONS

8.552.8.A. IHSS services must be documented on an approved IHSS Care Plan and prior authorized before any services are rendered. The IHSS Care Plan and ~~prior authorization request (~~PAR~~)~~ must be submitted and approved by the Case Manager and received by the IHSS Agency prior to services being rendered. Services rendered in advance of approval and receipt of these documents are not reimbursable.

8.552.8.B. IHSS Personal Care services must comply with the rules for reimbursement set forth at ~~10 C.C.R. 2505-10 §~~Section 8.489.50. IHSS Homemaker services must comply with the rules for reimbursement set forth at ~~10 C.C.R. 2505-10 §~~Section 8.490.5.

8.552.8.C. Family Members are authorized to provide only Personal Care services or Health Maintenance Activities for eligible adults and Health Maintenance Activities for eligible children.

8.552.8.D. Services rendered by an Attendant who shares living space with the client or Family Members are reimbursable only when there is a determination by the Case Manager, made prior to the services being rendered, that the services meet the definition of Extraordinary Care.

8.552.8.E. Family Members shall not be reimbursed for more than forty (40) hours of Personal Care services in a seven (7) day period.

8.5522.8.F. Health Maintenance Activities may include related Personal Care and/or Homemaker services if such tasks are completed in conjunction with the Health Maintenance Activity and are secondary or contiguous to the Health Maintenance Activity.

a. Secondary means in support of the main task(s). Secondary tasks must be routine and regularly performed in conjunction with a Health Maintenance Activity. There must be documented evidence that the secondary task is necessary for the health and safety of the client. Secondary tasks do not add units to the care plan.

b. Contiguous means before, during or after the main task(s). Contiguous tasks must be completed before, during, or after the Health Maintenance Activity. There must be documented evidence that the contiguous task is necessary for the health and safety of the client. Contiguous tasks do not add units to the care plan.

c. The IHSS Agency shall not submit claims for Health Maintenance Activities when only Personal Care and/or Homemaking services are completed. ~~Health Maintenance Activities may include related Personal Care and Homemaker services if such tasks are completed during the Health Maintenance visit and are secondary and contiguous to the Health Maintenance Activity.~~

8.552.8.G. Restrictions on allowable Personal Care units shall not apply to parents who provide Attendant services to their eligible adult children under In-Home Support Services as set forth at ~~10 C.C.R. 2505-10 §~~Section ~~Section~~ 8.485.204.D.

8.552.8.H. The IHSS Agency shall not submit claims for services missing documentation of the services rendered, for services which are not on the Care Plan, or for services which are not on an approved PAR. The IHSS Agency shall not submit claims for more time or units than were required to render the service regardless of whether more time or units were prior authorized. Reimbursement for claims for such services is not allowable.

8.522.8.I. The IHSS Agency shall request a reallocation of previously authorized service units for 24-hour back-up care prior to submission of a claim.

8.552.8.J. Services by an Authorized Representative to represent the client are not reimbursable. IHSS services performed by an Authorized Representative for the client that they represent are not reimbursable.

8.552.8.K. An IHSS Agency shall not be reimbursed for more than twenty-four ~~24~~ hours of IHSS service in one day by an Attendant for one or more clients collectively.

8.552.8.L. A client cannot receive IHSS and Consumer Directed Attendant Support Services (CDASS) at the same time.

8.552.8.M. Independent Living Core Services, attendant training, and oversight or supervision provided by the IHSS Agency's L~~l~~icensed H~~h~~ealth C~~c~~are P~~p~~rofessional are not separately reimbursable. No additional compensation is allowable for IHSS Agencies for providing these services.

8.552.8.N. Travel time shall not be reimbursed.

8.552.8.O. Companionship is not a benefit of IHSS and shall not be reimbursed.

8.552.9 DISCONTINUATION AND TERMINATION OF IN-HOME SUPPORT SERVICES

8.552.9.A. A client may elect to discontinue IHSS or use an alternate service-delivery option at any time.

8.552.9.B. A client may be discontinued from IHSS when equivalent care in the community has been secured.

8.552.9.C. The Case Manager may terminate a client's participation in IHSS for the following reasons:

1. The client or their Authorized Representative fails to comply with IHSS program requirements as defined in ~~10 C.C.R. 2505-10 §~~Section 8.552.4, or

2. A client no longer meets program criteria, or

3. The client provides false information, false records, or is convicted of fraud, or

4. The client or their Authorized Representative exhibits Inappropriate Behavior and The Department has determined that the IHSS Agency has made adequate attempts at dispute resolution and dispute resolution has failed.

a. The IHSS Agency and Case Manager are required to assist the client or their Authorized Representative to resolve the Inappropriate Behavior, which may include the addition of or a change of Authorized Representative. All ~~and to document all~~ attempts to resolve the Inappropriate Behavior must be documented prior to notice of termination~~.~~

8.552.9.D. When an IHSS Agency discontinues services, the agency shall give the client and the client's Authorized Representative written notice of at least thirty ~~30~~ days. Notice shall be provided in person, by certified mail or another verifiable-receipt service. Notice shall be considered given when it is documented that the client or Authorized Representative has received the notice. The notice shall provide the reason for discontinuation. A copy of the 30-day notice shall be given to the Case Management Agency.

1. Exceptions will be made to the requirement for advanced notice when the IHSS Agency has documented that there is an immediate threat to the client, IHSS Agency, or Attendants.

2. Upon IHSS Agency discretion, the agency may allow the client or their Authorized Representative to use the 30-day notice period to address conflicts that have resulted in discontinuation.

8.552.9.E. If continued services are needed with another agency, the current IHSS Agency shall collaborate with the Case Manager and client or their Authorized Representative to facilitate a smooth transition between agencies. The IHSS Agency shall document due diligence in ensuring continuity of care upon discharge as necessary to protect the client's safety and welfare.

8.552.9.F. In the event of discontinuation or termination from IHSS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the client or the Authorized Representative with the reasons for termination, information about the client's rights to fair hearing, and appeal procedures. Once notice has been given, the client or Authorized Representative may contact the Case Manager for assistance in obtaining other home care services or additional benefits if needed.

DO NOT PUBLISH THIS PAGE

Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports Rule Concerning Consumer Directed Attendant Support Services, Section 8.510
Rule Number: MSB 18-09-18-A
Division / Contact / Phone: Long Term Services and Supports / Rhyann Lubitz / (303) 866-3641

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 18-09-18-A, Revision to the Medical Assistance Long-Term Services and Supports Rule Concerning Consumer Directed Attendant Support Services, Section 8.510

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) 8.510, 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 8.510 with the proposed text beginning at 8.510.1 through the end of 8.510.18.D. This rule is effective July 30, 2019.

*to be completed by MSB Board Coordinator

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Title of Rule: Revision to the Medical Assistance Long-Term Services and Supports Rule Concerning Consumer Directed Attendant Support Services, Section 8.510
Rule Number: MSB 18-09-18-A
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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).

   With this rulemaking, the Department is clarifying roles and responsibilities of Case Management Agencies, clients, Authorized Representatives and Financial Management Service vendors. The rule change identifies additional services which are currently performed as health maintenance activities in Consumer Directed Attendant Support Services (CDASS). The Department is also identifying services that may be participant-directed under the Home and Community Based Supported Living Services (HCBS-SLS) waiver. The Department is identifying service limitations for attendant support to ensure participants who are directing and managing their own care are aware when attendant services cannot be performed for reimbursement. The Department is also implementing a monthly service utilization limit to allow a participant flexibility in managing their services while creating measures to limit premature depletion of funds that can create a hardship in receiving future services.

   This rule change is necessary to ensure the rule encompasses services allowed in CDASS as well as roles and responsibilities of all entities involved with CDASS.

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 U.S.C. §1396n(c)

4. State Authority for the Rule:

   Sections 25.5-1-301 through 25.5-1-303, C.R.S. (2018);
   C.R.S. 25.5-6-1101

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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.

   Individuals and organizations affected by the proposed rule will be clients, Case Managers, and Financial Management Services vendors. Clients utilizing CDASS will continue to receive services with increased support and clarity on roles and responsibilities. Clients will continue to have the flexibility to direct and manage their CDASS monthly Allocation with limitations on expenditures that exceed the monthly Allocation. The Department contracts with Financial Management Service (FMS) vendors to manage payment for services for CDASS.

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

   In terms of qualitative impact, the proposed rule will bring increased structure to the CDASS delivery option and prevent premature depletion of funds from a client's annual Allocation that can impact the ability to receive Attendant services.

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 are no probable additional costs to the Department for implementation and enforcement of this proposed rule. The Department contracts with FMS vendors, Case Management Agencies and a Training and Operations Vendor to implement changes to CDASS.

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

   There are numerous benefits of the proposed rule. The proposed changes bring clarity to the roles of Case Management Agencies, clients and Authorized Representatives. The rule also provides additional clarification on health maintenance tasks performed by an Attendant. The Department is making these

clarifications to benefit our CDASS clients and decrease confusion or risk of error. Changes to the rule to prevent premature depletion of funds from client service utilization is necessary to ensure access to services and sound stewardship of resources. There are no costs associated with the proposed rule, and there are no benefits of inaction.

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

   The Department will not experience costs associated with this rule change. There are no less intrusive methods to carry out these changes, because alternative methods would have resulted in increased costs or decreased client control over services.

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.

   The Department considered utilizing technical assistance with Case Management Agencies and training to clarify roles and responsibilities. Ultimately, it was determined that having clearly defined rules for allowable services and case management tasks is preferred to ensure consistent performance throughout Colorado.

8.510 CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES

8.510.1 DEFINITIONS

A. Adaptive Equipment means one or more ~~a~~ device~~(s)~~ ~~that is~~ used to assist with completing activities of daily living.

B. Allocation means the funds determined by the ~~case manager~~Case Manager in ~~conjunction~~collaboration with the client and made available by the Department through the Financial Management Service (FMS) vendor ~~to clients receiving~~for ~~a~~Attendant support services available in the Consumer Directed Attendant Support Services (CDASS) delivery option~~and administered by the Financial Management Services (FMS) authorized for attendant support services, and administrative fees paid to the FMS.~~

C. Assessment means a comprehensive evaluation with the client seeking services and appropriate collaterals (such as family members, advocates, friends and/or caregivers) conducted by the Case Manager, with supporting diagnostic information from the client's medical provider to determine the client's level of functioning, service needs, available resources, and potential funding sources. Case Managers shall use the Department's prescribed tool to complete assessments.

~~C.~~D. Attendant means the individual who meets qualifications in ~~10 CCR 2505-10, §~~ 8.510.8 who provides CDASS as ~~determined by~~described in ~~10 CCR 2505-10, §~~ 8.510.3 and is hired by the client or Authorized Representative ~~or by a~~through the contracted FMS vendor.

~~D.~~E. Attendant Support Management Plan (ASMP) means the documented plan described in ~~at 10 CCR 2505-10, §~~ 8.510.5, ~~for~~detailing management of Attendant support needs through CDASS. ~~clients to manage their care as determined by 10 CCR 2505-10, § 8.510.4 which is reviewed and approved by the Case Manager.~~

~~E.~~F. Authorized Representative (AR) means an individual designated by the client or the client's legal guardian, if ~~appropriate~~applicable, who has the judgment and ability to direct CDASS on a client's behalf and meets the qualifications ~~as defined~~contained in ~~at 10 CCR 2505-10, §~~ 8.510.6 and ~~§~~ 8.510.7.

~~Benefits Utilization System (BUS) means the web based data system maintained by the Department for recording case management activities associated with Long Term Services and Supports (LTSS).~~

~~F.~~G. Case Management Agency (CMA) means a public or private entity 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 §§ 25.5-10-209.5 and 25.5-6-~~-~~106, C.R.S.~~-~~, and has a current provider participation agreement with the Department. ~~Department approved agency within a designated service area where an applicant or client can obtain Long Term Services and Supports case management services.~~

~~G.~~H. Case Manager means an individual employed by a Case Management Agency who is qualified to perform the following case management activities: determination of an individual client's functional eligibility for one or more Home and Community Based Services (HCBS) waivers, development and implementation of an individualized and person-centered care plan for the client, coordination and monitoring of HCBS waiver services delivery, evaluation of service effectiveness, and periodic reassessment of client needs.~~Case Manager means an individual who meets the qualifications to perform case management activities by contract with the Department.~~

I. Consumer--Directed Attendant Support Services (CDASS) means the service delivery option ~~for services that assist~~that empowers ~~an individual~~clients to direct their care and services to assist them in accomplishing activities of daily living when included as a waiver benefit. CDASS benefits ~~that~~ may include assistance with health maintenance, personal care, and homemaker activities.

J. CDASS Certification Period Allocation means the funds determined by the Case Manager and made available by the Department for Attendant services for the date span the client is approved to receive CDASS within the annual certification period.

~~H.~~K. CDASS Task Worksheet: A tool used by a Case Manager to indicate the number of hours of assistance a client needs for each covered CDASS personal care services, homemaker services, and health maintenance activities.

~~I.~~L. CDASS Training means the required CDASS training~~, including a final,~~ and comprehensive assessment~~,~~ provided by the Training and Operations Vendor ~~Department or its designee~~ to a client or Authorized Representative~~/AR who is interested in CDASS~~.

~~Continued Stay Review (CSR) means a periodic face to face review of a client's condition and service needs by a Case Manager to determine a client's continued eligibility for Long Term Services and Supports in the client's residence.~~

~~J. Cost Containment means the cost of providing care in the community is less than or equal to the cost of providing care in an institutional setting based on the average aggregate amount. The cost of providing care in the community shall include the cost of providing Home and Community Based Services.~~

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

~~K.~~N. Family Member means any person related to the client by blood, marriage, adoption, or common law as determined by a court of law.

~~L.~~O. Financial Eligibility means the Health First Colorado financial eligibility criteria based on client income and resources. ~~.a . client qualifies for Medicaid based on the applicable eligibility category and the client's individual financial circumstances, including, but not limited to, income and resources.~~

~~M.~~P. Financial Management Services (FMS) vendor means an entity contracted with the Department and chosen by the client or Authorized Representative to complete employment-related functions for CDASS A~~a~~ttendants and to track and report on individual client CDASS A~~a~~llocations ~~for CDASS~~.

~~N.~~Q. Fiscal/Employer Agent (F/EA) ~~is an FMS model where the FMS is an agent of the client as the employer.~~provides FMS by performing payroll and administrative functions for clients receiving CDASS benefits. ~~The program participant or representative is the common law employer of workers hired, trained and managed by the participant or representative.~~ The F/EA pays ~~workers~~ Attendants for CDASS services and ~~vendors~~ maintains workers' compensation policies on the ~~participant's~~ client-employer's behalf. The F/EA withholds, calculates, deposits and files withheld Federal Income Tax and both client-employer and Attendant-employee Social Security and Medicare t~~T~~axes.

~~O.~~R. Functional Eligibility means the physical and cognitive functioning criteria a client must meet to qualify for a Medicaid waiver program, as determined by the Department's functional eligibility assessment tool.~~means an applicant or client meets the criteria for Long Term Services~~

and Supports as determined by the Department's prescribed instrument as defined in 10 CCR 2505-10, § 8.401.

Functional Needs Assessment means a component of the Assessment process which includes a comprehensive evaluation using the ULTC (Uniform Long Term Care) Instrument to determine if the client meets the appropriate Level of Care (LOC).

P.S. Home and Community-Based Services (HCBS) means a variety of supportive services delivered in conjunction with Colorado Medicaid Waivers to clients in community settings. These services are designed to help older persons and persons with disabilities to remain living live in the communityat home.

Q.T. Inappropriate Behavior means offensive behavior toward Attendants, Case Managers, the Training and Operations Vendor or the FMS, and which includes: documented verbal, sexual and/or physical abuse. Verbal abuse may include threats, insults or offensive language over a period of time.

R.U. Licensed Medical Professional means a person who has completed a 2-year or longer program leading to an academic degree or certificate in a medically related profession. This is limited to those who possess the following medical licenses: physician, physician assistant and nurse the primary care provider of the client, who possesses one of the following licenses: Physician (MD/DO), Physician Assistant (PA) and Advanced Practicing Nurse (APN), as governed by the Colorado Medical Practice Act and the Colorado Nurse Practice Act.

Long Term Services and Supports (LTSS) means Nursing Facilities, Intermediate Care Facilities for the Intellectually/Developmentally Disabled (ICF/IDD), Home and Community Based Services (HCBS), Long Term Home Health or the Program of All-inclusive Care for the Elderly (PACE), Swing Bed and Hospital Back Up Program (HBU).

Long Term Services and Supports Certification Period means the designated period of time in which a client is functionally eligible to receive Long Term Services and Supports not to exceed one year.

S.V. Prior Authorization Request (PAR) means the Department-prescribed form process that used to authorize HCBS waiver services before they are provided to the client. assures the provider that the service is medically necessary and a Colorado Medical Assistance Program benefit.

T.W. Notification means the routine methods in which thea communication from the Department or its designee conveys with information about CDASS. Methods Notification methods include but are not limited to announcements via the Department's CDASS web site, client account statements, Case Manager contact, or FMS vendor contact.

Reassessment means a review of the Assessment, to determine and document a change in the client's condition and/or client's service needs.

U.X. Stable Health means a medically predictable progression or variation of disability or illness.

V.Y. Training and Operations Vendor means the organization contracted by the Department to provide training and customer service for self-directed service delivery options to CDASS cClients,., / Aauthorized Rrepresentatives, and Case Managers., provide training to case managers on participant direction, and provide customer service related to participant direction.

8.510.2 ELIGIBILITY

8.510.2.A. To be eligible for the CDASS delivery option, ~~a~~the client shall meet the following eligibility criteria~~:n individual shall meet all of the following:~~

1. Choose the CDASS delivery ~~service delivery~~ option.

~~2. Meet medical assistance Financial Eligibility requirements~~

~~3. Meet Long Term Services and Supports Functional Eligibility requirements~~

~~4~~2. ~~Be~~ Meet HCBS waiver functional and financial ~~eligible for an HCBS Waiver with the CDASS~~ eligibility requirements.

~~3~~5. Demonstrate a current need for covered Attendant support services.

~~6~~4. Document a pattern of stable client health ~~that necessitates~~indicating appropriateness for community-based services and a predictable pattern of CDASS Attendant support ~~and appropriateness of CDASS~~. ~~services~~

~~5~~7. Provide a statement, at an interval determined by the Department, from the client's primary care physician, physician assistant, or advanced practice nurse, attesting to the client's ability to direct ~~his or her~~their care with sound judgment or a required AR with the ability to direct the care on the client's behalf.

~~6~~8. Complete all aspects of the ASMP and training and demonstrate the ability to direct care or have care directed by an AR.

~~a.~~ a. Client training obligations

~~i.~~ i.

~~a.~~ a. Client~~'~~s and AR~~'~~s who have received training through the Training and Operations Vendor in the past two years and have utilized CDASS in the previous six months may receive a modified training to restart CDASS following an episode of closure. ~~-~~The Case Manager will review the allocation and attendant management for the client's previous service utilization and consult with the Department to determine whether full retraining is required, or an abbreviated training based on history of managing allocation and services is needed.

ii. A client who was terminated from CDASS due to a Medicaid financial eligibility denial that has been resolved may resume CDASS without attending training if they had received CDASS in the previous six months.

8.510.3 ~~CDASS~~ COVERED SERVICES

8.510.3.A. Covered services shall be for the benefit of only the client and not for the benefit of other persons. ~~living in the home.~~

8.510.3.B. Services include:

1. Homemaker~~.~~: General household activities provided by an Attendant in a client's home to maintain a healthy and safe environment for the client. Homemaker activities shall be ~~applied only to~~provided only in the ~~permanent~~ primary living space of the client and

multiple Aattendants may not be reimbursed for duplicating ~~household~~ homemaker tasks. Tasks may include the following activities or teaching the following activities:

a. ~~Routine light h~~Housekeeping, such as~~:~~ dusting, vacuuming, mopping, and cleaning bathroom and kitchen areas;

b. Meal preparation;

c. Dishwashing;

d. Bed making;

e. Laundry;

f. Shopping for necessary items to meet basic household needs.

2. Personal C~~c~~are~~:~~ Services furnished to an eligible client in the community or in the client's home to meet the client's physical, maintenance, and supportive needs. ~~Including~~Personal care tasks may include:

a. Eating/feeding, which includes assistance with eating by mouth using common eating utensils such as spoons, forks, knives, and straws;~~.~~

b. Respiratory assistance with cleaning or changing oxygen equipment tubes, filling ~~the~~ distilled water reservoirs, and moving ~~the~~ a cannula or mask from or to the client's face;~~.~~

c. Preventive s~~S~~kin care ~~preventative in nature~~ when skin is unbroken,~~;~~ including the application of non-medicated/non-prescription lotions, ~~and/or~~ sprays, and/or solutions, ~~rubbing of reddened areas, and routine foot checks for people with diabetes~~and monitoring for skin changes.

d. Bladder/Bowel Care:

i) Assisting client to and from the bathroom;

ii) Assistance with bed pans, urinals, and commodes;

iii) Changing ~~of~~ incontinence clothing or pads;

iv) Emptying Foley or suprapubic catheter bags, but only if there is no disruption of the closed system;

v) Emptying ostomy bags;

vi) Perineal care.

e. Personal hygiene:

i) Bathing, including washing~~,~~ and shampooing;~~, and shaving~~

ii) Grooming;

iii) Shaving with an electric or safety razor;

~~iii~~iv) Combing and styling ~~of~~ hair;

~~i~~v) ~~Trimming, cutting, and s~~Filing and soaking ~~of~~ nails;

v~~i~~) Basic oral hygiene and denture care.

f. Dressing assistance with ordinary clothing and the application of non-prescription support stockings, braces and splints; and the application of ~~orthopedic devices such as splints and braces or~~ artificial limbs when the client is able to assist or direct.

g. Transferring a client when the client has sufficient balance and strength to reliably stand and pivot and assist with the transfer. Adaptive and safety equipment may be used in transfers, provided that the client and Attendant are fully trained in the use of the equipment and the client can direct and assist with the transfer. ~~assist with and can direct the transfer~~

h. ~~Assistance with m~~Mobility assistance when the client has the ability to reliably balance and bear weight or when the client is independent with an assistive device. ~~.~~

i. Positioning when the client is able to verbally or non-verbally identify when their position needs to be changed, including simple alignment in a bed, wheelchair, or other furniture.

j. ~~Assistance with self- administered~~ Medication Reminders ~~-~~when the medications have been preselected by the client, a ~~F~~family ~~M~~member, a nurse or a pharmacist, and the medications are stored in containers other than the prescription bottles, such as medication minders and ~~: medication reminding:~~

i) Medication minders ~~must be~~are clearly marked ~~as to~~with the day, ~~and~~ time, ~~of~~ and dosage and ~~must be~~ kept in a way as to prevent tampering; ~~.~~

ii) Medication reminding includes only inquiries as to whether medications were taken, verbal prompting to take medications, handing the appropriately marked medication minder container to the client and opening the appropriately marked medication minder if the client is unable to do so independently.

k. Cleaning and basic maintenance of durable medical equipment.

l. Protective oversight when the client requires supervision to prevent or mitigate disability ~~-~~related behaviors that may result in imminent harm to people or property.

m. Accompanying includes going with the client, as ~~necessary on~~indicated in the care plan, to medical appointments ~~,~~ and errands, such as banking and household shopping. Accompanying the client to provide one or more personal care services as needed during the trip. Attendant may assist with communication, documentation, verbal prompting, and/or hands ~~-~~on assistance when tasks cannot be completed without the support of the Attendant.

3. Health Maintenance Activities:~~.~~ ~~Routine~~ Health maintenance activities include 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 physically 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~~,~~ and the client is unable to apply creams, lotions, sprays, or medications independently due to illness, injury or disability. Skin care may include: wound care, dressing changes, application of prescription medicine, and foot care for people with diabetes when ~~prescribed~~ directed by a ~~l~~Licensed M~~m~~edical P~~p~~rofessional.

   b. Nail care in the presence of medical conditions that may involve peripheral circulatory problems or loss of sensation; includes soaking, filing and trimming.

   c. Mouth care performed when health maintenance level skin care is required in conjunction with the task, or:

      i) T~~t~~here is injury or disease of the face, mouth, head or neck;

      ii) I~~i~~n the presence of communicable disease;

      iii) When the client is ~~unconscious~~unable to participate in the task;

      iv) ~~o~~Oral suctioning is required;

      v) There is decreased oral sensitivity or hypersensitivity; ~~or~~

      vi) Client is at risk for choking and aspiration.

   d. Dressing performed when health maintenance~~-~~-level skin care or transfers are required in conjunction with the dressing, or:~~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~~

      i) The client is unable to assist or direct care;

      ii) Assistance with the application of prescribed anti-embolic or pressure stockings is required;

      iii) Assistance with the application of prescribed orthopedic devices such as splints, braces, or artificial limbs is required.

   e. Feeding is considered a health maintenance task when the client requires health maintenance~~-~~-level skin care or dressing in conjunction with the task, or:

      i) ~~When o~~Oral suctioning is needed on a stand-by or intermittent ~~other~~ basis;

      ii) The client is on a prescribed modified texture diet;~~When~~

      iii) The client has a physiological or neurogenic chewing or swallowing problem; ~~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~~iv) Syringe feeding or feeding using adaptive utensils is required;

~~iv) Feeding using apparatus~~

v) Oral feeding when the client is unable to communicate verbally, non-verbally or through other means.

f. Exercise prescribed by a L~~l~~icensed M~~m~~edical P~~p~~rofessional, including passive range of motion.

g. Transferring a client when they are not able to perform transfers independently due to illness, injury or disability, or: ~~a client when he/she is unable to assist or the use of a lift such as a Hoyer is needed~~

i) The client lacks the strength and stability to stand, maintain balance or bear weight reliably;

ii) The client has not been deemed independent with adaptive equipment or assistive devices by a Licensed Medical Professional;

iii) The use of a mechanical lift is needed.

h. Bowel care performed when health maintenance ~~-~~level skin care or transfers are required in conjunction with the bowel care, or:

i) The client is unable to assist or direct care;

ii) Administration of a bowel program including but not limited to ~~-~~ digital stimulation, enemas, or suppositories; ~~provided to a client including digital stimulation, enemas, care of ostomies, and insertion of a suppository if the client is unable to assist.~~

iii) Care of a colostomy or ileostomy that includes emptying and changing the ostomy bag and application of prescribed skin care products at the site of the ostomy.

i. ~~i.~~ Bladder care performed when health maintenance ~~-~~level skin care or transfers are required in conjunction with bladder care, or;

i) ~~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.~~ The client is unable to assist or direct care;

ii) Care of external, indwelling and suprapubic catheters;

iii) Changing from a leg to a bed bag and cleaning of tubing and bags as well as perineal care.

j. Medical management ~~required~~ as directed by a Licensed ~~m~~Medical P~~p~~rofessional to routinely monitor a documented health condition, including but not limited to: blood pressures, pulses, respiratory ~~assessment~~rate, 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/or nose;

v) Nebulizers;

vi) Ventilator and tracheostomy care;

vii) ~~Prescribed respiratory equipment~~ Assistance with set-up and use of respiratory equipment.

l. Bathing assistance is considered a health maintenance task when the client requires health maintenance--level skin care, transfers or dressing in conjunction with bathing.

m. Medication assistance, which may include setup, handling and administering medications.

n. Accompanying includes going with the client, as necessary according ~~on~~to the care plan,~~,~~ to medical appointments, and errands such as banking and household shopping. Accompanying the client to provide one or more health maintenance tasks as needed during the trip. Attendant may assist with communication, documentation, verbal prompting and/or hands on assistance when the task cannot be completed without the support of the Attendant.

o. Mobility assistance is considered a health maintenance task when health maintenance--level transfers are required in conjunction with the mobility assistance, or:

i) The client is unable to assist or direct care;

ii) When hands--on assistance is required for safe ambulation and the client is unable to maintain balance or to bear weight reliably due to illness, injury, or disability; and/or

iii) The client has not been deemed independent with adaptive equipment or assistive devices ordered by a Licensed Medical Professional

p. Positioning includes moving the client from the starting position to a new position while maintaining proper body alignment, support to a client's extremities and avoiding skin breakdown. May be performed when health maintenance level skin care is required in conjunction with positioning, or;

i) The client is unable to assist or direct care, or

ii) The client is unable to complete task independently

4. Services that may be directed by the client or their selected AR under the Home and Community Based Supported Living Services (HCBS-SLS) waiver are as follows:

a. Homemaker services, as defined at ~~s~~Section ~~10 CCR 2505-10 §~~ 8.500.94.

b. Personal care services, as defined at ~~s~~Section ~~10 CCR 2505-10 §~~ 8.500.94.

c. Health maintenance activities as defined at S~~s~~ection ~~10 CCR 2505-10 §~~ 8.500.94.

8.510.4 EXCLUDED SERVICES

8.510.4.A. CDASS Attendants are not authorized to perform services and payment is prohibited:

1. ~~—~~While client is admitted to a nursing facility, hospital, a long-term care facility or incarcerated;~~.~~

~~1.~~2. ~~—~~Following the death of client;~~.~~

~~2.~~3. That are duplicative or overlapping. The Attendant cannot be reimbursed to perform tasks at the time a client is concurrently receiving a waiver service in which the provider is required to perform the tasks in conjunction with the service being rendered;

~~B. —~~Companionship is not a covered CDASS service.

8.510.~~5~~4 ATTENDANT SUPPORT MANAGEMENT PLAN

8.510.~~5~~4.A. The client/AR shall develop a written ASMP after completion of training but prior to the start date of services, which shall be reviewed by the Training and Operations Vendor and approved by the Case Manager. CDASS shall not begin until the Case Manager approves the plan and provides a start date to the FMS. The ASMP is required ~~by the FMS~~ following initial training and~~,~~ retraining and shall be modified when there is a change in the client's needs. The plan shall describe the ~~individual's~~client's:

~~1. Current health status~~

~~2~~1. Need~~sed~~ Attendant support~~; and requirements for CDASS.~~;

~~2~~3. Plans for locating and hiring Attendants~~; securing CDASS.~~;

~~4~~3. Plans for handling emergencies;~~.~~

~~5~~4. Assurances and plans regarding direction of CDASS Services, as described at ~~10 CCR 2505 -10, §~~ 8.510.3 and ~~§~~ 8.510.6, if applicable.

~~6~~5. Plans for budget management ~~of the budget~~ within the client's ~~Individual~~ Allocation.

~~7~~6. Designation of an ~~Authorized Representative~~AR, if applicable.

~~8~~7. Designation of regular and back-up employees proposed or approved for hire.

8.510.~~5~~4.B. If the ASMP is disapproved by the Case Manager, the client or AR has the right to review ~~that~~ the disapproval. The client or AR shall submit a written request to the CMA stating the reason for the review and justification of the proposed ASMP. The client's most recently approved ASMP shall remain in effect while the review is in process.

~~8.510.5 TRAINING ACTIVITIES~~

~~8.510.5.A. When necessary to obtain the goals of the ASMP, the client/AR shall verify that each attendant has been or will be trained in all necessary health maintenance activities prior to performance by the attendant.~~

~~8.510.5.B The verification requirement of 10 CCR 2505-10, §8.510.5.A above will be on a form provided by the FMS and returned to the FMS with the client/AR completed employment packet.~~

8.510.~~6~~6 CLIENT/AR RESPONSIBILITES

8.510.~~6~~6.A. Client/AR responsibilities for CDASS Management:

1. ~~Attend~~ Complete training provided by the Training and Operations Vendor.~~;~~ ~~clients~~ Clients who cannot ~~attend~~ complete trainings shall designate an AR.

2. Develop an ASMP at initial enrollment and at time of an Allocation change based on the client's needs.

3. Determine wages for each Attendant not to exceed the rate established by the Department. Wages shall be established in accordance with Colorado Department of Labor and Employment standards including, but not limited to, minimum wage and overtime requirements. Attendant wages may not be below the state and federal requirements at the location where the service is provided.

4. Determine the required qualifications~~credentials~~ for Attendants.

5. Recruit, hire and manage Attendants.

6. ~~5.~~ Complete ~~previous~~ employment reference checks on Attendants.

7. Train Attendants to meet the client's needs. ~~-~~When necessary to meet the goals of the ASMP, the client/AR shall verify that each Attendant has been or will be trained in all necessary health maintenance activities prior to performance by the Attendant.

8. Terminate Attendants when necessary, including when an Attendant is not meeting the client's needs.

9. Operate as the Attendant's legal employer of record.

10. Complete necessary employment~~-~~-related functions through the FMS vendor, including hiring and termination of Attendants and employer~~-~~-related paperwork necessary to obtain an employer tax ID.

11. Ensure all Attendant employment documents have been completed and accepted by the FMS vendor prior to beginning Attendant services.

~~6~~12. Follow all relevant laws and regulations applicable to ~~client's~~ the supervision of Attendants.

13~~7~~. Explain the role of the FMS vendor to the Attendant.

~~8~~14.~~.~~ Budget for Attendant care within the established monthly and CDASS Certification Period Allocation. Services that exceed the client's monthly CDASS Allocation by 30% or higher are not allowed and cannot be authorized by the client or AR for reimbursement through the FMS vendor.

15. Authorize Attendant to perform services allowed through CDASS.

~~9~~165. Review all Attendant timesheets and statements for accuracy of time worked, completeness, and client/AR and Attendant signatures. Timesheets shall reflect actual time spent providing CDASS. ~~services~~

~~10~~176. Review and submit approved Attendant timesheets to the FMS by the established timelines for Attendant reimbursement.

~~11~~187. Authorize the FMS vendor to make any changes in the Attendant wages.

~~12~~189. Understand that misrepresentations or false statements may result in administrative penalties, criminal prosecution, and/or termination from CDASS. Client/AR is responsible for assuring timesheets submitted are not altered in any way and that any misrepresentations are immediately reported to the FMS vendor.

~~13~~1209. ~~——~~Completing and managing all paperwork and maintaining employment records.

~~14~~201. Select an FMS vendor upon enrollment into CDASS.

~~8.510.6.B. Client/AR responsibilities for CDASS in the F/EA FMS model:~~

~~1. Recruit, hire, fire and manage Attendants~~

~~2. Train Attendants to meet client needs~~

~~3. Terminate Attendants who are not meeting client needs~~

~~4. Operate as the sole employer of the attendant~~

~~5. Complete necessary employment related functions through the FMS agent, including hiring and termination of Attendants and employer related paperwork necessary to obtain an employer tax ID~~

8.510.~~6.~~6.B.~~C~~ Client/AR responsibilities for Verification:

1. Sign and return a responsibilities acknowledgement form for activities listed in ~~10 CCR 2505-10, §~~8.510.6 to the Case Manager.

8.510.~~66~~.~~CD~~. Clients ~~receiving~~ utilizing CDASS ~~services~~ have the following r~~R~~ights:

1. Right to receive ~~instruction~~ training on managing CDASS.

2. Right to receive program materials in accessible format.

3. Right to receive advance N~~n~~otification of changes to CDASS.

4. Right to participate in Department~~-~~-sponsored opportunities for input.

5. ~~CDASS c~~Clients using CDASS have the right to transition ~~back~~ to alternative service delivery options at any time. ~~Personal Care, Homemaker, and Home Health Aide and Nursing services provided by an agency at any time. A client who wishes to transition back to an agency-provided services shall contact the Case Manager.~~ The Case

Manager shall coordinate ~~arrangements~~ the transition and referral process. ~~for the services.~~

6. A client/AR may request a re-assessment~~, as described at 10 CCR 2505-10, § 8.390.1 (N),~~ if ~~his or her~~the client's level of service needs have changed.

7. A client/AR may revise the ASMP at any time with ~~CM~~ Case Manager approval. ~~CM shall notify FMS of changes.~~

8.510.~~7~~7 AUTHORIZED REPRESENTATIVES (AR)

8.510.~~7~~7.A. A person who has been designated as an AR shall submit an AR designation affidavit attesting that he or she:

1. Is least eighteen years of age;

2. Has known the eligible person for at least two years;

3. Has not been convicted of any crime involving exploitation, abuse, or assault on another person; and

4. Does not have a mental, emotional, or physical condition that could result in harm to the client.

8.510.7.B. CDASS clients who require an AR may not serve as an AR for another CDASS client.

8.510.~~7~~7.~~C~~B. ~~Authorized Representatives~~An AR shall not receive reimbursement for CDASS AR services and shall not be reimbursed ~~for CDASS services~~ as an Attendant for the client they represent.

8.510.7.D. An AR must comply with all requirements contained in ~~10 CCR 2505-10, §~~ 8.510.6.

8.510.~~8~~8 ATTENDANTS

8.510.~~8~~8.A. Attendants shall be at least 18 years of age and demonstrate competency in caring for the client to the satisfaction of the client/AR.

8.510.~~8~~8.B. Attendants may not be reimbursed for more than 24 hours of CDASS service in one day for one or more clients collectively.

8.510.~~8~~8.C. ~~Authorized Representatives~~An AR shall not be employed as an Attendant for the same client for whom they are an AR.

8.510.~~8~~8.D. Attendants must be able to perform the tasks on the ~~Service Plan~~ ASMP they are being reimbursed for and the client must have adequate Attendants to assure compliance with all tasks on the ~~service plan~~ASMP.

8.510.8.E. Attendant timesheets submitted for approval must be accurate and reflect time worked.

8.510.~~8~~8.~~F~~E. Attendants shall not misrepresent themselves to the public as a licensed nurse, a certified nurse's aide, a licensed practical or professional nurse, a registered nurse or a registered professional nurse.

8.510.~~8~~8.~~G~~F. Attendants shall not have had his or her license as a nurse or certification as a nurse aide suspended or revoked or his or her application for such license or certification denied.

8.510.88.HG. Attendants shall receive an hourly wage based on the rate negotiated between the Attendant and the client/AR not to exceed the amount established by the Department. The FMS vendor shall make all payments from the client's Individual Allocation under the direction of the client/AR within the limits established by the Department.

8.510.8.I. Attendants are not eligible for hire if their background check identifies a conviction of a crime that the Department has identified as a barrier crime that can create a health and safety risk to the client. A list of barrier crimes is available through the Training and Operations Vendor and FMS vendors.

8.510.88.JH. Attendants may not attend training provided by the Training and Operations Vendor during instruction. Attendants may not participate in training provided by the Training and Operations Vendor. Clients may request to have their Attendant, or a person of their choice, present to assist them during the training based on their personal assistance needs. Attendants may not be present during the budgeting portion of the training.

8.510.985 FINANCIAL MANAGEMENT SERVICES (FMS)

8.510.895.A. The FMS vendors shall be responsible for the following tasks:

1. Collect and process timesheets submitted by attendants within agreed--upon timeframes as identified in FMS vendor materials and websites.

2. Conduct payroll functions, including withholding employment--related taxes such as worker's' compensation insurance, unemployment compensation insurancebenefits, withholding of all federal and state taxes, and compliance with federal and state laws regarding overtime pay and minimum wage requirements.

3. Distribute paychecks in accordance with agreements made with client/AR and timelines established by the Colorado Department of Labor and Employment.

4. Submit authorized claims for CDASS provided to an eligible client.

5. Verify Attendants' citizenship status and maintain copies of the I-9 documents.

6. Track and report utilization of client allocations.

7. Comply with Department regulations at 10 CCR 2505-10 and the FMS vendor contract with the Department.

8. Maintain system prompts in the FMS vendor portal requiring case managerCase Managers to verify that all requirements and forms have been completed prior to completing submitting a prior authorization requestPAR for services.

9. Comply with all requirements set forth by the Affordable Care Act.

8.510.895.B. In addition to the requirements set forth at 10 CCR 2505-10, § 8.510.9.A, the FMS vendor operating under the F/EA model shall be responsible for obtaining designation as a Fiscal/Employer Agent per in accordance with Section 3504 of the IRS Internal Revenue Code. This statute is hereby incorporated by reference. The incorporation of these statutes excludes later amendments to, or editions of the referenced material. Pursuant to C.R.S. § 24-4-103(12.5), the Department maintains copies of this incorporated text in its entirety, available for public inspection during regular business hours at 1570 Grant Street, Denver, CO, 80203. Certified copies of incorporated materials are provided at cost upon request.

8.510.~~8~~10~~6~~ SELECTION OF FMS VENDORS

8.510.~~8~~10~~6~~.A. The client/AR shall select an FMS vendor at the time of enrollment into CDASS from the vendors contracted with the Department.

8.510.~~8~~10.~~6.~~B The client/AR may select a new FMS vendor during the designated open enrollment periods. The client/AR shall remain with the selected FMS vendor until the ~~selection~~ transition to the new ~~of~~ FMS vendor is ~~changed~~ completed ~~during the designated open enrollment period~~.

8.510.~~9~~ 11 START OF SERVICES

8.510.~~9~~11.A. The CDASS start date shall not occur until all of the requirements ~~defined at~~contained in ~~10 C.C.R.~~CCR ~~2505-10, §§~~ 8.510.2, ~~8.510.4,~~ 8.510.5, 8.510.6 and 8.510.8 have been met.

8.510.~~9~~11.B. The Case Manager shall approve the ASMP, establish a ~~certification~~ service period, submit a PAR and receive a PAR approval before a client is given ~~the~~ a start date and can begin CDASS.

8.510.~~9~~11.C. The FMS vendor shall process the Attendant's employment packet within the Department's prescribed timeframe and ensure the client has a minimum of two approved Attendants prior to starting CDASS. ~~Employment~~ The client must maintain employment relationships with two Attendants ~~must be maintained~~ while participating in CDASS.

8.510.~~9~~11.D. The FMS vendor will not reimburse Attendants for services provided prior to the CDASS start date. Attendants are not approved until the FMS vendor provides the client/AR with ~~an~~ employee numbers and confirms Attendants' employment status.

8.510.~~9~~11.E. If a client is transitioning from a ~~Hospital~~hospital, ~~Nursing~~ nursing ~~Facility~~facility, or HCBS agency services, the ~~CM~~ Case Manager shall coordinate with the ~~Discharge~~ discharge ~~Coordinator~~ coordinator to ensure that the client's discharge date and CDASS start date correspond.

8.510.~~10~~12 SERVICE SUBSTITUTION

8.510.~~10~~12.A. Once a start date has been established for CDASS, the Case Manager shall establish an end date and ~~disenroll~~ discontinue the ~~individual~~ client from any other Medicaid-funded Attendant support including Long Term H~~h~~ome H~~h~~ealth, homemaker and personal care services effective as of the start date of CDASS.

8.510.~~10~~12.B. Case Managers shall not authorize PARs with ~~, on the PAR,~~ concurrent payments for CDASS and other waiver service delivery options for Personal Care services, Homemaker services, and Health Maintenance Activities for the same ~~individual~~client.

8.510.~~10~~12.C. Clients may receive up to sixty days of Medicaid ~~acute~~ Acute H~~h~~ome ~~health~~ Health ~~agency based~~ services directly following acute episodes as defined by ~~10 CCR 2505-10, §~~ 8.523.11.K.1. ~~-~~CDASS service plans shall be modified to ensure no duplication of services.~~Client allocations shall not be changed for sixty days in response to an acute episode unless acute home health services are unavailable. If acute home health is unavailable, a client's allocation may be temporarily adjusted to meet a client's need.~~

8.510.~~10~~12.D. Clients may receive Hospice services in conjunction with CDASS services. CDASS service plans shall be modified to ensure no duplication of services.

~~8.510.11 ENDING CONSUMER DIRECTED ATTENDANT SUPPORT SERVICES~~

~~8.510.11.A. If an individual chooses to use an alternate care option, an institutional setting, or is terminated involuntarily, a client will be terminated from CDASS when the Case Manager has secured an adequate alternative to CDASS in the community.~~

8.510.~~11~~31.B. FAILURE TO MEET CLIENT/AR RESPONSIBILITIES

8.510.13.A. If a client/AR fails to meet their CDASS responsibilities, the client may be terminated from CDASS. Prior to a client being terminated from CDASS ~~for reasons other than those listed in section 10 CCR 2505-10, §8.510.13,~~ the following steps ~~may~~ shall be taken:

1. Mandatory re-training conducted by the contracted Training and Operations Vendor.

2. Required designation of an AR if one is not in place, or mandatory re-designation of an AR if one has already been assigned.

8.510.13.B. Actions requiring retraining, or appointment or change of an AR include any of the following:

~~3. Discontinuation according to the following:~~

~~i) The notice shall provide the client/AR with the reasons for termination and with information about the client's rights to fair hearing and appeal procedures, in accordance with 10 CCR 2505-10, §§ 8.057. Once notice has been given for termination, the client/AR shall contact the Case Manager for assistance in obtaining other home care services. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS services and begin alternate care services. Exceptions may be made to the thirty (30) day advance notice requirement when the Department has documented that there is danger to the client or to the Attendant(s). The Case Manager shall notify the FMS of the date on which the client is being terminated from CDASS.~~

~~**8.510.12 TERMINATION**~~

~~8.510.12.A. Clients may be terminated for the following reasons:~~

1. The client/AR ~~fails to~~does not comply with CDASS program requirements including service exclusions.

2. The client/AR demonstrates an inability to manage Attendant support.

3. The~~A~~ client~~/AR~~ no longer meets program eligibility criteria due to deterioration in physical or cognitive health as determined by the client's physician, physician assistant, or advance practice nurse.

4. The client/AR spends the monthly Allocation in a manner ~~indicating~~ causing premature depletion of funds without authorization from the Case Manager or reserved funds. The Case Manager will follow the service utilization protocol.

~~5. The client's medical condition causes an unsafe situation for the client, as determined by the treating physician.~~

5. The client/AR exhibits Inappropriate Behavior as defined at ~~10 C.C.R. 2505-10, §~~ 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor, or the FMS vendor.

6. The client/AR authorizes the Attendant to perform services while the client is in a ~~N~~nursing f~~F~~acility, ~~H~~hospital, a long-term care facility or while incarcerated.

~~6. The client provides false information or false records as determined by the Department~~

~~8.510.12.B Clients who are terminated according to 10 CCR 2505-10, § 8.510.12 may be re-enrolled for future CDASS service delivery~~

8.510.1~~3~~4 IMMEDIATE INVOLUNTARY TERMINATION

8.510.1~~3~~4.A. ~~Clients who are involuntarily terminated may not be re-enrolled in CDASS as a service delivery option.~~ Clients may be involuntarily terminated immediately from CDASS for the following reasons:

1. A client~~/AR~~ no longer meets program criteria due to deterioration in physical or cognitive health AND the client refuses to designate an AR to direct services.

2. The client/AR demonstrates a consistent pattern of overspending their monthly Allocation leading to the premature depletion of funds AND the ~~Department~~ Case Manager has determined that ~~adequate~~ attempts using the service utilization protocol to assist the client/AR to resolve the overspending have failed.

3. The client/AR exhibits Inappropriate Behavior as defined at ~~10 C.C.R. 2505-10, §~~ 8.510.1 toward Attendants, Case Managers, the Training and Operations Vendor or the FMS vendor, and the Department has determined that the Training and Operations Vendor has made ~~adequate~~ attempts to assist the client/AR to resolve the Inappropriate Behavior or assign a new AR, and those attempts have failed.

4. Client/AR authorized the Attendant to perform services for a person other than the client, authorized services not available in CDASS, or allowed services to be performed while the client is in a hospital, nursing facility, a long term care facility or while incarcerated and the Department has determined the Training and Operations Vendor has made adequate attempts to assist the client/AR in managing appropriate services through retraining.~~Documented misuse of the monthly Allocation by client/AR has occurred~~

5. Intentional submission of fraudulent CDASS documents or information to Case Managers, the Training and Operations Vendor, the Department, or the FMS vendor.

6. Instances of ~~convicted~~ proven fraud ~~and/or abuse~~, abuse, and/or theft in connection with the Colorado Medical Assistance program.

7. Client/AR fails to complete retraining, appoint an AR, or remediate CDASS management per ~~10 C.C.R. 2505-10, §~~ 8.510.13.A.

~~8.510.143.B. Termination may be initiated immediately for clients being involuntarily terminated.~~

8.510.15 ENDING THE CDASS DELIVERY OPTION

8.510.15.A. If a client chooses to use an alternate care option or is terminated involuntarily, the client will be terminated from CDASS when the Case Manager has secured an adequate alternative to CDASS in the community.

8.510.15.B. In the event of discontinuation of or termination from CDASS, the Case Manager shall:

1. Complete the Notice Services Status (LTC-803) and provide the client or AR with the reasons for termination, information about the client's rights to fair hearing, and appeal procedures. Once notice has been given for termination, the client or AR may contact the Case Manager for assistance in obtaining other home care services or additional benefits, if needed.

2. The Case Manager has thirty (30) calendar days prior to the date of termination to discontinue CDASS and begin alternate care services. Exceptions may be made to increase or decrease the thirty (30) day advance notice requirement when the Department has documented that there is danger to the client. The Case Manager shall notify the FMS vendor of the date on which the client is being terminated from CDASS.

8.510.135.C. Clients who are involuntarily terminated ~~according~~ pursuant to ~~10 CCR 2505-10, §§~~ 8.510.14.A 2., 8.510.14.A.4., 8.510.14.A.5, 8.510.14.A.6., and 8.510.14.A.7. may not be re-enrolled in CDASS as a service delivery option.

8.510.15.D. Clients who are involuntary terminated pursuant to ~~10 CCR 2505-10, §~~ 8.510.14.A.1. are eligible for enrollment in CDASS with the appointment of an AR or eligibility documentation as defined at ~~10 CCR 2505-10, §~~ 8.510.2.A.5. The client or AR must have successfully completed CDASS training prior to enrollment in CDASS.

8.510.15.E. Clients who are involuntary terminated pursuant to ~~10 CCR 2505-10, §~~ 8.510.14.A.3 are eligible for enrollment in CDASS with the appointment of an AR. The client must meet all CDASS eligibility requirements with the AR completing CDASS training prior to enrollment in CDASS.

8.510.146 CASE MANAGEMENT FUNCTIONS

8.510.164.A. The Case Manager shall review and approve the ASMP completed by the client/AR. The Case Manager shall notify the client/AR of ASMP~~the~~ approval and establish a ~~certification~~ service period and Allocation.

8.510.164.B. If the Case Manager determines that the ASMP is inadequate to meet the client's CDASS needs, the Case Manager shall work with the client/AR to complete a fully-developed ASMP. ~~.assist the client/AR with further development of the ASMP.~~

8.510.164.C. The Case Manager shall calculate the ~~Individual~~ Allocation for each client who chooses CDASS as follows:

1. Calculate the number of ~~P~~personal c~~C~~are, h~~H~~omemaker, and h~~H~~ealth m~~M~~aintenance a~~A~~ctivities hours needed on a monthly basis using the Department's prescribed method. The needs determined for the Allocation should reflect the needs in the ~~ULTC~~ Department~~-~~approved assessment tool and the service plan. The Case Manager shall use the Department's established rate for p~~P~~ersonal ~~C~~care, h~~H~~omemaker, and h~~H~~ealth m~~M~~aintenance a~~A~~ctivities to determine the client's Allocation.

2. The Allocation should be determined using the Department's prescribed method at the client's initial CDASS enrollment and at ~~CSR ,~~ and reassessment ~~should always match the client's need for service~~. ~~s.~~Service authorization will align with the client's need for services and adhere to all service authorization requirements and limitations established by the client's waiver program.

3. Allocations that exceed care in an institutional setting cannot be authorized by the Case Manager without Department approval. The Case Manager will follow the Department's

over--cost containment process and receive authorization prior to authorizing a start date for Attendant services.

8.510.164.D. Prior to training or when an Aallocation changes, the Case Manager shall provide written Nnotification of the ~~Individual~~ Allocation to ~~each~~ the client and the AR, if applicable.~~-~~

8.510.164.E. A client or ~~/~~AR who believes the client ~~he or she~~ needs a change in Attendant support, may request the Case Manager to perform a ~~reassessment~~review of the CDASS Task Worksheet and Allocation for services. Review should be completed within five (5) business days.

~~1.~~ If the ~~reassessment~~ review indicates that a change in Attendant support is justified, the following ~~-~~actions will be taken:~~, the client/AR shall amend the ASMP and the cCase mManager shall complete a PAR revision indicating the increase, and submit it to the Department's fiscal agent.~~

~~a.~~

a. ~~2.~~ The Case Manager shall provide notice of the Allocation change to the client/AR utilizing a long-term care notice of action form within ten (10) business days regarding their appeal rights in accordance with ~~10 CCR 2505-10,~~ Ssection 8.057, et seq.

b. The Case Manager shall complete a PAR revision indicating the increase in CDASS Allocation using the~~and make changes in the BUS~~Department's Medicaid Management Information System and FMS vendor system. PAR revisions shall be completed within five (5) business days of the Allocation determination.

c. The client/AR shall amend the ASMP and submit it to the Case Manager.

~~23~~. The Training and Operations Vendor is available to facilitate a review of services and provide mediation when there is a disagreement in the services authorized on the CDASS Task Worksheet.

~~34.~~ The Case Manager will notify the client of CDASS Allocation approval or disapproval by providing a long-term care notice of action form to clients within ten (10) business days regarding their appeal rights in accordance with S~~10 CCR 2505-10,~~ section 8.057, et seq.

8.510.164.F. In approving an increase in the client's ~~individual~~ Allocation, the Case Manager shall consider all of the following:

1. Any deterioration in the client's functioning or change in ~~the~~ availability of natural supports ~~condition~~, meaning assistance provided to the client without the requirement or expectation of compensation.

2. The appropriateness of Attendant wages as determined by Department's established rate for equivalent services.

3. The appropriate use and application of funds ~~to~~ for CDASS services.

8.510.164.G. In reducing a client'sn ~~Individual~~ Allocation, the Case Manager shall consider:

1. Improvement of functional condition or changes in the available natural supports.

2. Inaccuracies or misrepresentation in the client's previously reported condition or need for service.

3. The appropriate use and application of funds ~~to~~ for CDASS services.

8.510.164.H. Case Managers shall ~~notify the state fiscal agent to~~ cease payments for all existing Medicaid-funded ~~P~~personal ~~C~~care, ~~H~~homemaker, ~~H~~health m~~M~~aintenance ~~Activities~~ activities and/or ~~Long-Term~~Long-Term Home Health as defined under the Home Health Program at ~~10 CCR 2505-10,~~ Section §8.520 et seq. as of the client's CDASS start date.

8.510.164.I. For effective coordination, monitoring and evaluation of clients receiving CDASS, the Case Manager shall:

1. Contact the CDASS client/AR once a month during the first three months to assess their CDASS management, their satisfaction with ~~care providers~~Attendants, and the quality of services received. Case Managers may refer ~~clients~~ clients/ARs to the FMS vendor for assistance with payroll ~~and budgeting~~ and to the Training and Operations Vendor for training needs, budgeting, and supports.

2. Contact the client/AR quarterly~~,~~ after the first three months to assess their implementation of ~~service~~Attendant services ~~plans~~, CDASS management issues, ~~and~~ quality of care, ~~CDASS~~ Allocation expenditures, and general satisfaction.

3. Contact the client/AR when a change in AR occurs and contact the client/AR once a month for three months after the change takes place.

4. Review monthly FMS vendor reports to monitor ~~client~~ Allocation spending patterns and service utilization to ensure appropriate budgeting and follow up with the client/AR when discrepancies occur.

5. Utilize Department overspending protocol when needed to assist CDASS clients/AR.

6. Follow protocols established by the Department for case management activities.

8.510.164.J. Reassessment: ~~For clients receiving CDASS, the Case Manager shall conduct an interview with each client/AR every six months and at least every 12 months~~ The Case Manager will follow in-~~-~~person and phone contact requirements based on the client's waiver program.~~,~~ ~~the Interview shall be conducted face to face. The interview~~Contacts shall include a review of care needs, the ASMP, and documentation from the physician, physician assistant, or advance practice nurse stating the client's~~/AR's~~ ability to direct care.

8.510.16.K. Case Managers shall participate in training and consulting opportunities with the Department's contracted Training and Operations Vendor.

8.510.175 ATTENDANT REIMBURSEMENT

8.510.157.A. Attendants shall receive an hourly wage not to exceed the rate established by the Department and negotiated between the Attendant and the client/AR hiring the Attendant. The FMS vendor shall make all payments from the client's ~~Individual~~ Allocation under the direction of the client/AR. Attendant wages shall be commensurate with the level of skill required for the task and wages shall be justified ~~on~~ in the ASMP.

8.510.17.B. Attendant timesheets that exceed the client's monthly CDASS Allocation by 30% or more are not allowed and cannot be authorized by the client or AR for reimbursement through the FMS vendor.

8.510.~~15~~17.C~~B~~. Once the client's yearly Allocation is used, further payment will not be made by the FMS vendor, even if timesheets are submitted. Reimbursement to Attendants for services provided when a client is no longer eligible for CDASS or when the client's Allocation has been depleted are the responsibility of the client/AR.

8.510.~~15~~17.D~~C~~. Allocations that exceed the cost of providing services in a facility cannot be authorized by the Case Manager without Department approval. ~~Allocations shall not exceed the monthly cost containment cap. The Department may approve an over cost containment Allocation if it meets prescribed Department criteria.~~

8.510.~~16~~18 REIMBURSEMENT TO FAMILY MEMBERS

8.510.~~16~~18.A. Family M~~m~~embers/legal guardians may be employed by the client/AR ~~or FMS~~ to provide CDASS, subject to the conditions below. ~~For the purposes of this section, family shall be defined as all persons related to the client by virtue of blood, marriage, adoption, or common law.~~

8.510.~~16~~18.B. The family member or legal guardian shall be employed by the client/AR ~~or FMS~~ and be supervised by the client/AR~~. if providing CDASS.~~

8.510.~~16.C.~~18.C. ~~-~~The ~~family member~~Family Member and/~~-~~or legal guardian being reimbursed as a p~~P~~ersonal ~~C~~care, h~~H~~omemaker, and/or ~~H~~health ~~M~~maintenance ~~Activities~~ activities Attendant shall be reimbursed at an hourly rate with the following restrictions:

1. A ~~family member~~Family Member and/or legal guardian shall not be reimbursed for more than forty (40) hours of CDASS in a seven~~-~~day period from 12:00 am on Sunday to 11:59 pm on Saturday.

2. Family ~~member~~ Member wages shall be commensurate with the level of skill required for the task and should not deviate ~~greatly~~ from that of a non-~~family~~ Family ~~member~~ Member Attendant unless there is evidence of ~~a~~ that the Family Member has a higher level of skill.

3. A member of the client's household may only be paid to furnish extraordinary care as determined by the Case Manager. Extraordinary care is determined by assessing whether the care to be provided exceeds the range of care that a ~~family member~~Family Member would ordinarily perform in the household on behalf of a person without a disability or chronic illness of the same age, and which ~~are~~ is necessary to assure the health and welfare of the client and avoid institutionalization. Extraordinary care shall be documented on the service plan.

8.510.~~16~~18.D. A client/AR who chooses a ~~family member~~Family Member as a care provider, shall document the choice on the ~~Attendant Support Services management plan~~ASMP.